

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

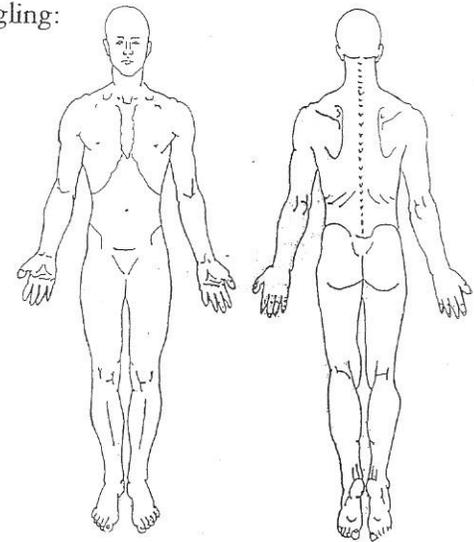
PATIENT CONDITION

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

EXERCISE

- None
 Moderate
 Daily
 Heavy

WORK ACTIVITY

- Sitting
 Standing
 Light Labor
 Heavy Labor

HABITS

- Smoking
 Alcohol
 Coffee/Caffeine drinks
 High Stress Level

Packs/day _____

Drinks/week _____

Cups/day _____

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 _____

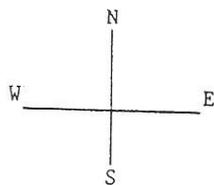
The following questions pertain to the other vehicle:

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: _____

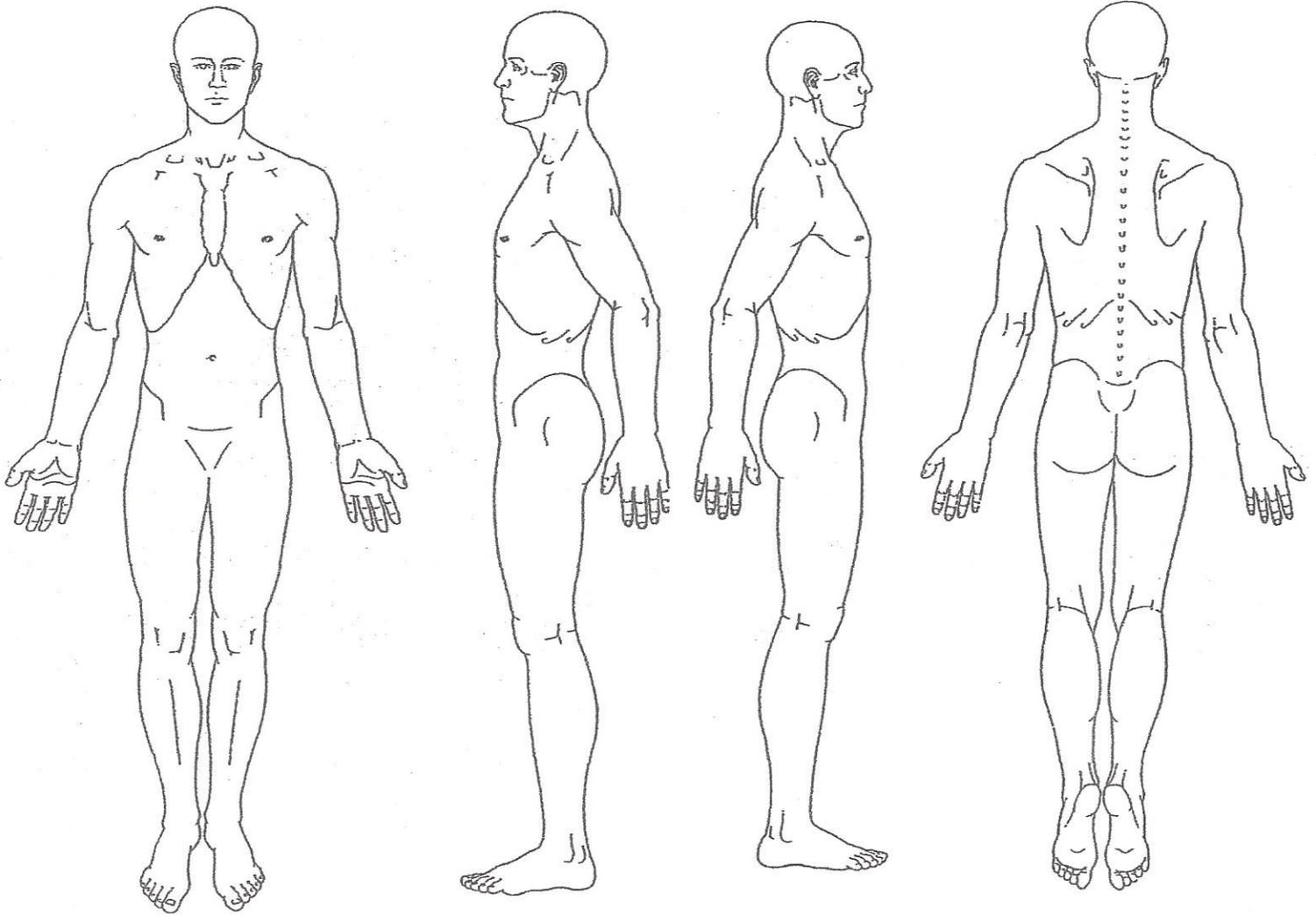
Please describe/illustrate, in your own words, how the accident occurred.

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 48-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 48-HOURS IN ADVANCE AND NO-SHOWS WILL BE CHARGED \$108.**

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 # _____

EMPLOYER _____ CLAIM # _____
ADDRESS _____ PHONE _____

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.



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: _____

