



# Swan Lake Chiropractic

724 Pearl Street, Boulder, CO 80302 | 303.449.3103 | swanlakechiro.com

## Confidential Patient Case History

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Who Referred you?: \_\_\_\_\_

Emergency Contact's Name & Phone: \_\_\_\_\_

What is/are your major complaints: \_\_\_\_\_

What do you think caused this condition?: \_\_\_\_\_

Date of Birth: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other _____ Pregnant: <input type="checkbox"/> Yes <input type="checkbox"/> No Occupation: _____
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Have you had this or a similar condition in the past? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when did it start: _____ Do any positions make it feel worse? <input type="checkbox"/> Yes <input type="checkbox"/> No Do any positions make it feel better? <input type="checkbox"/> Yes <input type="checkbox"/> No Is this condition: <input type="checkbox"/> Improved <input type="checkbox"/> Unchanged <input type="checkbox"/> Getting worse Is this condition interfering with your: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily Routine <input type="checkbox"/> Other: _____ Have you been to a chiropractor before?: <input type="checkbox"/> Yes <input type="checkbox"/> No Last Adjustment: _____ Doctors or Therapists who have treated THIS condition: _____
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Have you been in an accident or had any other significant injury which caused or contributes to your current condition?  Yes  No If yes, describe: \_\_\_\_\_

Hospitalizations, Surgeries, Auto or Work injuries: (include dates and treatments): \_\_\_\_\_

Do you have Spinal X-Rays or MRI's?:  Yes  No Dates: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Birth trauma, childhood injuries, significant illnesses: \_\_\_\_\_

Activities you participated in ages 5-20: \_\_\_\_\_

What are your goals in seeking care for this condition?: \_\_\_\_\_

Hours per day sitting (work, car, leisure): \_\_\_\_\_

Times per week exercising ½ hour or more: \_\_\_\_\_

<p><b>PLEASE READ - Appointment Policy:</b> Our time together is important. Please do your best to arrive on time for all your appointments. As we get to know your body and treatment priorities, your appointment time will decrease. <i>If you arrive more than 5 minutes late to our scheduled time together, we may have to reschedule your appointment for another time or day.</i></p> <p>Patient Initials: _____</p>
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Please check ALL that apply:

**Musculo/Skeletal:**

- Spinal pain greater than 3 weeks
- Hip pain
- Shoulder pain
- Foot pain
- Swollen or painful joints
- Arthritis
- Gout
- Osteoporosis
- Bursitis
- Fractured bones
- Muscle weakness or paralysis
- Numbness in arms, hands or fingers
- Pain in arms, hands or fingers
- Numbness in legs, feet or toes
- Pain in legs, feet or toes
- Numbness or pain in groin

**Head**

- Headaches
- Dizziness/poor balance
- Direct head trauma
- Memory loss
- Lost consciousness
- Poor coordination
- Trouble concentrating
- Seizures
- Tremor
- Jaw pain

**Ears, Nose and Throat**

- Loss of smell
- Swallowing problems
- Speech problems
- Sinus problems
- Hearing problems
- Ringing in ears
- Dental problems
- Wear glasses or contacts
- Glaucoma
- Light bothers eyes

- Intolerance to noise
- Speech difficulties
- "Clunk" sound with moving neck

**Heart/Lung**

- Heart disease or murmur
- Racing, pounding heart
- High blood pressure
- Low blood pressure
- High cholesterol
- Stroke
- Chest pain
- Asthma
- Allergies
- Shortness of breath
- Difficulty breathing
- Chronic cough

**Urological**

- Pain or blood with urination
- Leaking urine
- Urinating at night
- Loss of bladder or bowel control
- Kidney or bladder infection
- Kidney stones

**Gastro-Intestinal**

- Recurrent abdominal pain
- Diarrhea
- Acid Reflux
- Constipation
- Bloody or black stools
- Liver problems
- Gall bladder problems
- Ulcers
- Heartburn
- Hernia
- Hemorrhoids
- Nausea
- Vomited blood

**Emotional/Stress**

- Depression

- Sleep problems
- Anxiety
- Mood swings
- Apathy
- Nightmares
- Sleep disturbances
- Relationship difficulties
- Impaired comprehension
- Attention impairment
- Panic attacks
- Concentration difficulty
- Social withdrawal
- Reading problems

**Misc.**

- History of Cancer: \_\_\_\_\_
- Thyroid problems
- Anemia
- Bleeding or bruising tendency
- Unexplained weight loss or gain
- Night sweats
- Eczema
- Pain fails to improve with rest
- Varicose veins
- Ankle swelling
- Unusual fatigue
- Cold hands or feet
- Prostate problems
- Menstrual problems
- Diabetes
- Other: \_\_\_\_\_

**Family History**

- Cancer
- Musculo-skeletal conditions
- Ear/nose/throat conditions
- Heart/lung conditions
- Urological conditions
- Gastro-intestinal conditions
- Emotional Problems
- Diabetes
- Dementia/Alzheimer's

**General Consent Form:** The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment; and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatment are not clear to me, I understand that further information may be requested from the Doctors. The information in this chart is confidential. I understand that all requests for release of my records must be in writing. Protected health information will be released with written authorization, with minimum disclosure as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with the Doctors and to notify them of any changes in my health status.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party's Signature, if patient is a minor: \_\_\_\_\_ Date: \_\_\_\_\_



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Please read our **PAYMENT GUIDELINES** and select one of the following options:

\_\_\_\_\_ **Self Pay Plan** – I, the patient, understand that I am responsible for all charges accrued from office visits. Payment is required when services are rendered. No third party is involved. A receipt or superbill can be generated for me to pursue my own reimbursement.

\_\_\_\_\_ **Medical Insurance Plan** – I hereby authorize the assignment of benefits to Swan Lake Chiropractic as well as the release of any medical information necessary for the payment of claims. I, the patient, am responsible for any co-pays or deductibles due at the time the services are rendered. If after 90 days Swan Lake Chiropractic is unsuccessful recovering monies from my insurance carrier, I understand that I am ultimately responsible for charges accrued from office visits, etc.

I have read and understand the payment policy of Swan Lake Chiropractic Health Centre as explained in the **PAYMENT GUIDELINES**. I also acknowledge that all charges incurred in this office are ultimately my responsibility.

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

Please read our **NO-SHOW/LATE CANCELLATION** policy:

If a patient fails to appear at the time of their appointment and has not contacted our office **with at least 3 hours' notice**, they will be considered a No Show. Because we understand life happens and obstacles come up that are beyond your control, we will not charge any fee for the first No Show. We will, however, contact you for a credit card number to keep on file so we have means of collecting a fee if it happens a second time.

Any patient who fails to appear at their appointment, who cancels/reschedules within a 3-hour period for a second time, or **who is more than 10 minutes late** for their appointment will be charged our full adjustment rate of \$60. This same charge will be applied for any subsequent No Shows. The fee will be charged immediately on the card on file.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. In such instances, please contact us before the appointment and we will waive the No Show fee when appropriate.

**Signature:** \_\_\_\_\_



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**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

**\*\*You May Refuse to Sign This Acknowledgement\*\***

I, \_\_\_\_\_ have been notified of my option to receive a copy of this office's Notice of Privacy Practices and that this practice abides by those policies.

\_\_\_\_\_ (Signature)

\_\_\_\_\_ (Date)

\_\_\_\_\_ FOR OFFICE USE ONLY \_\_\_\_\_

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtainment
- An emergency situation prevented us from obtainment
- Other (please specify):

\_\_\_\_\_