Kiviok Hight, DC

CORTEZ CHIROPRACTIC

112 W. Montezuma Ave. Cortez CO 81321
Phone: 970-564-9515

**Patient Name:**_____ **Date:**_____

Address_____City_____ State _____ Zip Code _____

H. Phone _____W. Phone_____ Cell Phone _____

Email Address: _____ Social Security #_____

Emergency Contact: _____ Phone Number:_____

Sex: M F Marital Status: M S D W Date of Birth_____ Age_____

Height_____ Weight_____

Insurance Information _____ Insurance ID# _____

Occupation_____

Employer_____

Have you ever received Chiropractic Care? Yes No If yes, when? _____
Name of most recent Chiropractor: _____

1. **Reasons for seeking chiropractic care:**

Primary reason:

_____

Secondary reason:

_____

2. **Previous interventions, treatments, medications, surgery, or care you've sought for your complaint(s):**

_____
_____
_____

3. **Past Health History:**

   A. **Please indicate if you have a history of any of the following:**
   ☐ Anticoagulant use ☐ Heart problems/high blood pressure/chest pain ☐ Bleeding problems
   ☐ Lung problems/shortness of breath ☐ Cancer ☐ Diabetes ☐ Psychiatric disorders
   ☐ Bipolar disorder ☐ Major depression ☐ Schizophrenia ☐ Stroke/TIA's ☐ Other _____
   ☐ None of the above

**B. Previous Injury or Trauma:**

_____

**Have you ever broken any bones? Which?**

_____

**C. Allergies:**

_____

**D. Medications:**

Medication Reason for taking

_____

_____

**E. Surgeries:**

Date Type of Surgery

_____

_____

**F. Females/ Pregnancies and outcomes:**

Pregnancies/Date of Delivery Outcome

_____

_____

**2. Family Health History:**

Do you have a family history of? (Please indicate all that apply)

☐ Cancer ☐ Strokes/TIA's ☐ Headaches ☐ Cardiac disease ☐ Neurological diseases
☐ Adopted/Unknown ☐ Cardiac disease below age 40 ☐ Psychiatric disease ☐ Diabetes
☐ Other _____ ☐ None of the above

Deaths in immediate family: _____

Cause of parents or siblings death Age at death

_____

_____

**Social and Occupational History:**

**A. Job description:**

_____

**B. Work schedule:**

_____

**C. Recreational activities:**

_____

**D. Lifestyle (hobbies, level of exercise, alcohol, tobacco and drug use, diet):**

_____

**Review of Systems**

Have you had any of the following **pulmonary (lung-related)** issues?
□ Asthma/difficulty breathing □ COPD □ Emphysema □ Other _____ □ None of the above

Have you had any of the following **cardiovascular (heart-related)** issues or procedures?
□ Heart surgeries □ Congestive heart failure □ Murmurs or valvular disease □ Heart attacks/MIs □ Heart disease/problems □ Hypertension □ Pacemaker □ Angina/chest pain □ Irregular heartbeat □ Other _____ □ None of the above

Have you had any of the following **neurological (nerve-related)** issues?
□ Visual changes/loss of vision □ One-sided weakness of face or body □ History of seizures □ One-sided decreased feeling in the face or body □ Headaches □ Memory loss □ Tremors □ Vertigo □ Loss of sense of smell □ Strokes/TIAs □ Other _____ □ None of the above

Have you had any of the following **endocrine (glandular/hormonal)** related issues or procedures?
□ Thyroid disease □ Hormone replacement therapy □ Injectable steroid replacements □ Diabetes □ Other _____ □ None of the above

Have you had any of the following **renal (kidney-related)** issues or procedures?
□ Renal calculi/stones □ Hematuria (blood in the urine) □ Incontinence (can't control) □ Bladder Infections □ Difficulty urinating □ Kidney disease □ Dialysis □ Other _____ □ None of the above

Have you had any of the following **gastroenterological (stomach-related)** issues?
□ Nausea □ Difficulty swallowing □ Ulcerative disease □ Frequent abdominal pain □ Hiatal hernia □ Constipation □ Pancreatic disease □ Irritable bowel/colitis □ Hepatitis or liver disease □ Bloody or black tarry stools □ Vomiting blood □ Bowel incontinence □ Gastroesophageal reflux/heartburn □ Other _____ □ None of the above

Have you had any of the following **hematological (blood-related)** issues?
□ Anemia □ Regular anti-inflammatory use (Motrin/Ibuprofen/Naproxen/Naprosyn/Aleve) □ HIV positive □ Abnormal bleeding/bruising □ Sickle-cell anemia □ Enlarged lymph nodes □ Hemophilia □ Hypercoagulation or deep venous thrombosis/history of blood clots □ Anticoagulant therapy □ Regular aspirin use □ Other _____ □ None of the above

