SPRINGS
CHIROPRACTIC HEALTH

Today's Date_____

Name _____ Birthdate _____ Age_____

Address _____

City _____State _____ Zip _____

Home Phone _____ Cell Phone _____

Significant Other's Name _____

Your Employer _____ Type of Work _____
***(if this is related to a work injury or motor vehicle injury we may need some additional paper work*).**
e-Mail Address _____
Have you been to a chiropractor before? □ No □ Yes
Emergency Contact _____ph# _____
Medical Doctor(s)_____

- **I authorize the Dr. Storey/Springs Chiropractic Health or his staff to render care as deemed appropriate for me and / or my child.**
- **I authorize Dr. Storey/Springs Chiropractic Health to release and / or request records to or from other providers as may be necessary.**
- **I understand I am responsible for all bills incurred in this office.**
- **I authorize assignment of my insurance benefits (if applicable) directly to the provider.**
- **Person responsible for this account if other than the patient?_____**
- **I understand that after any initial promotional services all care is rendered at usual and customary fees. Please give yourself the opportunity to follow up after an initial visit.**

_____ _____

Patient / Parent Signature **(This represents a long term authorization for all occasions of service)** **Date**

6645 Delmonico Dr. Suite 100
Colorado Springs, CO 80919
Office: 719-598-5000
www.springschirohealth.com

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General Health History

Patient Name_____ *Mark the conditions that only apply to you.*

Past	Present		Past	Present	
❑	❑	Headaches	❑	❑	Urinary Problems
❑	❑	Migraines	❑	❑	Easy Bruising
❑	❑	Shortness of Breath	❑	❑	Tobacco Use
❑	❑	Allergies / Asthma	❑	❑	Dental Problems
❑	❑	Medication Side Effects	❑	❑	Fibromyalgia
❑	❑	Diabetes	❑	❑	Blood Thinner use
❑	❑	Hands or Feet cold	❑	❑	HIV Positive
❑	❑	Muscle aches	❑	❑	Cancer
❑	❑	Trouble Walking	❑	❑	Depression
❑	❑	Leg / Foot Numbness	❑	❑	Alcohol Use
❑	❑	Fainting	❑	❑	___High or ___Low Blood Pressure
❑	❑	Gall Bladder Trouble	❑	❑	Stroke History
❑	❑	Ringing in Ears	❑	❑	High Cholesterol
❑	❑	Ear Problems	❑	❑	TMJ
❑	❑	Sleeping Problems	❑	❑	Digestive Problems
❑	❑	Vision Problems	❑	❑	Pain all Over
❑	❑	Thyroid Problems	❑	❑	Tension / Irritability
❑	❑	Liver Disease	❑	❑	Chest Pains
❑	❑	Kidney Problems	❑	❑	Heart Pacemaker
❑	❑	Light Bothers Eyes	❑	❑	Heart Problems
❑	❑	Other			

Past History

List any past auto collisions:_____ **Was any care received?**_____

5. List any past work injuries: _____ **Was any care received?**_____

6. List any past sport, recreational, or home injuries_____

7. Please describe any past conditions and treatment received:

_____

Family History:

Father's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Mother's side: □ Heart Disease □ Cancer □ Diabetes □ Heavy Medication use □ Arthritis □ Other_____

Is there any other family history you want us to know?_____

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On the diagram below Please mark or draw an X where your primary complaint is.

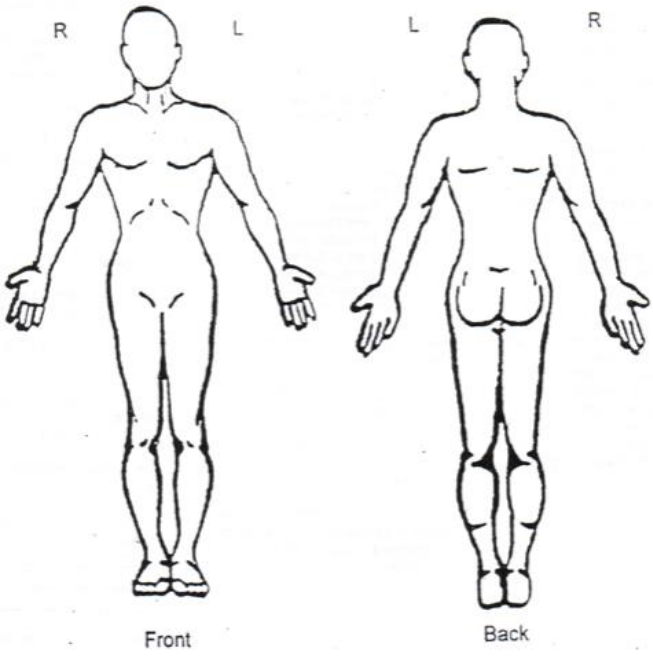
On a scale of 0-10 what are your discomfort levels? (0 no pain and 10 being extremely painful). _____ , Achy, Dull, Sharp, Numbness, Tingling.

Is the Pain; Constant 100%, Frequent 75-50% of the time, Intermitten 50-25%

How long has this been bother you? _____ days, months, years (circle one)

What makes this better? _____

What makes this worse? _____



Medical History: Surgeries ____ yes _____no What surgeries if any? _____

Are you taking any Medications: ____ yes _____no
List any medications you are taking:

_____

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Office Policy & Procedures

SPINAL CHECK-UP:

- We recommend everyone have their spine checked early for spinal problems. Prevention is the best medicine.
- Children especially to see if their spine is developing abnormally? A spinal check—up is easy and fun for kids.

WE ALSO OFFER:

- Supplements, ice packs, nutritional/exercise counseling,

AGREEMENTS FOR TOP RESULTS:

- **Remember it takes time and effort to improve your health. *No time + No effort = No results***

- **Please keep your appointments and make-up any missed or rescheduled visits within a day whenever possible.**

- **Please call if you are going to be late or need to reschedule.**

- **Feel welcome to refer your family and friends in for care. We are here to help them too.**

- **I agree to allow my/family name, photo, video, or testimonial to be used during the normal course of business.**

- **I understand that adjusting time is for adjustments and I can always talk to the Doctor by special appointment or phone call. He is here to help you any way he can. We want you to do great!** ☺

Patient initial:_____ Date _____

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Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: Dr. Storey is a musculoskeletal specialist. He is a Doctor of Chiropractic with a Master's Degree in Sports Rehabilitation. Dr. Storey will use his/her hands or a mechanical device in order to move your joints. He will also use some soft tissue work combined with an exercise or stretch. Dr. Storey's objective combined with your goals is to relieve your discomfort and keep you at a high functioning optimal level of health. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, dry needling, cupping, or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a 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 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".

Soft Tissue/Dry Needling Injury: In some cases of soft tissue and dry needling there can be bruising associated. Therapeutic soreness is most common in soft tissue and dry needling procedures. Typically, 24 hrs. of soreness is to be expected.

Risks of remaining untreated: Delay of treatment allows 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 delay of 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 fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

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PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have reviewed the privacy practice notice (4 pages) Springs Chiropractic Health and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my Application For Care) on my first visit, whenever that may have occurred.

I understand that this office will properly maintain my records and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient Signature Date

_____

Print the Patient Name

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