

LIVE WELL CHIROPRACTIC CLINIC, LLC

3900 S. Wadsworth Blvd, Suite 400

Lakewood CO 80235 (303)934-3753

Today's Date _____

Name _____ Date of Birth _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____

Email Address _____

Employer _____

Employer Address _____

City _____ State _____ Zip Code _____

Occupation _____ Describe your daily activities _____

Spouse or Significant Other's Name _____ Phone Number _____

In Case of Emergency Contact _____ Phone Number _____

Relationship _____

Who referred you to the office? _____

Have you received chiropractic care before? _____ When? _____

Is this injury work related? _____ Reported to our employer? _____

Is this injury related to an automotive accident? _____

HEALTH INSURANCE (Please allow us to take a copy of your insurance card)

Name of Primary Insured _____

Primary Insured's Date of Birth _____ Relationship _____

Name of Insurance Company _____

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Patient Name _____ Date _____

Height _____ Weight _____ Hand dominance (circle one): Right/Left/Ambidextrous

How much change are you willing to make at this time to improve your health?

_____ 25% _____ 50% _____ 75% _____ 100%

What are your most pressing health problems? Please list in order of concern. (Low back pain, diet/nutrition, hypertension, overall fitness, diabetes, etc.)

1. _____ 3. _____

2. _____ 4. _____

Who is your Primary Care Physician? _____

Do you have any allergies? _____

Please list hospitalizations and surgeries _____

Please list any medications or supplements you are currently taking _____

Do you use tobacco? Never/Rarely/Social/Daily Do you drink alcohol? Never/Rarely/Social/Daily

Do you get regular exercise? Yes/No How many days a week? _____ For how long? _____

How much water do you consume on a daily basis? _____

How much coffee, tea and soft drinks do you consume on a daily basis? _____

How many hours of sleep do you get a night? _____

Do you consume 4-6 servings of fruits and vegetables a day? _____

Please rate your stress levels as it pertains to work, family life, etc. (1=low stress/1=high stress) _____

Do you have a family history of cancer, cardiovascular disease, arthritis, diabetes? Please list any condition that applies. _____

Do you have or have you had a change in: (please circle all that apply)

Vertigo Blurred vision Numbness Slurred Speech Loss of Consciousness Loss of Bowel/Bladder Control

Headaches Night Sweats Double Vision Nausea/Vomiting Ringing in Ears Cough up blood/Blood in stool

Would you be interested in a complete nutritional evaluation and treatment plan? Yes__ No__

Would you be interested in being fitted for a pair of custom-made orthotics? Yes __ No __

PATIENT HEALTH QUESTIONNAIRE - PHQ

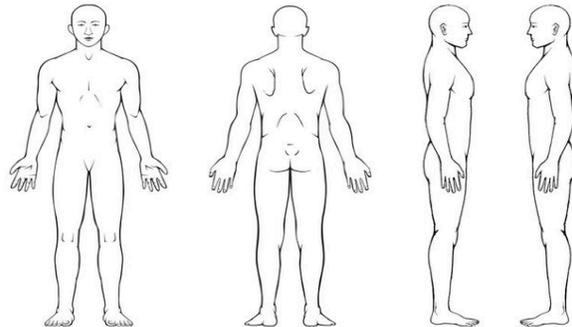
Patient Name _____ Date _____

1. Describe your symptoms _____

- a. When did your symptoms start? _____
- b. How did your symptoms begin? _____

2. How often do you experience our symptoms? Indicate where you have pain or other symptoms

- 1. Constantly (76-100% of the day)
- 2. Frequently (51-75% of the day)
- 3. Occasionally (26-50% of the day)
- 4. Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- Sharp
- Dull Ache
- Numb
- Shooting
- Burning
- Tingling

4. How are your symptoms changing?

- 1. Getting better
- 2. Not changing
- 3. Getting worse

5. During the past 4 weeks:

- a. Indicate the average intensity of your symptoms None 0 1 2 3 4 5 6 7 8 9 10 Unbearable
- b. How much has pain interfered with your normal work (including both work outside the home, and housework)
Not at all A little bit Moderately Quite a bit Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

