

# Spine Spot Chiropractic

341 Market St  
Basalt, CO 81621  
970-924-1015

Date \_\_\_\_\_

Referred by \_\_\_\_\_

First Name \_\_\_\_\_

Last Name \_\_\_\_\_

Nick Name or Preferred Name \_\_\_\_\_

Sex  Male  Female

Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age \_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Cell Phone Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_

E-Mail Address \_\_\_\_\_

Employer \_\_\_\_\_

Occupation \_\_\_\_\_

## CANCELLATION POLICY

We require 24 hours' notice to cancel an appointment. Failure to show up for a scheduled appointment or cancel an appointment with less than 24 hours' notice, will result in a charge of \$140 for a new patient appointment or \$85 for an existing patient appointment.

I have read the cancellation policy for Spine Spot Chiropractic, and agree to the terms stated above.

**PATIENT'S SIGNATURE** \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

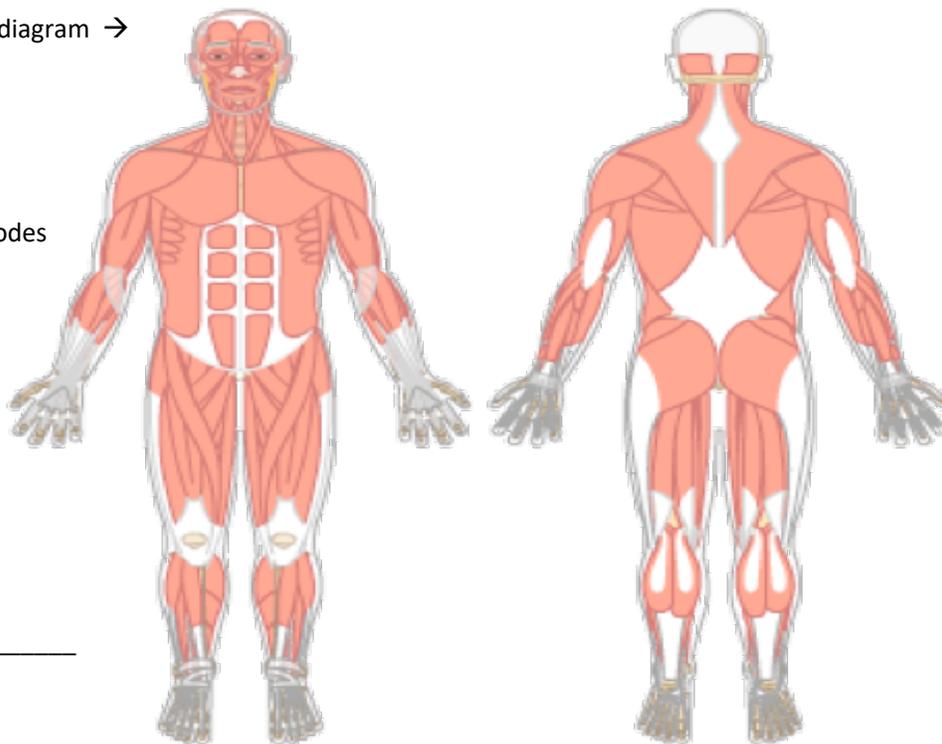
**PATIENT'S PRINTED NAME** \_\_\_\_\_

Be sure to list **all** conditions or symptoms, **Both past, and present.**

1. What are you being **seen** for today, mark on the diagram →

What kind of pain are you experiencing?

- Aching
- Burning
- Constant dull with frequent sharp episodes
- Constand dull achy with occasional sharp episodes
- Dull achy pain
- Numbness
- Paresthesia
- Sharp shooting pain
- Sharp stabbing pain
- Soreness
- Spasm
- Stiffness
- Tenderness
- Tightness
- Tingling
- Other \_\_\_\_\_



Rate the intensity of pain

( 0 1 2 3 4 5 6 7 8 9 10 )

Mark on the **diagram** above where you are having **pain**

2. Have you had any **X-rays, MRI, CT scans**, or other **diagnostic imaging** taken?  NO  YES if yes please list below:  
 X-Ray  MRI  CT scan  CAT scan  Nerve conduction study  Other \_\_\_\_\_