Have you had any of the following **dermatological (skin-related)** issues?
□ Significant burns □ Significant rashes □ Skin grafts □ Psoriatic disorders □ Other _____ □ None of the above

Have you had any of the following **musculoskeletal (bone/muscle-related)** issues?
□ Rheumatoid arthritis □ Gout □ Osteoarthritis □ Broken bones □ Spinal fracture □ Spinal surgery □ Joint surgery □ Arthritis (unknown type) □ Scoliosis □ Metal implants □ Other _____ □ None of the above

Have you had any of the following **psychological** issues?
□ Psychiatric diagnosis □ Depression □ Suicidal ideations □ Bipolar disorder □ Homicidal ideations □ Schizophrenia □ Psychiatric hospitalizations □ Other _____ □ None of the above

Is there anything else in your past medical history that you feel is important to your care here? _____

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of Chiropractic to provide me with chiropractic care, in accordance with this state's statutes. If my insurance will be billed, I authorize payment of medical benefits to **Cortez Chiropractic** for services performed.

Patient or Guardian Signature _____

Date_____

# HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

**Use and Disclosures of Protected Health Information:**
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations:** We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

**NEW PATIENT HISTORY FORM**

***Please start at the top of your body and work your way down, i.e. Headache, Neck Pain, etc.***

Symptom 1 _____

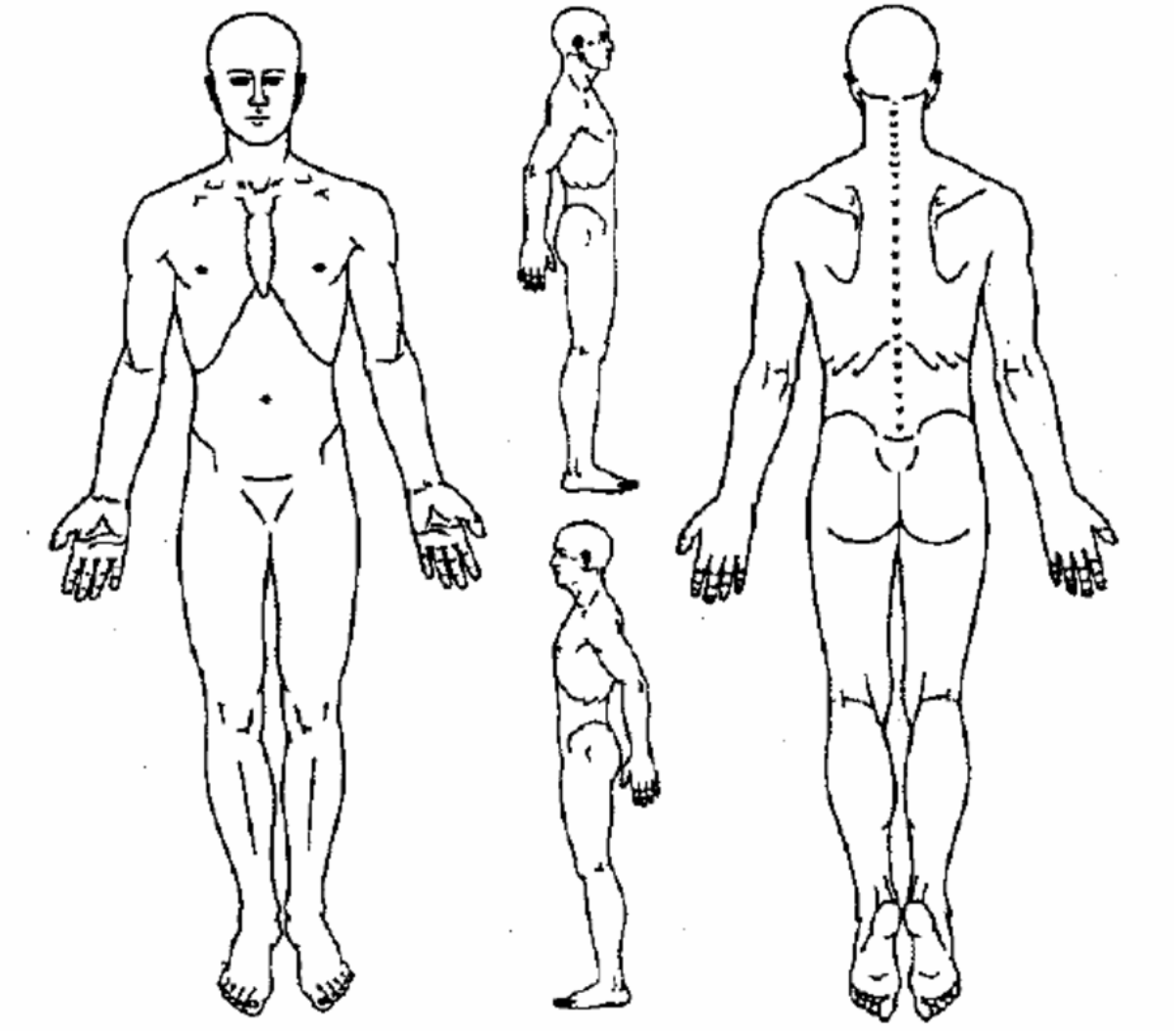
- On a scale from 0-10, with 10 being the worst, check the number that best describes the symptom most of the time:
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100
- When did the symptom begin? _____
  - Did the symptom begin ☐ suddenly or ☐ gradually?
  - How did the symptom begin? _____
- What makes the symptom worse? (Check all that Apply):
  ☐ Bending neck forward ☐ Tilting head left ☐ Tilting head right ☐ Turning head left ☐ Turning head right
  ☐ Bending neck backward ☐ Bending forward ☐ bending back ☐ Lifting ☐ Sitting ☐ Getting up from sitting
  ☐ Driving ☐ Walking ☐ Running ☐ Nothing ☐ Any Movement Other _____
- What makes the symptom better? (Check all that Apply):
  ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Stretching ☐ Pain Medication ☐ Muscle Relaxers ☐ Nothing
  ☐ Chiropractic Care ☐ Nothing ☐ Other _____
- Describe the quality of the symptom (Check all that Apply):
  ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep ☐ Nagging
  ☐ Shooting ☐Stabbing ☐ Tingling ☐ Numb ☐ Other _____
- Does the symptom radiate to another part of your body: ☐ Yes ☐ No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (check all that apply)
  ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

