

W
E
L
C
O
M
E

Last Name: _____ First Name: _____

Home Address: _____
Street Address/P.O. Box City State Zip Code

Email address: _____ Who may we thank for referring you? _____

Home Phone #: _____ Cell phone #: _____ Occupation: _____

Work Status: Working without restrictions Working with restrictions Not working/off since _____

Work Phone #: _____ Primary Care Physician: _____

Number of hours sitting per day _____ Number of hours on your feet per day _____

Male Female Date of Birth ____/____/____ Age ____ Height ____ Weight ____ SS# _____

Dominant Hand: Right Left Both

Are we seeing you for an injury from:

Auto Sports Injury Work
 Other No injury

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____

Phone #: _____ Relationship: _____

INSURANCE INFORMATION:

Please bill: Auto Insurance Worker's Compensation Health Insurance Other I will be paying for the services myself OR

General Consent Form: The undersigned hereby consents to evaluation and treatment rendered by the licensed Doctors of Chiropractic in this office and their assistants according to the applicable standards of care. It is understood that options exist for treatment and that any/all treatments have risks and benefits. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts given, is in my best interest. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested by the doctor and that as a patient, I have a responsibility to ask any questions that I may have regarding treatment. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment. I understand that I have a responsibility to communicate honestly with the Doctors and to notify them of any changes to my health status. The information in my chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimal disclosure necessary as related to your care. Please see the Notice of Privacy Practices for more detailed information. By signing below, I consent to the treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Financial Awareness and Consent: I understand I am financially responsible, WHETHER OR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Vital Link Chiropractic of Fort Collins. I understand that all plans are different and I may have one or more of the following that I am responsible for: referral from PCP/ deductible/ co-pays/ percentage owed for each date of service. I understand that any accounts that are 90 days overdue are subject to collection proceedings, regardless of case type. Please be aware that a \$20.00 fee will be assessed for any check returned for non-sufficient funds.

*Payment for services is required at the time of service. Any balances left unpaid are subject to a \$10.00 billing fee and will incur an additional \$10.00 billing fee each time a balance is re-billed.

** If you have a deductible on your insurance plan, a minimum of \$57.00 is due at the time of service for each visit. Remaining charges applied to your deductible will be billed to you after it is processed by your insurance company.

'Payment at time of service' discount: I understand that I may pay for my treatment in full at the time of service and will receive any and all treatments for a \$48 flat rate (subject to change). This does not include exams and x-rays. If I choose to bill any insurance company, all services will be itemized and will exceed \$57. I also authorize Vital Link Chiropractic of Fort Collins to release any protected health information required to secure payment.

Release of Records: I authorize Vital Link Chiropractic of Fort Collins to release all health records necessary for my treatment and/or evaluation.

Cancellation policy: I understand that I will be responsible for an office visit of \$57 for failure to cancel or reschedule my appointment within 24 hours of my scheduled appointment. Payment will be required within 14 days of missed appointment.

Please be aware that any patients arriving late for their scheduled appointment may be required to wait until the next available opening or reschedule their appointment and thus will be subject to the above stated cancellation policy.

Patient's Signature: _____ Date: ____/____/____

Responsible Party's Signature (if patient is a minor): _____ Date: ____/____/____

What is your **major** complaint? _____

When did your condition develop? _____

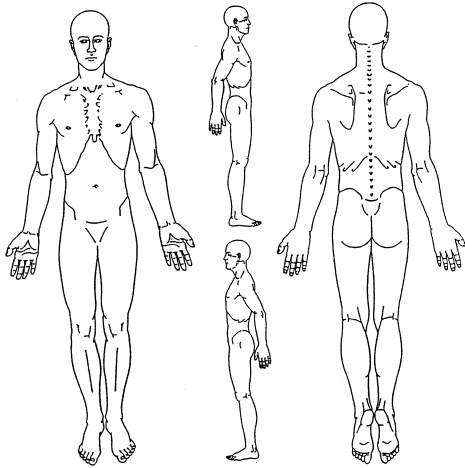
How did your condition develop? _____

Has your condition been getting better, worse or staying the same? _____

What makes your condition better? _____ What makes it worse? _____

Please mark on the diagram to explain and locate the areas of complaint.

A = ACHE	B = BURNING	C = STABBING
N = NUMBING	P = PINS & NEEDLES	O = OTHER



Do you currently or in the past have: Please mark all that apply,

Please mark all that apply:	When	# episodes
<input type="checkbox"/> Back pain or stiffness	_____	_____
<input type="checkbox"/> Neck pain or stiffness	_____	_____
<input type="checkbox"/> Shoulder pain	_____	_____
<input type="checkbox"/> Hip pain	_____	_____
<input type="checkbox"/> Foot pain or trouble	_____	_____
<input type="checkbox"/> Swollen or painful joints	_____	_____
<input type="checkbox"/> Cold hands or feet	_____	_____
<input type="checkbox"/> Numbness or pain in the arms, hands, or fingers	_____	_____
<input type="checkbox"/> Numbness or pain in the legs, feet, or toes	_____	_____

TESTS: Please list the MOST recent date:

Chest X-ray _____ EKG _____ Other X-ray _____ MRI/CT Scans _____

HABITS:

	YES	NO	If yes, please describe:
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Packs per day: 0 - 1/2 <input type="checkbox"/> 1/2 - 1 <input type="checkbox"/> 2 or more <input type="checkbox"/> Duration _____
Alcohol Consumption	<input type="checkbox"/>	<input type="checkbox"/>	# Drinks per day _____ Drinks per week _____
Coffee or Tea Consumption	<input type="checkbox"/>	<input type="checkbox"/>	Cups per day _____
Other Drug Use (Street Drugs)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Type _____

MEDICINES: Please list all currently used medicines. Include prescription and non-prescription drugs, vitamins, and herbs.