3. Are you currently taking any **prescription** medications or **Non-prescription** medications?  NO  YES  
 Please list all current medications below:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_,  
 \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

4. Are you taking any **vitamins/herbs/supplements**?  NO  YES Please list below:

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

5. Do you have any known **allergies**?  NO  YES Please list below:

Environmental: \_\_\_\_\_ Reaction(s): \_\_\_\_\_  
 Food(s): \_\_\_\_\_ Reaction(s): \_\_\_\_\_  
 Medication(s): \_\_\_\_\_ Reaction(s): \_\_\_\_\_

6. List all **surgeries** you have had (ie appendix, tonsils, C-Section, wisdom teeth, Spinal fusions, Disc surgery Etc ...)

Surgery: \_\_\_\_\_ Date \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Date \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Date \_\_\_\_\_  
 Surgery: \_\_\_\_\_ Date \_\_\_\_\_

7. Have you ever been **hospitalized** for any reason other than surgeries listed above?  NO  YES Please list below:

Hospital name: \_\_\_\_\_ Date \_\_\_\_\_ Reason for stay: \_\_\_\_\_  
 Hospital name: \_\_\_\_\_ Date \_\_\_\_\_ Reason for stay: \_\_\_\_\_

8. List any **diseases or illnesses** which you have had in the past, including child diseases (chicken pox, measles, flu ect.). list below:

\_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

9. Have you been diagnosed or treated for any **major illness** (COPD, Diabetes, AIDS/HIV, Cancer, etc.). list below:

\_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

10. Have you suffered from any physical **injuries** such as falls, blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones etc.  NO  YES

Please list below:

\_\_\_\_\_ , \_\_\_\_\_ , \_\_\_\_\_

11. List any new or recent **immunizations or vaccinations** received

Vaccine \_\_\_\_\_ Date \_\_\_\_\_ Flu shot \_\_\_\_\_ Date \_\_\_\_\_  
 Vaccine \_\_\_\_\_ Date \_\_\_\_\_ Other \_\_\_\_\_ Date \_\_\_\_\_

12. **Diseases** that run in the **family** both living and deceased (arthritis, heart disease, cancer, diabetes, osteoporosis etc ...)

Unknown family history *M – Maternal (mother’s side)* *P – Paternal (father’s side)*

Father: _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Mother: _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Brother(s): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Brother(s): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Sister(s): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Sister(s): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Grandfather (M): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Grandmother (M): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Grandfather (P): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____
Grandmother (P): _____	Deceased <input type="checkbox"/> NO <input type="checkbox"/> YES (age) _____	Cause _____

13. Current **marital status**:  Single  engaged  Married  Separated  Divorced  widowed  complicated

14. How often do you **exercise**?  None  1-2 days a week  2-3 days a week  3-4 days a week  <5 days a week

15. Do you **currently** smoke or use tobacco/nicotine products (dip, chew, cigarettes, cigars, Vapor, gum)?  NO  YES

16. Have you **ever** smoked/dipped/chewed/vaped in the past?  NO  YES

17. Do you drink or use **caffeine**?

- None
- <3 cups /servings per day
- 3-6 cups/servings per day
- >6 cups/servings per day

18. Do you drink **alcohol**?

- None
- casual drinker
- moderate drinker
- heavy drinker

19. What do you **currently** do for a living?

- student
- work Physical demands at work?  Heavy  Moderate  Light
- retired What did you do before retirement? \_\_\_\_\_
- other: \_\_\_\_\_