- 1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

7. In general would you say your overall health right now is.....

- 1. Excellent 2. Very Good 3. Good 4. Fair 5. Poor

8. Who have you seen for your symptoms? 1. No one 2. Other chiropractor 3. Medical Doctor 4. Physical Therapist 5. Other

- a. What treatment did you receive and when? _____
- b. What tests have you had for your symptoms and when were they performed?
1. X Rays Date: _____ 3. CT scan Date: _____
2. MRI Date: _____ 4. Other Date: _____

9. Have you had similar symptoms in the past? 1. Yes 2. No

- a. If you have received treatment in the past for the same or similar symptoms, who did you see?
1. This Office 3. Medical doctor 5. Other
2. Other chiropractor 4. Physical Therapist

10. What is your occupation? _____

- 1. Professional/Executive
- 2. White collar/Secretarial
- 3. Tradesperson
- 4. Laborer
- 5. Homemaker
- 6. Full time Student
- 7. Retired
- 8. Other

- a. If you are not retired, a homemaker, or a Student, what is your current worth status?
*Full-time *Self employed *Off work
*Part-time *Unemployed *Other

Patient Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Dr. Amy Vermilyea, D.C. uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws), for administrative purposes, and to evaluate the quality of care that you receive.

Dr. Amy Vermilyea, D. C. will not disclose your information to provide appointment reminders information about treatment alternatives or other health-related issues.

Dr. Amy Vermilyea, D.C. may disclose your information for public health activities, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to the Privacy Officer, Dr. Amy Vermilyea, D.C. and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Dr. Amy Vermilyea, D.C. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of this notice, notify you if it was unable to agree to the requested restriction on your your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints, please contact Dr. Amy Vermilyea, D.C. at 303-934-3753.

Patient Signature

Date

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AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the health care staff to perform the necessary services I need.

Specific Risks Possibilities with Chiropractic Care:

Soreness - Chiropractic adjustments and physical therapy procedures are sometimes accompanied by post-treatment soreness. This is a normal and acceptable accompanying response to chiropractic care and physical therapy. While it is generally not dangerous, please advise your doctor if you experience soreness or discomfort.

Soft tissue injury - Occasionally chiropractic treatment may aggravate a disc injury, or cause other minor joint, ligament, tendon or other soft tissue injury.

Rib Injury - Manual adjustments to the thoracic region, in rare cases, may cause rib injury or fracture. Precautions, such as x-rays, are taken for cases considered at risk. Treatment is performed carefully to minimize risk.

Physical Therapy Burns - heat generated by physical therapy modalities may cause minor burns to the skin. These are rare, but if it occurs, please report it to your doctor.

Stroke - Stroke is the most serious complication of chiropractic treatment. Studies estimate the incident of this type of injury is 1 in every 3 million upper cervical adjustments, (Journal of the CAA, Vol.37 No.2, June 1993).

If you have any questions on this form, please ask your doctor.

I hereby give my informed consent to have chiropractic treatment administered.

Signature of Patient (Parent or Guardian if a Minor) _____

Print Name

Date

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Responsibility for Payment of Fees

Payment to be made to Dr. Amy Vermilyea, D.C.

I further understand and agree that I am directly and fully responsible to pay for all professional services and/or products provided to me and/or my dependents.

I further understand and agree that such payment is not contingent upon any settlement, claim, judgment or verdict by which I may eventually recover said fee.

I also agree to pay all reasonable costs of collection, attorney fees and interest at the ANNUAL PERCENTAGE RATE of 21% (1.75% per month) on any PAST DUE BALANCE (over 60 days old).

Patient/Guardian

Relationship to Patient

Date

AUTHORIZATION TO TREAT A MINOR

I, _____ authorize Dr. Amy Vermilyea, D.C., Dr. Jim Wood, D.C. to perform diagnostic tests and render chiropractic adjustments and other treatment to my son/daughter and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

DATE

SIGNATURE

PRINTED NAME

RELATIONSHIP TO PATIENT