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

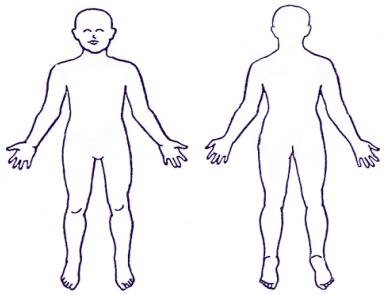
Name_____Date_____
Address_____City_____State_____Zip_____
Home Phone_____Work phone_____Cell_____
Date of Birth_____Age_____How did you hear about our office?_____
Have you ever received Chiropractic Care? ☐ Yes ☐ No When and Where?_____
Date of last X-ray_____ E-mail address_____

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**
What medications are you taking?_____
How Long?_____Have you had surgery?_____What?_____When?_____

Loss of Whole Body Health / Health History (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?	_____

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_____

INFORMED CONSENT FORM

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document, if anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis I Examination I Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulative therapy	Mechanical traction	Palpation
Range of motion testing	Orthopedic testing	Vital signs
Basic neurological testing	Postural analysis	Nutritional assessment
Muscle strength testing	Radiographic studies	Instrument-Assisted Soft-Tissue Mobilization

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which Corrective Chiropractic will check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

Open Adjusting Rooms

We keep an open environment in the office to create a sense of warmth, family, healing, and education. During adjustments, we do not go over private information; however, you will be in an open area where others may see

you and/or overhear conversation. If there is a need to discuss something of a personal or private nature, you should request an appointment outside of regular adjusting hours or a phone call.

Nutritional Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.
A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.
Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.
Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Personal Health Information

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records.

We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

I understand that I have the right to revoke this authorization, in part or in whole, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that Corrective Chiropractic will only accept an original copy of written request to revoke by mail or in person.
I have read the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Patient's Name

_____

Signature **Dated**

_____ _____

Signature of Parent or Guardian (if a Minor)