WELCOME!

PATIENT INFORMATION

Date _____

Patient Name _____

Address _____

City/State/ZIP _____

Sex ☐ M ☐ F Age _____ Birthdate _____

Patient SS# _____

Occupation _____

Employer _____

Employer Phone _____

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Cell _____

Home _____ Work _____ Ext.___

Best time and place to reach you _____

Email address: _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home phone _____ Work _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Type of accident: ☐ Auto ☐ Home ☐ Work ☐ Other

To whom have you made a report of your accident?

☐ Auto Ins. ☐ Employer ☐ Worker's comp ☐ Other

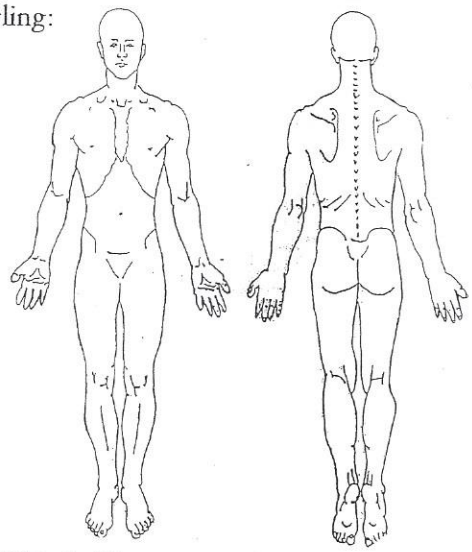
PATIENT CONDITION

Reason for visit _____

When did your symptoms appear? _____

Is condition getting progressively worse? ☐ Yes ☐ No

Mark an X on the picture where you continue to have pain, numbness, or tingling:



Type of pain: ☐ Sharp ☐Dull ☐Throbbing ☐Shooting
☐ Aching ☐ Burning ☐ Numbness ☐ Tingling
☐ Stiffness ☐ Swelling ☐ Cramps ☐ Other

How often do you have this pain? _____

The pain is ☐ constant ☐ comes and goes

Does it interfere with ☐ Work ☐ Daily routine
☐ Sleep ☐ Recreation

Activities or movements that are painful to perform:

☐Sitting☐Standing☐Walking☐Bending☐Lying Down

Have you ever had chiropractic care for other problems? ☐ No ☐ Yes When? _____

Do you take ☐ Muscle Relaxers ☐ Pain Killers ☐ Insulin ☐ Birth Control Pills ☐ Over-the-counter meds
☐ Other prescription drugs. Please list: _____

Sleep _____hrs/night Do you sleep on your ☐ Back ☐ Side ☐ Stomach Non-job exercise _____hrs/week

Age of mattress _____ or waterbed _____ Is your bed comfortable? ☐ No ☐ Yes

What kind of pillow do you use? ☐ Thick ☐ Medium ☐Thin ☐ None ☐ Support

Do you wear ☐ Heel lifts ☐ Shoe lifts ☐ Arch supports ☐ Orthotics, describe: _____

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for this condition: _____

Date of last: Physical Exam _____ Spinal XRay _____ Blood Test _____

Spinal Exam _____ Chest XRay _____ Urine Test _____

Dental XRay _____ MRI, CT-Scan, Bone Scan _____

Please mark "Yes" or "No" to indicate if you have had any of the following:

AIDA/HIV	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Multiple		Suicide Attempt	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Sclerosis	☐ Yes ☐ No	Thyroid Problem	☐ Yes ☐ No
Anorexia	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tumors,Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Parkinson's		Typhoid Fever	☐ Yes ☐ No
Bleeding		Hepatitis	☐ Yes ☐ No	Disease	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Disorders	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Vaaginal	
Breast Lump	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Infections	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Venereal	
Bulimia	☐ Yes ☐ No	High		Prostate		Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Cholesterol	☐ Yes ☐ No	Problem	☐ Yes ☐ No	Whooping	
Cataracts	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Cough	☐ Yes ☐ No
Chemical		Liver Disease	☐ Yes ☐ No	Pschiatric Care	☐ Yes ☐ No	Other _____	
Dependancy	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Rheumatoid			
Chicken Pox	☐ Yes ☐ No	Migraine		Arthritis	☐ Yes ☐ No		
Diabetes	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	RheumaticFever	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking — Packs/day _____
☐ Alcohol — Drinks/week _____
☐ Coffee/Caffeine drinks — Cups/day _____
☐ High Stress Level — Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date: _____

