A BETTER BACK CLINIC

3600 S Wadsworth Blvd Lakewood, CO 80235
Office: (303) 985-0646 **Fax:** (303) 985-3834
www.abetterbackclinic.com

Patient Intake Form

Today's Date: ___ / ___ / ____

Full Name: _____

Preferred Name / Nickname: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: (____) ____ - _____ **Cell:** (____) ____ - _____ **Work:** (____) ____ - _____

Email: _____

What is the best number to contact you? ◯ Home ◯ Cell ◉ Work

Occupation:_____ **Employer:** _____

Social Security #: _____-_____-_____ **Date of Birth:** ___ / ___ / ____

Age: _____ **Sex:** ◯ M ◉ F

Marital Status:
◯ Single ◯ Married ◯ Partnered ◯ Widowed ◯ Separated ◯ Divorced

Spouse / Partner Name: _____

Spouse / Partner Occupation: _____

Do you have children? ◯ Yes ◯ No **If yes, how many?** _____

Reason for Office Visit: ◯ Auto Accident ◯ Injury/Accident ◯ Other

If other, please explain: _____
_____

Date problem began? ___ / ___ / ____

Gradual onset or is the problem old/recurring? ◯ Gradual ◯ Old/Recurring

Health Practitioners you sought out for current or any other health concern:
◯ Chiropractor ◯ Massage Therapist ◯ Acupuncturist ◯ Physical Therapist
◯ Other: _____

Primary Care Physician: _____

Office Address: _____ **Office Phone:** (____) ____ - _____

PREVIOUS CHIROPRACTIC CARE

Have you been treated by a chiropractor before? ◯ Yes ◯ No

If yes, what chiropractor? _____

Date of Last Adjustment: ___ / ___ / ____

Frequency of Care: ____ x / ◯ week ◯ month

Duration of Care: ____ ◯ week(s) ◯ month(s) ◯ year(s)

Why did you not return to that chiropractor? _____

_____

GENERAL HEALTH QUESTIONS

List Approximate Date of Last:

Blood Test: ___ / ___ / ____ Hospitalization: ___ / ___ / ____

Physical: ___ / ___ / ____ X-Ray: ___ / ___ / ____

Daily Fluid Intake:

Alcohol: ___ ounce(s) / day Coffee: ___ cup(s) / day

Soda: ___ ounce(s) / day Water: ___ ounce(s) / day

Sleep / Rest Habits:

Hours of Sleep: ___ / night Mattress Age: ___ year(s) Pillow Age: ___ year(s)

What position do you sleep in? ◯ Side ◯ Back ◯ Stomach

How many pillows? ◯ 1 ◯ 2 ◯ 3+ **Pillow Type:** ◯ Soft ◯ Firm ◯ Orthopedic

Not including work responsibilities, what are your exercise habits?

___ x per week ___% Aerobic ___ % Weights

List Recreational / Relaxation Activities: _____
_____
_____

Smoke tobacco? ◯ No ◯ Yes
If yes, how many packs per week? _____

Smoke / consume marijuana? ◯ No ◯ Yes
If yes, for? ◯ Social ◯ Pain control ◯ Health issue

Do you use prescription, over the counter, or recreational drugs / medications?
◯ No ◯ Yes
If yes, please list: _____
_____
_____

Any injuries or accidents that stand out in your life? ◯ No ◯ Yes
If yes, please list: _____
_____
_____

Any known disorders?
◯ Diabetes ◯ Heart ◯ Stroke ◯ Cancer ◯ Lung ◯ Kidney ◯ Other
If other, please list: _____

Any previous surgeries? ◯ Yes ◯ No
If yes, please list what type / area and approximate year or your age:
_____
_____

Stress can contribute to any symptom along with poor health and diminished quality of life. Please rate your overall perceived level of stress.

Low Stress ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 High Stress

Select Symptoms / Conditions that you Currently or Occasionally Experience:

- ☐ Headaches/Migraines
- ☐ Neck Pain
- ☐ On Top of Shoulder Pain
- ☐ Mid Back Pain
- ☐ Along Shoulder Blades
- ☐ Low Back Pain
- ☐ Sacral-Iliac Pain
- ☐ Hip Pain
- ☐ Leg/Sciatica Pain
- ☐ Numbness Leg/Foot
- ☐ Numbness Arm/Hand
- ☐ Other
- ☐ In Shoulder Pain
- ☐ Upper Arm Pain
- ☐ Elbow Pain
- ☐ Forearm Pain
- ☐ Wrist/Carpal Tunnel
- ☐ Hand/Finger Pain
- ☐ Knee Pain
- ☐ Lower Leg Pain
- ☐ Foot/Ankle Pain
- ☐ Toe Pain
- ☐ Problem Sleeping
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Chest/Rib Pain
- ☐ Allergies
- ☐ Dizziness/Vertigo
- ☐ Ringing in Ear(s)
- ☐ Loss of Balance
- ☐ High Blood Pressure
- ☐ Digestive Problems
- ☐ Menstrual Pain
- ☐ Depression

If other, please list: _____

Please tell us more about each of the primary symptoms / conditions you listed.