Symptom 2 _____

- On a scale from 0-10, with 10 being the worst, check the number that best describes the symptom most of the time:
  ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 ☐ 95 ☐ 100
- When did the symptom begin? _____
  - Did the symptom begin ☐ suddenly or ☐ gradually?
  - How did the symptom begin? _____
- What makes the symptom worse? (Check all that Apply):
  ☐ Bending neck forward ☐ Tilting head left ☐ Tilting head right ☐ Turning head left ☐ Turning head right
  ☐ Bending neck backward ☐ Bending forward ☐ bending back ☐ Lifting ☐ Sitting ☐ Getting up from sitting
  ☐ Driving ☐ Walking ☐ Running ☐ Nothing ☐ Any Movement Other _____
- What makes the symptom better? (Check all that Apply):
  ☐ Rest ☐ Ice ☐ Heat ☐ Massage ☐ Stretching ☐ Pain Medication ☐ Muscle Relaxers ☐ Nothing
  ☐ Chiropractic Care ☐ Nothing ☐ Other _____
- Describe the quality of the symptom (Check all that Apply):
- ☐ Sharp ☐ Dull ☐ Achy ☐ Burning ☐ Throbbing ☐ Piercing ☐ Stabbing ☐ Deep ☐ Nagging
  ☐ Shooting ☐Stabbing ☐ Tingling ☐ Numb ☐ Other _____
- Does the symptom radiate to another part of your body: ☐ Yes ☐ No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (check all that apply)
  ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Unaffected by time of day

# Pain Location, Intensity, and Quality Questionnaire

| *Use Letters Below to Indicate Type and Location of Discomfort* | | |
|---|---|---|
| **A** = Ache | **B** = Burning | **C** = Stabbing |
| **N** = Numbing | **P** = Pins and Needles | **O** = Other |



Additional Notes:

# Payment Agreement

The best health services are based on a friendly, mutual understanding between provider and patient. We invite you to discuss with us any questions regarding our services.

Our policy requires payment in full for all services rendered at the time of visits, unless other arrangements have been made by our office manager, If the account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for all collection fees including a 20% interest fee, legal fees, and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information that I have provided.

I understand and agree that all services rendered to me will be charged to me, and I'm responsible for all payments of such services. I understand and agree that health/accident insurance policies are an arrangement between insurance carrier and myself.

Our office is committed to providing appointment availability to all of our patients. In order to maintain this with everyone, we ask that you give the office 24 hours' notice of any cancelations. Cortez Chiropractic reserves the right to charge $45.00 no show fee to any patient who fails to keep their regularly scheduled appointment based on circumstances. This fee will be your responsibility and due before your next scheduled appointment.

Our office also does our best to keep appointments on schedule. So, if you arrive later than your scheduled time, out of respect for patients who have arrived on time for their appointment, you may be asked to reschedule your appointment. We will make every effort to honor your appointment as a "work in" as our schedule allows upon arrival, but there may be times this is not possible.

I understand that fees for professional services will become immediately due upon suspension or termination of my care or treatment.

Signature _____ Date_____