Have you experienced the following? Please describe: Date

☐ Falls _____ _____
☐ Head Injuries _____ _____
☐ Fractures/Dislocations _____ _____
☐ Surgeries _____ _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor responsible for any errors or omissions that I may have made in the completion of this form. Patient signature: _____ Date: _____

ALTERNATIVE HEALTH CLINIC, P.C.
Dr. Pamela L. Hart
5761 N. Orchard Creek Circle
Boulder, CO 80301

Automobile Accident History Form

Name:_____ Date:_____
Date of Accident:_____ Time:_____ AM / PM City:_____
Street of Accident:_____
Road Conditions at the time of the Accident: Dry / Wet / Icy / Other
Did the Police come to the Accident Scene? Yes / No
Were you taken to the Hospital? Yes / No
If Yes, Which Hospital_____
In What City_____
What part of the body did the Hospital X-ray?_____
_____
Have you lost any days of work due to the Accident? Yes / No
If Yes, you have been off work from:_____ to:_____

The following questions pertain to you, the patient, and the vehicle you were in:

1. Where were you seated in the vehicle?_____
2. Were you aware of the approaching collision prior to impact or did the impact catch you by surprise?_____
3. Did you lose consciousness (black out) upon impact?_____
   If Yes, estimate for how long?_____
4. How far is the top of the headrest or seatback from the top of your head?_____ (approximately) inches Above / Below.
5. Were you wearing a seatbelt? Yes / No
   If Yes, then was it Lap Seatbelt / Shoulder-Lap Seatbelt?
6. List the Year, Make, and Model of the vehicle you were in:
   Year_____ Make_____ Model_____
7. Was your vehicle stopped at the time of impact? Yes / No
   If Yes then was the driver's foot also on the brake? Yes / No
   If No then estimate the speed of the vehicle you were in:_____MPH
8. If your vehicle was moving at the time of impact, was it:
   Slowing Down / Gaining Speed / Steady Rate of Speed
9. What bleeding cuts did you get during the accident?_____
   _____
10. What bruises did you get during this accident?_____
    _____

11. On what part of the vehicle did the following body parts hit?
    Head _____
    Chest _____
    Right / Left Shoulder _____
    Right / Left Arm _____
    Right / Left Hip _____
    Right / Left Leg _____
    Right / Left Knee _____
    Other _____
12. What is the cost of damage to the vehicle you were in? _____
13. Which of the following car parts broke during the accident:
    Windshield / Front Seat Back / Side Window (Right / Left) /
    Steering Wheel / Other: _____
14. Was the trunk of your body pointed straight forward at the time of collision? Yes / No
    If No, which direction was it turned, and by how much? _____
    _____
15. Was your head pointed straight forward? Yes / No
    If No, which direction was it turned, and by how much? _____
    _____
16. Check the symptoms you have noticed since the accident:

Headache	Nervousness	Head Seems Too Heavy	Fainting
Neck Pain	Tension	Shortness of Breath	Chest Pain
Neck Stiffness	Irritability	Pins & Needles in Arms	Back Pain
Loss of Memory	Fatigue	Pins & Needles in Legs	Hands Cold
Loss of Balance	Depression	Numbness in Finger	Feet Cold
Loss of Smell	Face Flushed	Numbness in Toes	Fever
Loss of Taste	Ears Ring	Buzzing in Ears	Cold Sweat
Leg Pain	Stomach Upset	Problems Sleeping	Diarrhea
Knee Pain	Blurred Vision	Light Bothers Eyes	Constipation
Ankle Pain	Left Shoulder Pain	Right Shoulder Pain	

Other _____
_____
_____

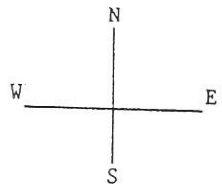
The following questions pertain to the other vehicle:

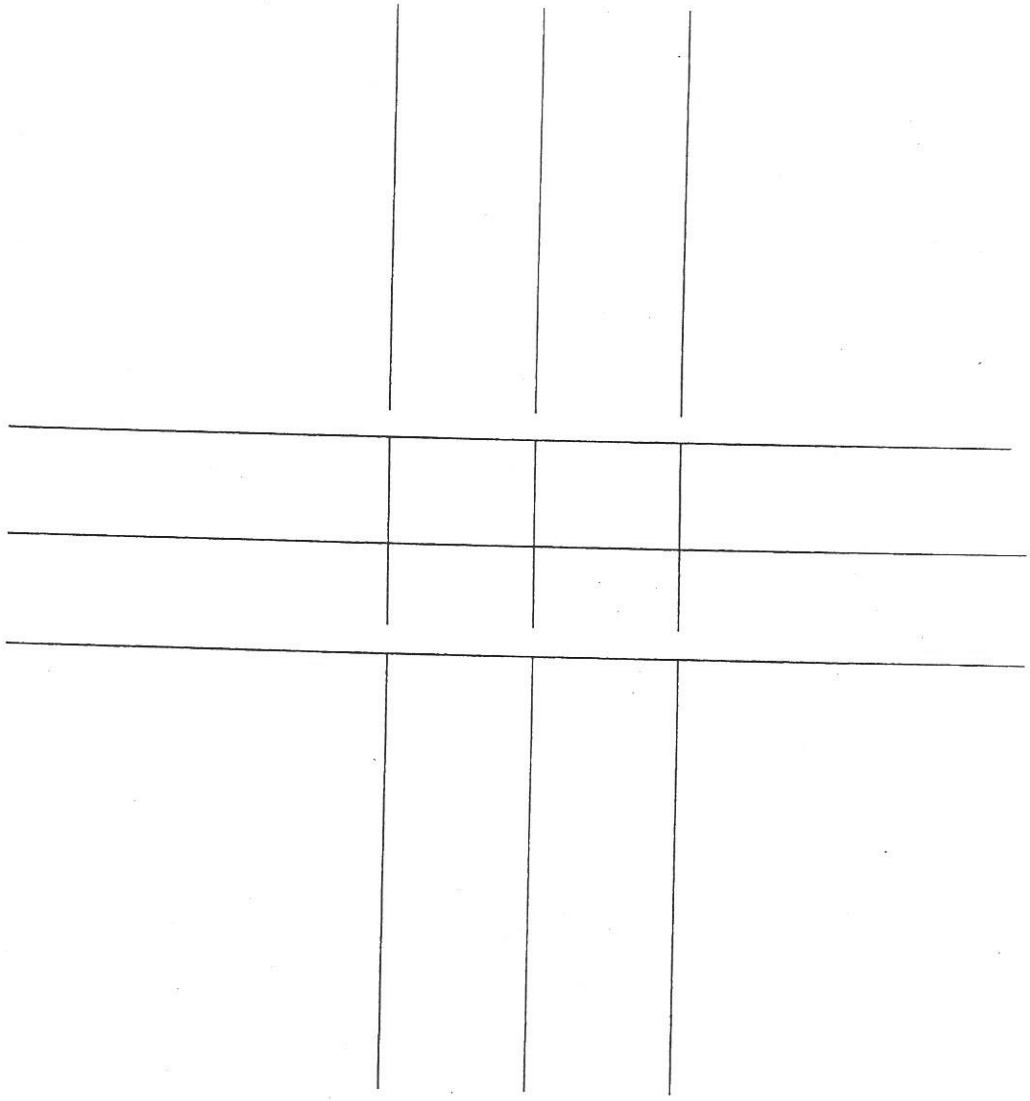
1. What is the Year, Make, and Model of the other vehicle?
   Year _____ Make _____ Model _____
2. Was the other vehicle moving at the time of collision? Yes / No
   If Yes, what was its approximate speed? _____ MPH
3. If the other vehicle was moving at the time of collision, was it:
   Slowing Down / Gaining Speed / Steady Rate of Speed

Name: _____ Date: _____

Please describe/illustrate, in your own words, how the accident occurred.