## Review of systems

20. **Constitutional** -Do you have any: fevers, chills, fatigue, **night sweats**, out of country **travel** and recent weight change recently?  
 NO  YES If yes please explain \_\_\_\_\_
21. **Allergies/Immunology** -Do you have any Allergies/Immunology problems such as: **recurrent infections**, HIV/AIDS, recent vaccinations?  
 NO  YES If yes please explain \_\_\_\_\_
22. **Neurological** -Do you have Neurological problems or issues such as: any **changes in bowel** or **bladder**, dizziness, fainting, numbness, tingling, tremors, **seizures**, weakness?  
 NO  YES If yes please explain \_\_\_\_\_
23. **Gastrointestinal** -Do you have any stomach or bowel problems such as: constipation, diarrhea, **hepatitis**, blood loss and peptic ulcer disease, change in **stool color**?  
 NO  YES If yes please explain \_\_\_\_\_
24. **Respiratory** -Do you have any breathing problems such as: **wheezing**, cough and spitting of blood?  
 NO  YES If yes please explain \_\_\_\_\_
25. **Eyes** -Do you have any problems with your eyes such as: blurry vision, cataracts, double vision, eye pain, **eyeglasses** use, glaucoma, redness, vision loss, contacts, flashing light?  
 NO  YES If yes please explain \_\_\_\_\_
26. **Ears** -Do you have any ear problems such as: any discharge, **hearing impairment**, tinnitus, vertigo?  
 NO  YES If yes please explain \_\_\_\_\_
27. **Nose** -Do you have any nose or sinus problems such as: discharge, hay fever, nosebleeds, itching, stuffiness, **sinus pain**?  
 NO  YES If yes please explain \_\_\_\_\_
28. **Mouth** -Do you have any mouth problems such as: thrush, sore tongue, sore teeth, sore gums, **non-healing sores**, bleeding, dentures, dry mouth?  
 NO  YES If yes please explain \_\_\_\_\_
29. **Throat/Neck** -Do you have any neck or throat problems such as: lumps, **swollen glands**, pain, stiffness, non-healing sores, hoarseness, sore throat?  
 NO  YES If yes please explain \_\_\_\_\_
30. **Genitourinary** -Do you have any change in bowel and bladder function such as: **frequent urination**, dysuria, hematuria, history of stones, **incontinence**, or urgency?  
 NO  YES If yes please explain \_\_\_\_\_
31. **Psychological** -Do you have or experience any psychological problems such as: depression, nervousness, **stress** etc.?  
 NO  YES If yes please explain \_\_\_\_\_
32. **Integumentary** -Do you have a change in your skin hair or nails such as: any silvery plaques, butterfly rash, **red shin bumps**, itching, dryness, **hair** texture changes, lumps, **nail** texture changes, skin color changes?  
 NO  YES If yes please explain \_\_\_\_\_
33. **Cardiovascular** -Do you have any heart problems such as: any chest pain, palpitations, **swelling of legs**, chest tightness, chest discomfort, difficulty breathing, **calf pain when walking**, shortness of breath?  
 NO  YES If yes please explain \_\_\_\_\_
34. **Hematological/Lymphatic** -Do you have any blood or lymph problems such as: any anemia and past transfusion, bleeding easily, **bruising easily**?  
 NO  YES If yes please explain \_\_\_\_\_
35. **Musculoskeletal** -Do you have any **muscle** or joint complaints such as: **muscle** pain, trauma, **joint** pain, stiffness, multiple ache/pain, fibromyalgia, **arthritis**, osteopenia, osteoporosis, Degenerative joint disease, **Disc problems**?  
 NO  YES If yes please explain \_\_\_\_\_
36. **Endocrine** -Do you have any change in: hot or cold intolerance, **increased thirst**, sweats, frequent urination, **change in appetite**, diabetes, change in hair or skin?  
 NO  YES If yes please explain \_\_\_\_\_

Females only section

- 1. Any **menstrual problems** (menopause, painful cycle etc)?  
 NO  YES
- 2. Have you ever taken **birth control**?  
 NO  YES
- 3. Is there a chance you may be **currently pregnant**?  
 NO  YES
- 4. Do you have any breast problems?  
 NO  YES
- 5. Any thickening/**lump** in the **breast** tissue?  
 NO  YES
- 6. Have you ever had an **epidural**?  
 NO  YES

Male only section

- 1. Any **change in urination**, frequency, or urgency?  
 NO  YES
- 2. Do you have increasing **Erectile Dysfunction** problems?  
 NO  YES
- 3. Any thickening/**lump** in the breasts or **testicles**?  
 NO  YES
- 4. Have you any **blood** or discharge in your **urine**?  
 NO  YES