Concern 1

Please list Concern 1: _____

Start date or length of time you have had concern 1? _____

Last time / day you felt concern 1? _____

What best describes how Concern 1 feels or the type of pain?

◯ Sharp ◯ Achy ◯ Burning ◯ Tingling ◯ Numb ◯ Other

Rate concern 1 on the following scale. Most of the time, discomfort felt is:

(None) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Hospital)

Concern 2

Please ist Concern 2: _____

Start date or length of time you have had concern 2? _____

Last time / day you felt concern 2? _____

What best describes how Concern 2 feels or the type of pain?

◯ Sharp ◯ Achy ◯ Burning ◯ Tingling ◯ Numb ◯ Other

Rate concern 2 on the following scale. Most of the time, discomfort felt is:

(None) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Hospital)

Concern 3

Please list Concern 3: _____

Start date or length of time you have had concern 3? _____

Last time / day you felt concern 3? _____

What best describes how Concern 3 feels or the type of pain?

◯ Sharp ◯ Achy ◯ Burning ◯ Tingling ◯ Numb ◯ Other

Rate concern 3 on the following scale. Most of the time, discomfort felt is:

(None) ◯ 0 ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7 ◯ 8 ◯ 9 ◯ 10 (Hospital)

Payment Information

◯ **Self-Pay (do not have health insurance coverage)**

◉ **Bill My Insurance**

***Primary Insurance Name:** _____

*You must provide a current insurance card in order for insurance to be verified and/or billed.

As a courtesy, Complete Care Health Services will verify benefit coverage and bill your primary/secondary insurance. However, we will not be able to process your insurance claims unless all information has been provided by you, the patient. If all information is not provided you will be responsible for the remaining balance.

Again, we will assist you in obtaining payment from your insurance carrier, the responsibility for payment of all bills in connection with this clinic lies with the patient.

Payment is expected at the time of service, all Deductibles, Co-insurance, and copays will be collected in full.

Assignment of Benefits and Release of Related Medical Records**

Consent to Treatment or Testing with Liability Release:
**You authorize Complete Care Health Services (CCHS), its authorized subsidiaries and technicians to administer treatment and/or testing. Furthermore, while the chance of injury is slim, you agree to hold CCHS and its staff without fault for any injuries that may occur during the procedures or advice you have had done for you. Special note to patients with breast augmentation, although rare there may be risk of implant rupture - Please advise your Chiropractic Physician before any manipulation procedures.

Verification of Non-Pregnancy:
**You attest, to the best of your knowledge, that you are not pregnant, nor is the pregnancy suspected or confirmed at this particular time. If you think you might be pregnant, please advise your physician.

Release of Patient Records:
**You authorize CCHS to furnish your insurance carrier, attorney, and/or referring physician with documentation / reports relating to your case history, examination, diagnosis, treatment, and prognosis. This release of records is pursuant to only the representative above, and only for the accident/illness for which you are being treated. Furthermore, CCHS has the right to release any and all records required for remuneration purposes. Fees relating to such records are the patient's responsibility.

Missed Appointment Notice:
If you cannot make an appointment and need to cancel, we require **24 hours advance notice. Should we not receive such notice a **$50.00** no show fee will be assessed to your account. This is a non-reimbursable fee that your insurance carrier does not pay and is your sole responsibility.

Returned Checks:
All returned or unpaid checks will have a **$45.00 returned check fee assessed to your account.

Verification of Information:
**Any information asked of me is / will be accurately given. I understand that providing incorrect information can be dangerous to my health. I authorize CCHS to release any said information, including the diagnosis, the records of any treatment and/or examination rendered to me during my care, to a third party payer and/or healthcare practitioners.

I also authorize payment to be made directly to CCHS and the amount due for all service charges for myself or my eligible dependents. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for all services rendered on my behalf or my dependents. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibilities of the person(s), including parent or legal guardian, named on the account.

I certify that I have read and understand the above information to the best of my knowledge.

Patient Name

Print: _____

_____ Date: ___ / ___ / _____
Signature

Parent / Legal Guardian Name

Print: _____

_____ Date: ___ / ___ / _____
Signature of Parent / Legal Guardian

I grant permission for my child to receive any care including consent to evaluate and treat the minor and/or child.