Patient Information

Legal First Name: _____ MI: _____ Last Name: _____

Street: _____Apt: _____

City: _____ State: _____ Zip: _____

Social Security #:_____Marital Status: S M W D Spouse:--_____

Language: _____English _____ Spanish _____Other_____

Race: _____ White _____American Indian or Alaska Native _____ Asian _____
Native Hawaiian/Other Pacific Islander_____ Black or African American _____ Hispanic or Latino _____
Decline to Answer _____Other_____

Ethnicity: _____ Hispanic or Latino _____Not Hispanic or Latino _____ Decline to Answer

DOB: _____ Home Phone: _____ Work Phone:_____

Cell Phone: _____ Cell Carrier_____

Please check your contact preference: _____Home _____ Work _____ Cell _____Email _____ Postal Mail

Email hm: _____ Email wk: _____

Emergency Contact:_____ Phone Number: _____

Whom may we thank for referring you to our office? _____

Occupation: _____ Employer: _____

Employer Address: _____

Insurance Information

We will make a copy of your insurance card/s. However, please complete the following information.
Are you the policy holder? Y N If no, who is policy holder: Spouse Parent Employer Other

Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Do you have secondary insurance coverage? Y N If yes, please complete the following:
Policy Holder's Name:
First Name: _____ M.I. _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's SS#: _____

Policy Holder's Employer: _____

Patient Intake Form

Name:_____ Today's Date:_____

Height:_____ Weight:_____ Hand Dominance: Right/Left/Both

Blood Pressure:_____ Pulse:_____ *Radial/Carotid L/R*

Are you pregnant? Yes No If so how far along are you_____

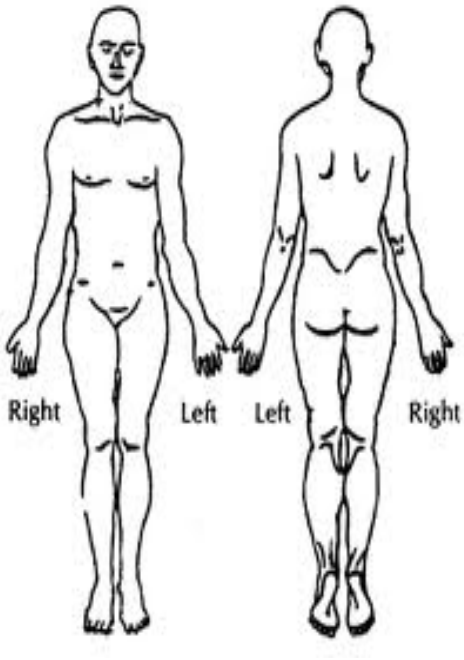
Chief Complaint

Problem that brings you to our facility:_____ Left side/Right side

How were you injured:_____

Previous Treatment for this problem:_____

Date of Injury/Onset:_____ Is this a work compensation injury? Yes/No



What is your pain on a scale of 0-10 (10 being the worst):
___/10 (best) ___/10 (worst)

Please Mark on Body where you problem is

Please Circle Appropirate Answer

Describe Pain:
Mild Moderate Severe

Dull Sharp Achy Throbbing Shooting Other:_____

How Often:
Constant Frequent Intermittent Occasional

When is it better or worse?

Worse: Morning Day Evening

Better: Morning Day Evening

What makes the pain better:_____

What makes the pain worse:_____

Any Muscle Weakness:_____

Any numbness or tingling:_____

General Medical History *Please circle appropriate answers*

Neurological

Stroke	Yes	No
Migraine	Yes	No
Concussion	Yes	No
Peripheral Neuropathy	Yes	No
Epilepsy	Yes	No

Cardiovascular

Heart Attack	Yes	No
High Blood Pressure	Yes	No
Coronary Artery Disease	Yes	No
High Cholesterol	Yes	No

Kidney

Renal Insufficiency	Yes	No
Kidney Stones	Yes	No
Frequent Urination	Yes	No
Infrequent Urination	Yes	No

Gastrointestinal

Ulcers	Yes	No
Reflux	Yes	No

Skin

Psoriasis	Yes	No
Eczema	Yes	No

Pulmonary

Asthma	Yes	No
Emphysema	Yes	No
COPD	Yes	No
Pulmonary Embolism	Yes	No

Infectious

HIV/AIDS	Yes	No
Hepatitis B	Yes	No
Hepatitis C	Yes	No
TB	Yes	No
MRSA (last 5 years)	Yes	No

Hematological

Bleeding Problems	Yes	No
Blood Clots	Yes	No
Concussion	Yes	No
Blood Transfusion	Yes	No
Anemia	Yes	No

Musculoskeletal

Osteoarthritis	Yes	No
Rheumatoid Arthritis	Yes	No
Fibromyalgia	Yes	No
Osteoporosis	Yes	No
Gout	Yes	No

Endocrine

Diabetes	Yes	No
Thyroid Disease	Yes	No
Prednisone Use	Yes	No

Psychological

Depression	Yes	No
Anxiety	Yes	No
ADHD	Yes	No
Bipolar	Yes	No
Claustrophobia	Yes	No

Problem not Listed

Explain:

Current Medications *I do not currently take any medications*:_____

	Medication	Reason for Medication	Date Started
1.			
2.			
3.			
4.			
5.			

