Peakview Sport & Spine
1793 Lake Woodmoor Dr, Monument CO 80132

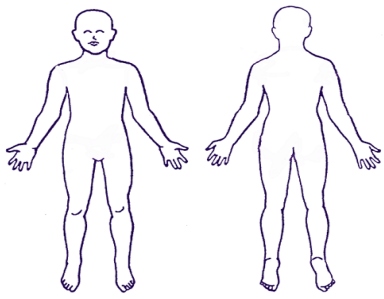
Name_____Date_____
Address_____City_____State_____Zip_____
Home Phone_____Work phone_____Cell_____
Date of Birth_____Age_____How did you hear about our office?_____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse's Name_____
Spouses Occupation_____Number of Children & ages_____
Have you ever received Chiropractic Care? ☐ Yes ☐ No When and Where?_____
Date of last X-ray_____Social Security #_____ E-mail address_____

Symptoms and Ill Health (Present State)

Major Complaint_____
Pain or Problem Started_____
Pains are __Sharp __Dull __ Constant __Intermittent (frequency_____)
What activities aggravate your condition/pain?_____
Is the condition worse during certain times of the day?_____
Is the condition interfering with work?_____Sleep?_____Routine?_____Other?_____
Is the condition getting progressively worse?_____
Other Doctors seen for this condition_____
Any home remedies?_____
Other symptoms:

__Headaches	__Jaw Problems	__Neck Pain/Tension	__Back Pain
__Dizziness/Fainting	__Eye Problems	__Thyroid Issues	__Numbness in Toes
__Nervousness	__Lights Bother Eyes	__Pins & Needles in Arms	__Pins & Needles in legs
__Fatigue	__Ears Ring	__Shortness of Breath	__Hands or Feet Cold
__Depression	__Hearing Problems	__Night Sweats	__Stomach Upset
__Sleeping Problems	__Loss of Memory	__High/Low Blood Pressure	__Constipation/Diarrhea
__Irritability	__Loss of Smell	__Chest Pain	__Loss of Balance
__Allergies	__Loss of Taste	__Sudden Weight Gain/Loss	__Fever

Please indicate where your complaint is on the following diagram:



Please rate the pain on the following scale:
No Pain 0_____1_____2_____3_____4_____5_____6_____7_____8_____9_____10 **The Worst Pain Ever**
Have you been under drug and medical care?_____
What medications are you taking?_____
How Long?_____Have you had surgery?_____What?_____When?_____

Loss of Whole Body Health (Birth-Present)

Name_____Date_____

Yes	**No**		
__	__	Did/do you smoke?	_____
__	__	Did/Do you drink any alcohol	_____
__	__	Diet (do you eat healthy foods?)	_____
__	__	Have you been in accidents?	_____
__	__	Drugs? (Prescriptive or non-prescriptive)	_____
__	__	Exercise regularly?	_____
__	__	Did/do you have occupational stress?	_____
__	__	Physical stress?	_____
__	__	Mental stress?	_____
__	__	Hobbies/Sports injuries?	_____
		Sleeping posture__Side__Stomach__Back__	_____
__	__	Other traumas or problems	_____

FOR PEAKVIEW OFFICE USE ONLY

NOTES:_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature_____ Date_____

Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our ONLY practice objective is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements. (print name) All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature_____Date_____

Consent To Evaluate And Adjust A Minor

I,_____being the parent or legal guardian of_____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature_____Date_____

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period:_____

Signature_____Date_____

Patient Privacy Acknowledgement Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA Notice that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time.. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in or office.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refused to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic practice has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Name of Patient:_____ Date:_____

Patient Signature:_____

I acknowledge that I will receive a copy of my records on my second visit.

Patient_____

Should you agree to share your information with anyone, please list his or her names below.

_____

_____