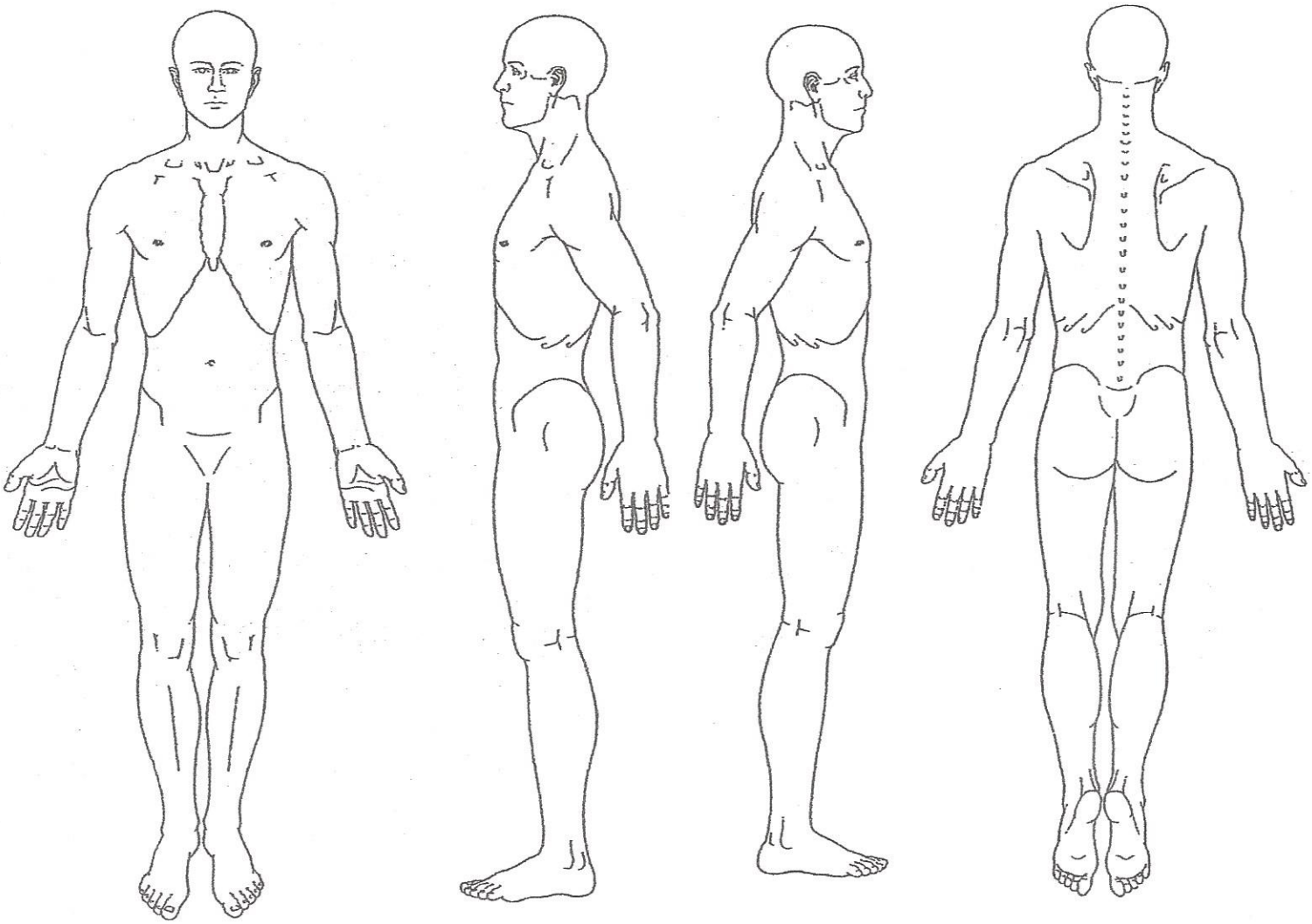
Draw Out How Your Accident Happened





PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE _____ DATE _____

ALTERNATIVE HEALTH CLINIC: FINANCIAL AND OFFICE POLICY

Thank you for choosing us as your health care provider. We are committed to bringing you the highest level of professional service. The following is our financial and office policy. By being clear now and taking care of administrative needs, we hope to avoid any unstated assumptions later on, which can interfere with the treatment process.

Since we offer a wide range of services, when scheduling an appointment, please request the type of service you desire so as to block off the appropriate amount of time: Nutrition only, Adjustment only, or both Nutrition and Adjustment. Each treatment is allotted a set of time and we wish to be respectful of your busy schedule and avoid wait times. If you think you will need more time than what is scheduled due to a sickness or new injury, please call ahead to let us know and we will do everything possible to address your needs.

CANCELLATION OF AN APPOINTMENT REQUIRES A 24-HOUR NOTIFICATION. For an appointment following a holiday or on a Monday, notice must be given on the last business day prior to the appointment. **I UNDERSTAND THAT ALL APPOINTMENTS CANCELLED LESS THAN 24-HOURS IN ADVANCE AND NO-SHOWS WILL BE CHARGED $90.**

FEES: Fees for exams and nutritional testing are based on time, anywhere from 5 minutes to 60 minutes. Each of the following services is charged at an hourly rate:

1) Oral or written reports
2) Phone consultations, phone calls made by you to the doctor or the doctor on your behalf
3) Faxing and copying information on your behalf
4) Reading/researching materials sent to the doctor for review
5) Any other services performed by the doctor on your behalf

