WASHINGTON PARK
CHIROPRACTIC

heal thrive evolve

1313 S. Clarkson St. Unit 1, Denver, CO 80210 P: 303-744-7100 F: 303-744-7109 washparkchiro.com

Thank you for choosing Washington Park Chiropractic. Please complete this confidential patient form.

Patient Information

Date_____

Name _____ Date of Birth _____
Address _____
City _____ State _____ Zip _____ Gender _____
Preferred Phone _____ Email Address _____
Emergency Contact _____ *Relationship* _____ *Phone* _____
Who may we thank for referring you to our office? _____

Financial and Insurance Information

Insurance Carrier _____ Do you have a health savings account? ❒ Yes ❒ No
Insurance ID# _____ Are you eligible for Medicare (over age 65) ❒ Yes ❒ No

Employment Information

Employer_____ Occupation _____
Hours of computer use daily? _____ Right or Left Handed? _____ Hours worked each week?_____
Hours driving daily? _____ Hours on your feet daily?_____
Describe a typical work day _____

Reason For Today's Visit

Please Rank your health concerns and rate their severity (on a scale from 1-10, 10 being the worst)

1 _____
2 _____
3 _____
4 _____

Please list conditions you have been diagnosed with or are currently being treated for and the treating practitioner: _____
_____

Is today's visit due to a car accident? ❒ Yes ❒ No If yes, date of accident _____
Please list all car accidents by year _____

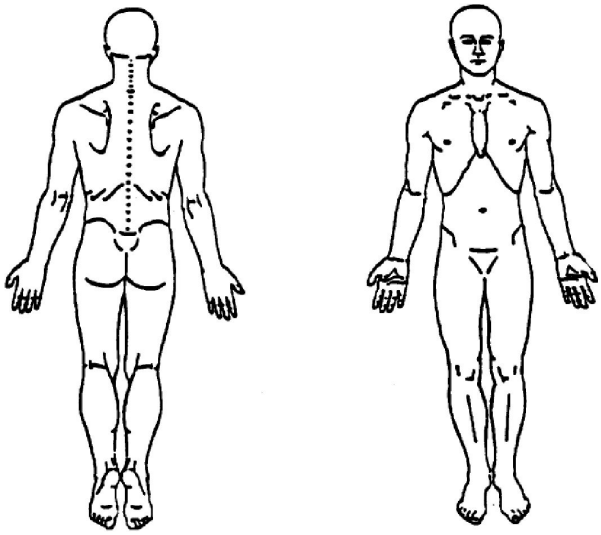
Is today's visit due to an accident at work? ❒ Yes ❒ No If yes, date of accident _____

Please list all fractures and dislocations and year _____
_____
List all prior surgeries, hospitalizations and year _____
_____
Please list all allergies _____
Please list all medications and supplements you are currently taking _____

Chiropractic Intake

Current Symptoms

On the diagram to the right please mark all areas where you are currently having pain or other symptoms. Please also indicate where your pain travels (if appropriate).



Relating to your area of concern:

1. Please circle your current level of pain (1 2 3 4 5 6 7 8 9 10)

2. How long has this been going on? _____

3.What is the cause of the current symptom? _____
_____

4. Have you been treated by any other health care professional? □Medical Doctor □Dentist □Massage □Acupuncture □Chiropractic □Other _____ Name/Facility_____
_____

5.What makes it feel worse? _____
_____

6. What makes it feel better? _____
_____

7. Is it worse during a certain time of day? _____

8. Have you had this before? _____

9. What does it feel like (pain, etc) _____

Have you ever seen a chiropractor before? (Circle) Yes No Clinic or Doctor Name _____
When was your last adjustment? _____
Why did you discontinue care or change doctors? _____

Lifestyle

Hours of sleep each night ❒0-2 ❒ 3-5 ❒6-8 ❒9+ **What position do you sleep in?** ❒ Back ❒ Side ❒ Stomach ❒ Varies
Sports played ❒Golf ❒Snow Ski ❒Snowboard ❒ Crossfit ❒Tennis ❒Yoga ❒Running ❒Walking ❒Volleyball ❒Swimming ❒Basketball ❒Hockey ❒Cycling ❒Marathon ❒Triathlon ❒Hiking ❒Other _____

What gym do you work out at? _____

How much alcohol do you consume weekly?

