5280 CHIROPRACTIC

535 16th Street Mall, Suite 200
Denver, CO 80202
303-371-5280 Fax: 303-623-0446

Name _____ Date _____ SSN_____

Address _____ City / Zip Code _____

Employer _____ Occupation _____ Work Phone _____

DOB _____ Age _____ Sex - M / F E-mail _____ Cell Phone _____
(Please Print Clearly)

How did you hear about **5280 Chiropractic**? _____

HEALTH HISTORY

Are you taking any of the following medications?

❑ Nerve Pills ❑ Pain Killers (including aspirin) ❑ Insulin ❑ Other(s) _____
❑ Blood Thinners ❑ Muscle Relaxers ❑ Other(s)_____ ❑ Other(s) _____

Do you have, or have you ever had, any of the following diseases or conditions?

❑ Heart Attack / Stroke
❑ Congenital Heart Defect
❑ Heart Surgery / Pacemaker
❑ Mitral Valve Prolapse
❑ High / Low Blood Pressure
❑ Artificial Bones / Joints
❑ Diabetes / Tuberculosis
❑ Emphysema / Glaucoma
❑ Fainting / Seizures / Epilepsy
❑ Loss of Memory
❑ Loss of Balance
❑ Dizziness
❑ Heart Murmur
❑ Artificial Valves
❑ Hepatitis
❑ HIV / Aids
❑ Cancer
❑ Chemotherapy
❑ Shingles
❑ Ulcers / Colitis
❑ Asthma
❑ Sinus Problems
❑ Anemia
❑ Arthritis
❑ Alcohol / Drug Abuse
❑ Fatigue
❑ Sleeping Problems
❑ Kidney Problems
❑ Difficulty Breathing
❑ Psychiatric Problems

Please list any other serious medical condition(s) you have, or ever had: _____

List previous surgeries with dates: _____

Have you ever been treated by a Chiropractor? ❑ No ❑ Yes If so, whom? _____

Do you take Supplements or Vitamins? ❑ Yes ❑ No Do you smoke? ❑ No ❑ Yes / How much? _____How long?_____

Do you exercise? ❑ Yes ❑ No Are you wearing: ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Arch Supports
What is the age of your mattress? _____ Is it comfortable? ❑ Yes ❑ No

For Women Only:
Are you taking birth control? ❑ Yes ❑ No Are you pregnant? ❑ No ❑ Yes / How long? _____ Nursing? ❑ Yes ❑ No

People choose chiropractic care for a number of reasons. Please check the type of care you desire:
❑ Temporary Relief ❑ Lasting Correction ❑ Check here if you would like the Doctor to decide the best type of care for you.

Please share with us any specific benefits / goals you expect to gain from chiropractic care:_____

_____

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with the appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain).

If you don't have any symptoms and are here for Wellness Care, check here. ❑

Description
Symbol

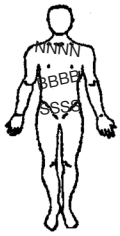
Numbness
NNNN

Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

Stabbing
SSSS

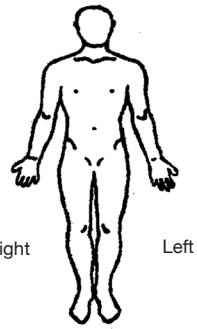


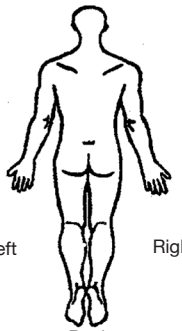
Example

"The doctor of the future will interest patients in the care of the human frame."
Thomas Edison

Circle any area of pain not represented by a symbol.


Right


Right Left
Front


Left Right
Back


Left

We're glad that you have chosen Dr. Kroese for your health care needs. The best health care services are based on mutual understanding, so we encourage you to discuss any questions or concerns with us. We are here to provide you with full-service, conservative health care, in a partnership with you.

5280 Chiropractic

Consent for Purposes of Treatment & Healthcare Operations

In this document, "I" and "my" refer to the patient

I consent to the use or disclosure of my protected health information by 5280 Chiropractic for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that analysis, diagnosis or treatment of me by 5280 Chiropractic may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. 5280 Chiropractic is not required to agree to the restrictions that I may request. However, if 5280 Chiropractic agrees to a restriction that I request, the restriction is binding on 5280 Chiropractic. I have the right to revoke this consent, in writing, at any time, except to the extent that 5280 Chiropractic has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I may obtain a copy of the Notice of Privacy Practices of 5280 Chiropractic and understand that I have a right to read the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of 5280 Chiropractic. This Notice of Privacy Practices also describes my rights and duties of 5280 Chiropractic with respect to my protected health information.

5280 Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of 5280 Chiropractic and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment. Our office sends thank you cards for referrals, sends periodic newsletters, posts names on a referral board, and participates in other non-private contact. If you prefer not to participate in this, please let 5280 Chiropractic know.

_____	_____
Signature of Patient or Personal Representative	Printed Name of Patient
_____	_____
Date of Signing	Description of Personal Representative's Authority