ALLERGIES: Please list all known allergies, especially to medicines. _____

Treatment you are receiving or have received:

- Medical Care Who is your Primary Care Physician? _____
- Chiropractic Care If yes, when and with whom? _____
- Other: (Please specify) _____

FEMALES ONLY: Do you have: Menstrual problems Breast lumps or pain Tubal Infections Problems getting pregnant

Are you currently or possibly pregnant? _____

MALES ONLY: Do you have: Changes in urine stream Prostrate trouble Lump in testicles

DOCTORS USE ONLY:

Left Eye: _____ Right Eye: _____ Corrected: Y / N BP: _____ Pulse: _____ Accom: L _____ R _____ Height: _____ Weight: _____

(Please be specific)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you currently or have you had:	Please mark all that apply.	
	Current	Past
Sleep Problems	<input type="checkbox"/>	<input type="checkbox"/>
Disabled	<input type="checkbox"/>	<input type="checkbox"/>
Nervous tension	<input type="checkbox"/>	<input type="checkbox"/>
Irritability	<input type="checkbox"/>	<input type="checkbox"/>
Mood Swings / changes	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently or have you had:	Please mark all that apply.	
	Current	Past
More frequent urination	<input type="checkbox"/>	<input type="checkbox"/>
Pain or blood with urination	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder infection	<input type="checkbox"/>	<input type="checkbox"/>
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing problems	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently or have you had:	Please mark all that apply.	
	Current	Past
Arthritis or gout	<input type="checkbox"/>	<input type="checkbox"/>
Bursitis	<input type="checkbox"/>	<input type="checkbox"/>
Fractured bones	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Tremor	<input type="checkbox"/>	<input type="checkbox"/>
Passing out	<input type="checkbox"/>	<input type="checkbox"/>
Speech problems	<input type="checkbox"/>	<input type="checkbox"/>
Trouble concentrating	<input type="checkbox"/>	<input type="checkbox"/>
Diarrhea or constipation	<input type="checkbox"/>	<input type="checkbox"/>

FAMILY HISTORY:

Please note any family history of any of the below Conditions and include relationship of relative to you.

- Cancer _____
- Diabetes _____
- Headaches _____
- High Blood Pressure _____
- Arthritis _____
- Epilepsy _____
- Heart Disease _____
- Stroke _____
- Spine or Back Disorder _____
- Multiple Sclerosis _____
- Psychological Problems _____

Do you currently or have you had:	Please mark all that apply:	
	Current	Past
History of trauma	<input type="checkbox"/>	<input type="checkbox"/>
Infection	<input type="checkbox"/>	<input type="checkbox"/>
Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
Unusual fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness / Poor balance	<input type="checkbox"/>	<input type="checkbox"/>
Vomited blood	<input type="checkbox"/>	<input type="checkbox"/>
Bloody or black stools	<input type="checkbox"/>	<input type="checkbox"/>
Change in appetite	<input type="checkbox"/>	<input type="checkbox"/>
Fevers	<input type="checkbox"/>	<input type="checkbox"/>
Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease or murmur	<input type="checkbox"/>	<input type="checkbox"/>
Loss of bowel or bladder control	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Muscle weakness or paralysis	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss	<input type="checkbox"/>	<input type="checkbox"/>
Severe trauma	<input type="checkbox"/>	<input type="checkbox"/>
Direct head trauma	<input type="checkbox"/>	<input type="checkbox"/>
Lost consciousness	<input type="checkbox"/>	<input type="checkbox"/>
Poor coordination	<input type="checkbox"/>	<input type="checkbox"/>
Night pain	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Recent infection	<input type="checkbox"/>	<input type="checkbox"/>
History of osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
History of cancer	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
Use of corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>
Use of anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>
Use of birth control pills	<input type="checkbox"/>	<input type="checkbox"/>
Numbness in groin (saddle anesthesia)	<input type="checkbox"/>	<input type="checkbox"/>
Loss of anal sphincter tone, fecal incontinence (bowel accidents)	<input type="checkbox"/>	<input type="checkbox"/>
Pain fails to improve with rest	<input type="checkbox"/>	<input type="checkbox"/>
Pain greater than 4 weeks	<input type="checkbox"/>	<input type="checkbox"/>
Prolonged use of corticosteroids	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous drug use	<input type="checkbox"/>	<input type="checkbox"/>

Do you currently or have you had:	Please mark all that apply.	
	Current	Past
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol or triglycerides	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid trouble	<input type="checkbox"/>	<input type="checkbox"/>
Liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or bruising tendency	<input type="checkbox"/>	<input type="checkbox"/>

Any other serious illnesses not mentioned here: _____