Nutritional Supplements are not returnable. They are temperature sensitive and therefore the potency can be changed or altered if left in a hot/freezing car.
Parking: please park in our driveway. If your car has an oil leak, please park directly in front of the house on the same side.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that if the Doctor's office prepares any necessary reports and forms to assist me in making collection from the insurance company, that I will be charged appropriately, and that any amount authorized to be paid directly to the Doctor's office (such as auto accident insurance check) will be credited to my account on receipt.
Personal Injury Patients: Payment for your initial treatment(s) will be expected at the time of service. Once auto insurance coverage is verified, we will submit claims on your behalf. Upon completion of treatment or end of insurance benefits, any credit on your account will be reimbursed or added to any balance owed or continued maintenance care. You are responsible for all services not covered or paid on a claim submitted to the insurance company.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. PAYMENT IS DUE AT TIME SERVICE IS RENDERED UNLESS ARRANGEMENTS ARE MADE PRIOR TO APPOINTMENT DAY. We accept cash, checks, MC, Visa, American Express, and Discover cards. A charge of $22 will be added for any check returned by the bank as un-payable. All debt must be discharged before another appointment will be scheduled. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Any balance beyond 7 days is considered past due and subject to a billing fee of $5.00 per week to be added to my bill until my account is current.

I acknowledge that should I not pay this account, it will automatically be turned over to a collection agency 3 months from the due date. I will be liable for any collection fee charged by the agency plus any other collection costs and any reasonable attorney fees and court costs. Further, I understand that interest will be assessed at the rate of 18% per annum on all outstanding balances.

By signing this form, I acknowledge that I have read, understand and agree to the above policy.

Patient's Signature:_____ *Date:*_____
Person responsible for the service fees, please sign (Parent's signature if patient under 18 years old)

INSURANCE VERIFICATION FORM
FOR AUTO ACCIDENTS

INSURANCE PLAN: _____

INSURANCE COMPANY _____
BILLING ADDRESS _____
_____

PHONE (TOLL FREE) (800) _____ COLLECT [Y N] _____
PERSON TO CONTACT _____
POSITION _____
POLICY # _____ CLAIM # _____
EMPLOYER _____ PHONE _____
ADDRESS _____

PATIENT INFORMATION: _____

PATIENT'S NAME _____ SOC.SEC.# _____
INSURED'S NAME _____ SOC.SEC.# _____
INSURED'S ADDRESS _____

COVERAGE INFORMATION: _____

IS CHIROPRACTIC CARE COVERED? [Y N]
PERCENTAGE COVERED AFTER DEDUCTIBLE _____
ANY RESTRICTIONS ON SELECTION OF PROVIDER [Y N]

FORMS AND AUTHORIZED SIGNATURE: _____

DOCTOR'S ASSIGNMENT OF PAYMENT HONORED [Y N]
PAYMENTS SENT TO PROVIDER [Y N]
E.O.B. SENT TO PROVIDER [Y N]

THIS FORM FILLED OUT BY _____ DATE _____

Alternative Health Clinic, P.C.
5761 North Orchard Creek Circle
Boulder, CO 80301
303-527-2977

Notice of Privacy Practices - Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____
Patient or Legally Authorized Individual Signature Date

_____
Print Patient's Full Name

_____ _____
Witness Signature Date

This form will be retained in your medical record.

DR. PAMELA L. HART
Doctor of Chiropractic

Alternative Health Clinic ♥ 5761 N. Orchard Creek Circle, Boulder, CO 80301 ♥

☐ I HEREBY AUTHORIZE the attending Doctor to release any information concerning my examination or treatment.

PATIENT'S SIGNATURE _____ SOC. SEC. NUMBER _____

☐ I HEREBY ASSIGN PAYMENT directly to this office for professional services rendered and I shall be personally responsible for any unpaid balance to the Doctor.

INSURED SIGNATURE _____ SOC. SEC. NUMBER _____

(The above only applies to Auto/Work Comp. Insurance. This office does not accept major medical insurance.)

Insurance Company Name/Address:

_____

_____

_____

Employer's Name/Address: (If other than above)

_____

Policy Holder's Name: _____

Claim #: _____

Policy #: _____

Date First Consulted for this condition: _____

Patient's relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other _____

Patient's Date of Birth: _____

Was condition related to:

Patient's Employment ☐ YES ☐ NO

Auto Accident ☐ YES ☐ NO

Has Patient ever had same or similar symptoms: ☐ YES ☐ NO

Dates of Disability: From _____ Through _____

☐ Total ☐ Partial

Date Patient able to return to work: _____

DIAGNOSIS (ICD - 9CM) / REMARKS:

_____

_____

_____