PEAK PERFORMANCE CHIROPRACTIC CLINIC, LLC
DR. DEAN YOUNKER 242-1903

Name_____ Date_____

Address_____City_____State____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Best Number to contact you: Home Work Cell Social Security#_____

Email Address_____ Cell Provider: Text(circle) Yes No

Birth Date_____ Age_____ Sex: M F Sex at birth: M F

Marital Status (circle one): Single Married Widowed Divorced Separated

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

Occupation_____ Employer_____

Spouse's Name_____ Names and Ages of Children _____

**Whom may we thank for referring you or how did you hear about us?** (Circle all that apply)

| | | | |
|---|---|---|---|
| TV | Google | Yellow Pages | Other_____ |
| Radio | Website | Facebook | Person_____ |

Would you like us to check your insurance benefits to see if they will contribute to your care? Yes___ No___
Main reason for consulting our office today_____ Symptoms Began_____

Anything about your Nerve System and Spine we should know about?_____

What is your level of commitment to yourself, your life and well-being? High _____Medium _____Low_____

Have you ever sought the services for this or any other health concern from the following:

___Massage Therapist ___Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist
___Personal Trainer ___Nutritionalist ___Rolfer ___Pilates ___Other_____

Who is your primary care doctor?_____ Phone #_____

Have you been adjusted by a chiropractor before? Yes_____ No_____
Who_____ Date of last Adjustment_____
Frequency of visits_____ times a week/month Duration of care _____weeks/months/yrs

- What is your daily fluid intake: Coffee_____/day Alcohol_____/day Water _____/day Soda ____/day
- Sleep/Rest Habits: Daytime naps: Y N Hours a night_____/hrs Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often)_____
- What type of work do you do?_____ Satisfied/Enjoy your work? Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list)
  _____
- What are your current play and relaxation activities?_____

****We Reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.****

# Electronic Health Records Intake Form

*In compliance with requirements for the government HER Incentive Program*

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail
Preferred Language:_____
Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Race (Circle One): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / Decline to Answer

Ethnicity (Circle One): Hispanic or Latino / Not Hispanic or Latino / Decline to Answer

☐ **I choose to decline receipt of my clinical summary after every visit.**
*(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature:_____ Date: _____

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# CANCELLATION AND MISSED APPOINTMENT POLICY

Peak Performance Chiropractic is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

**Please call us at (970) 242-1903 by 3:00 p.m. on the day prior to your scheduled appointment** to notify us of any changes or cancellations. **To cancel a *Monday* appointment, please call our office by 2:00 p.m. on *Friday*. Voicemails left 24 Hours prior to appointment will be accepted.** If prior notification is not given, you will be charged $50 for the missed appointment.

PLEASE SIGN BELOW TO CONSENT TO THESE TERMS

PRINT NAME_____

PATIENT SIGNATURE_____DATE_____

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# IN CASE OF EMERGENCY

**In an event of emergency, please list who would like us to notify:**

| NAME | PHONE | RELATIONSHIP |
|---|---|---|
| | | |
| | | |
| | | |

PEAK PERFORMANCE CHIROPRACTIC CLINIC, LLC
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# Initial Health History

Name _____ Date _____

- What symptoms are causing you to seek care in our office and where is it located?

- Please List any health concerns in your Family History.

- Past Health History (general health, illness, injuries, hospitalizations, medications, surgeries).

- Mechanism of trauma/injury (how did you hurt yourself)? When was the onset of symptoms?

- How would you describe your symptom/problem? Does it radiate?

- Duration (how long), intensity (scale of 1-10 how bad), frequency (how often).

- What makes it better or worse?

- What prior interventions, treatments, or medications have you used for this problem?

- Is there any reason you should not be adjusted?

**Check any of the symptoms or conditions below that you experience?**

___Headaches
___Neck Pain
___Mid-Back Pain
___Sciatic Pain
___Leg or Hip Pain
___Shoulder/Arm Pain
___Carpal Tunnel
___Problem Sleeping
___Ringing in the Ears
___Loss of Balance
___Weight Trouble
___Low Energy/Fatigued
___Asthma
___Vertigo
___Anxiety
___Cancer
___Allergies
___Dizziness
___Depression
___Digestive Problems
___Pain Between Shoulder Blades
___Shortness of Breath
___Tension across Top of Shoulders
___Numbness in Arms/Legs
___Menstrual Pain
___Other_____

If Female, are you pregnant or any chance of being pregnant? ____Yes ____No
Which one of the above symptoms is worst?_____ How long have you had it?_____
When it is at its worst, how does it feel?_____