- 37. Are you **losing weight** without trying?  NO  YES If yes please explain \_\_\_\_\_
- 38. Have you had any **change** in bowel or bladder functions (**loss of control**)?  
 NO  YES If yes please explain \_\_\_\_\_
- 39. Do you have **sores** that **won't heal**?  
 NO  YES If yes please explain \_\_\_\_\_
- 40. Do you have any **unusual bleeding** or discharge?  
 NO  YES If yes please explain \_\_\_\_\_
- 41. Any change in the **color** of your stool/bowel movements (**black and foul smelling, gray in color**)?  
 NO  YES If yes please explain \_\_\_\_\_
- 42. Have you had any obvious change in a **wort** or **mole**?  
 NO  YES If yes please explain \_\_\_\_\_
- 43. Have you had any **new** skin changes or **rashes** appear?  
 NO  YES If yes please explain \_\_\_\_\_
- 44. Do you have an **ongoing** nagging **cough** or hoarseness?  
 NO  YES If yes please explain \_\_\_\_\_

45. In the space below, please explain or give any **additional** details regarding the information you have given above. Also, if there is any information about your **health history** that was not requested.

Please fill in below. \_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Payments and SuperBills

**TIME OF SERVICE FEE** shall be paid by cash or card at the time of treatment. This price reflects our savings on bookkeeping and billing service fees.

New Patient Examination	\$ 140
Standard Office Visit	\$ 85
Extended Office visit	\$ 110
Physiotherapies	\$ 30
Pediatrics Standard Office Visit	\$ 55
New Patient Pediatrics Examination	\$ 120

**Pre-payment plans:**

Refresh	-	<b>4 Pack Punch Pass</b>	<b>\$295</b>	
			\$73 per visit (Saving \$45)	<u>One Year</u> Expiration Date
Altitude Armor	-	<b>24 Pack Punch Pass</b>	<b>\$1,320</b>	
			\$55 per visit (Saving \$720)	<u>NO</u> Expiration Date
Locals Special	-	<b>12 Pack Punch Pass</b>	<b>\$780</b>	
			\$65 Per visit (Saving \$240)	<u>Two Year</u> Expiration Date

**SuperBill** – Upon Request, we can provide you with a SuperBill to submit to insurance for reimbursement directly. We can also provide a SuperBill for Medicare patients to seek reimbursement directly.

PATIENT'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PATIENT'S PRINTED NAME \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

## ***Informed Consent to Chiropractic Treatment***

**The nature of chiropractic treatment:** The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel the movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, Cold laser, therapeutic ultrasound or dry hydrotherapy may also be used.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves, or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to the arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

**Probability of risks occurring:** The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

**Other treatment options which could be considered** may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to the stomach, liver, and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds the risk of exposure to virulent communicable diseases in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reactions to anesthesia, as well as an extended convalescent period in a significant number of cases.

**Risks of remaining untreated:** Delay of treatment allows the formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that a delay in treatment will complicate the condition and make future rehabilitation more difficult.

**Unusual risks:** I have had the following unusual risks of my case explained to me.

**I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have thoroughly evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.**

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Consent to evaluate and treat a minor I, \_\_\_\_\_ being the parent or legal guardian of \_\_\_\_\_ have read and fully understand the above-informed consent and hereby grant permission for my child to receive chiropractic care.

WITNESS: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name \_\_\_\_\_

Signature \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGMENT OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I am provided the opportunity to review a copy of the Notice of Privacy Practices, found on our website, [www.roaringforkchiropractor.com](http://www.roaringforkchiropractor.com), and that I have read it or declined the opportunity to read it, but I do understand that Spine Spot Chiropractic is bound by the Notice of Privacy Practices regarding my medical records.

I understand that this form will be placed in my patient chart and maintained for six years.

Date: \_\_\_\_\_

Patient name: \_\_\_\_\_  
(please print)

Patient signature: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_  
(if the patient is a minor)

\*\*\* If you would like a copy of the Notice of Privacy Practices for your own records,\*\*\*  
please let us know at the front desk and we will provide one for you.