Allergies

I do not have any allergies:_____

	Allergies	Reaction	Date
1.			
2.			
3.			
4.			
5.			

Previous Surgery/Hospitalizations

No past history of surgry/hospitalizations:_____

	Surgery/Reason for Hospitalization	Hospital/Facility	Date
1.			
2.			
3.			
4.			
5.			

Family History

Please list for immediate family (parents, grandparents, siblings, children)

Disease	**Yes**	**No**	**Relative**	**Age at Diagnosis**
High Blood Pressure				
Heart Disease				
Stroke				
Asthma				
Cancer (list relative and type)				
Other				

Social History

Smoking Status: *Please Circle and explain*

Never ***Current*** How Often:_____ ***Former Smoker*** How long ago_____

Alcohol Consumption: *Please Circle and explain*

None Casual Drinker Moderate Drinker Heavy Drinker

Type of Alcohol:_____

Caffeine Consumption: *Please Circle and explain*

None <3 drinks per day 3-6 drinks per day >6 drinks per day

Type of Caffeine:_____

Drug Use: *Please Circle and explain*

None Recreational User Addict Type of Drug:_____

Exercise: *Please Circle and explain*

Never Daily Weekly Type and Frequency:_____

Assignment & Release

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand tht this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this doctors office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees or outstanding balances for services I have received will be immediately due and payable.

Patients/Parent's/ Guardian's Signature:_____

Consent of Professional Services and Release of Information

I herby authorize and release the doctor and whomever he/she may designate as his/her assistants, to administer treatment, physical examination, x-ray studies, laboratory procedures, chiropractic care, massage therapy, or any clinic services that he/she deems necessary in my case; I furthermore authorize him/her to disclose all or any part of my patient record to any person or corporation which is or may be liable under a contract to this office or to the patient or to a family member or employer of the patient for all or part of the clinic's charge, including, and not limited to hospital or medical service companies, insurance companies, worker's compensation carriers, welfare funds, or the patiet's employer

Patients/Parent's/ Guardian's Signature:_____

Fruita Chiropractic and Massage

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

_____, hereby states that by signing this Consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning my home and leaving a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all *future* transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Name of Individual (Printed) Signature of Individual

_____ _____
Signature of Legal Representative Relationship
(e.g. attorney-in-fact, guardian, parent if minor)

_____ _____
Date signed Witness

This form was developed by the ACA (American Chiropractic Association and is distributed with their permission.

FRUITA Chiropractic & Massage

Cancellation Policy

At Fruita Chiropractic, we understand that unanticipated events occur in everyone's life. Unforeseen events such as flight delays, car problems, traffic considerations, business meetings, and project deadlines, are just a few reasons why one might consider canceling a appointment.
In our commitments to provide a unique and outstanding experience to all of our clients and out of consideration for our therapists' and doctors time, we have adopted the following policies:

ARRIVAL TO OUR PRACTICE

Please arrive for your appointment(s) 10 minutes prior to the scheduled starting time, this allows you the time to fill out the appropriate client form, change and prepare for the service. All services offered have a specific time schedule and early arrival allows for a relaxed and unhurried experience. If late arrival is inevitable, your service(s) may be shortened in order to keep on schedule.

CANCELLATION POLICY CHIROPRACTIC

We have a 24 hour cancellation policy. Full credit will be given For chiropractic if the appointment is cancelled or rescheduled 24 hours prior. No refund will be given for less than 24 hours cancellation notice as well as a **$25.00 fee** will be assessed. Consideration will be offered for emergencies or unforeseen events.

LATE ARRIVAL POLICY

As a courtesy to our other guests and staff, appointments will be automatically cancelled 20 minutes after scheduled start time and charged according to cancellation policy. We regret that late arrivals will not receive extension of scheduled appointments. In special cases, and when our schedule will allow, we may be able to accommodate a partial or full appointment; this will be at our discretion and only with proper, advanced notification of your late arrival.

Massage Appointments

Cancellation Policy & Fee:

Remember you need to arrive 15 minutes prior to your appointment time. Failure to do so may result in your massage time being reduced due to time spent on paperwork or set-up.
There is a **full price cancellation fee** Of Massage accessed to your account if you are a no-show or fail to cancel prior to 24 hours for any Massage appointment. Please note that appointment space is limited daily (first 10-20 patients depending) and we have a strict schedule that our therapists must stick to. This means if you are 15 minutes late your appointment will not be extended as our therapists are scheduled back-to-back based upon appointment time.

These policies were adopted to ensure that the therapists' time, the practice and its efforts be respected, as well as your scheduled service be a stress-free and relaxing experience

FRUITA Chiropractic & Massage

Cancellation Policy

I understand that I am asked to provide 24 hours notice if I need to cancel/reschedule my appointment, and that I may be charged the **$25.00 for Chiropractic or Full Fee for Massage** treatment scheduled, if I do not give sufficient notice.

Signature: _____

Date: _____