Do you smoke? ❒ Yes ❒ No **How much per day**? _____ _____

How much coffee/tea/caffeine do you consume daily? _____

Daily water intake: ❒When I'm thirsty ❒2-4 glasses ❒5-8 glasses ❒9-12 glasses ❒Constantly, I'm always thirsty

Women's Health

Are you Pregnant? ❒ Yes ❒ No Number of Pregnancies _____ Number of vaginal births _____ Cesareans _____

Names and Ages of Kids:

Review of Systems Please check any symptom or condition that you either have **Now** or in the **Past**:

General
(Now / Past)
❒ ❒ Weight loss
❒ ❒ Weight gain

Head
❒ ❒ Headache
❒ ❒ Dizziness
❒ ❒ Head trauma
❒ ❒ Fainting
❒ ❒ Concussion

Eyes
❒ ❒ Changes in vision
❒ ❒ Light sensitivity
❒ ❒ Spots in vision

Mouth
❒ ❒ Jaw Pain
❒ ❒ Bleeding gums
❒ ❒ Dentures

Lungs
(Now / Past)
❒ ❒ Difficulty breathing
❒ ❒ Asthma
❒ ❒ Persistent cough
❒ ❒ Coughing blood

Vascular
❒ ❒ Chest pain
❒ ❒ Palpitations
❒ ❒ Ankle swelling
❒ ❒ Cold feet/ hands
❒ ❒ Leg cramps
❒ ❒ Calf pain
❒ ❒ Varicose veins
❒ ❒ Low blood pressure
❒ ❒ High blood pressure

Skin
(Now / Past)
❒ ❒ Rash
❒ ❒ Easy bruising
❒ ❒ Itching/peeling
❒ ❒ Changes in moles

G-I System
❒ ❒ Heartburn
❒ ❒ Indigestion
❒ ❒ Ulcers
❒ ❒ Vomiting/Nausea
❒ ❒ Abdominal pain
❒ ❒ Persistent diarrhea
❒ ❒ Constipation
❒ ❒ Blood in stool
❒ ❒ Hemorrhoids

G-U system
❒ ❒ Difficulty urinating
❒ ❒ Pain urinating

(Now / Past)
❒ ❒ Blood in urine
❒ ❒ Incontinence
❒ ❒ Increase in urination

Nose
❒ ❒ Nosebleeds
❒ ❒ Sinus problems

Neurologic
❒ ❒ Seizures/epilepsy
❒ ❒ Stroke/TIA
❒ ❒ Tingling
❒ ❒ Numbness
❒ ❒ Weakness
❒ ❒ Difficulty walking
❒ ❒ Poor coordination

Muscle/Bone
❒ ❒ Joint pain
❒ ❒ Stiffness
❒ ❒ Muscle ache
❒ ❒ Bone pain

Conditions
(Now / Past)
❒ ❒ Anemia
❒ ❒ Osteopenia
❒ ❒ Osteoporosis
❒ ❒ Arthritis
❒ ❒ Cataracts
❒ ❒ Glaucoma
❒ ❒ Tuberculosis
❒ ❒ Gallbladder disease
❒ ❒ Liver disease
❒ ❒ Urinary infection
❒ ❒ Pneumonia
❒ ❒ Thyroid condition
❒ ❒ ADHD
❒ ❒ Anxiety
❒ ❒ Depression
❒ ❒ Multiple sclerosis
❒ ❒ Parkinson's disease
❒ ❒ Gout
❒ ❒ High Cholesterol
❒ ❒ Cancer

Family History: Please list if a parent or sibling has a history of the following:
Cancer _____
Heart Disease
_____
Hypertension _____
Diabetes_____
Auto-Immune Diseases _____
Epilepsy _____
Arthritis _____

Additional Information / Questions
Are there any specific questions about your condition or chiropractic that you want the doctor to address at today's visit?

_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic care to third party payers and or health practitioners. I authorize and request my insurance company to pay directly to Washington Park Chiropractic insurance benefits that are otherwise payable to me. I understand that my chiropractic insurance carrier may cover only a portion of or not cover all of the services rendered.

I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

X _____ _____
Signature of Patient (or guardian if minor) **Date**

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FINANCIAL POLICY

Insurance:

Washington Park Chiropractic is an out-of-network provider with all health insurance companies. It is your responsibility to verify if you have benefits for out-of-network chiropractic before your first appointment. Washington Park Chiropractic can also check your benefits prior to or the day of your visit. All patient responsible payment is due at the time of service.

If you receive services from an out-of-network provider or facility or agency, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance please contact the billing department.

No-Show/Cancellation:

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible, please observe our cancellation policy for chiropractic, massage, and acupuncture appointments.

We require a minimum 24-hour notice to cancel or reschedule massage, acupuncture, and new patient chiropractic appointments. We also require at least 2 hours notice for regular chiropractic appointments.

Fees:

Chiropractic: no-shows/late cancels will be billed $25 for the first missed appointment and full price for subsequent missed appointments.

Massage/Acupuncture: no-shows/late cancels will be billed for half of the price of the appointment for the first miss and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Packages:

All packages/ pre-payments expire after 3 years. They are non-refundable. Packages may be shared between family members.

Please check the box if you agree to share your packages with family members:
▢ YES ▢ NO

_____ _____
Patient's Signature Date

_____
Patient's Name (print)