**The following 3 areas can contribute to nerve interference and diminished quality of life.**
**Circle the areas that apply to you and when.**
**C=Child T=Teenager A=Adult N=Not at all (please circle)**

| **Physical Stress** | | **Emotional Stress** | | **Chemical Stress** | |
|---|---|---|---|---|---|
| Birth Stress | C T A N | Relationships | C T A N | Environmental | C T A N |
| Slip/fall | C T A N | Career | C T A N | Smoker | C T A N |
| Car Accident | C T A N | Family | C T A N | Second Hand Smoke | C T A N |
| Sports Injury | C T A N | Money | C T A N | Caffeine | C T A N |
| Physical Abuse | C T A N | Fast paced life | C T A N | Artificial Sweeteners | C T A N |
| Work Injury | C T A N | Hold in feelings | C T A N | Prescription Drugs | C T A N |
| Poor Posture | C T A N | Quick tempered | C T A N | Recreational Drugs | C T A N |
| Sitting on wallet | C T A N | Perfectionist | C T A N | Self Medicate | C T A N |
| Stomach sleeper | C T A N | Procrastinator | C T A N | Poor Diet | C T A N |
| Computer work | C T A N | Loss of loved one | C T A N | | |
| Repetitive lift/bending | C T A N | | | | |
| Prolonged Driving | C T A N | | | | |
| Prolonged Standing | C T A N | | | | |
| Prolonged Sitting | C T A N | | | | |
| Surgery/Broken bones | C T A N | | | | |
| Lack of Physical Activity | C T A N | | | | |
| Excess Physical Activity | C T A N | | | | |

- What do you feel is the primary stress in your life?
- Rate (circle) your combined overall level of stress from all sources listed above:
  No Stress -1-2-3-4-5-6-7-8-9-10- High Stress

# TERMS OF SERVICE

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT**: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

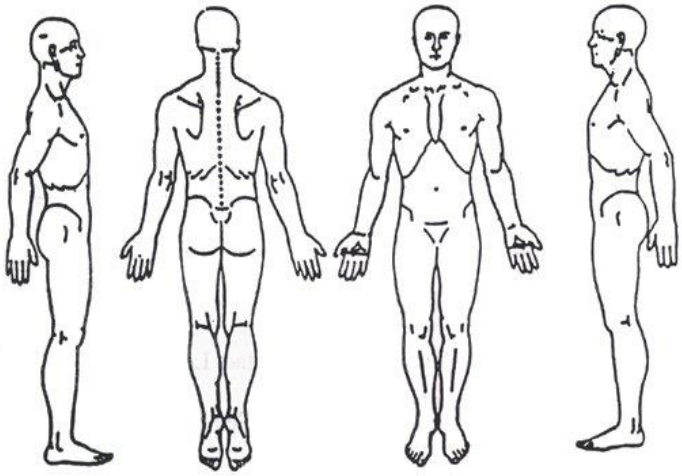
**HEALTH**: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION**: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what 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 eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I, (Printed name)_____ (Signature)_____
undertake chiropractic services on the understanding of and agreement with, the above explanation. _____(Date)

Consent to evaluate and adjust a minor and /or child: I, _____ (Print name) being the parent or legal guardian of _____(Print name) give permission for my child to receive chiropractic care.



## INITIAL/PROGRESS REPORT

PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

A=SHARP PAIN
B=DULL PAIN
C=BURNING PAIN
D=NUMBNESS
E=TINGLING

Name

Please mark the intensity of pain you are experiencing on the pain scale below.

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
|---|---|---|---|---|---|---|---|---|---|---|
| No Pain | Mild | | Discomforting | | | Distressing | | Horrible | | Excruciating |

**Daily Activities**: Effect of Current Condition on Performance

| | | | | | |
|---|---|---|---|---|---|
| 1. | Bending | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 2. | Carrying Groceries | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 3. | Change Posn-Sit-Stand | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 4. | Climb Stairs | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 5. | Driving | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 6. | Ext Computer Use | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 7. | Household Chores | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 8. | Kneeling | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 9. | Lift Children | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 10. | Lifting | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 11. | Reading (Concentration) | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 12. | Self Care –Bathing | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 13. | Self Care –Dressing | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 14. | Self Care –Shaving | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 15. | Sexual Activities | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 16. | Sleep | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 17. | Sitting | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 18. | Standing | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 19. | Walking | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 20. | Yard Work | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 21. | Other_____ | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |
| 22. | Other_____ | ☐ No Effect | ☐ Mild Pain (Can do) | ☐ Mod Pain (Limited) | ☐ Sev Unable to Do |

Date:_____ Name (Printed)_____ Signature_____

Name

# INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or his preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure to an particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease of condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctors' judgment and expertise in working with like cases.

I understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my case and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed where actually provided.

I understand and have been provided with a **HIPAA Privacy Practices** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that I have the right to request restrictions as to how my health information may be used of disclosed to carry out treatment, payment, or health care operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 30 days of the date of service and no financial arrangements have been made, you will be responsible for any expenses incurred in collecting your account. Including ALL Collection Agency fees, ALL Attorney's fees, ALL Court costs, and ALL collection costs, whether suit is filed or not. The account may be assessed interest at a rate of 1 ½% per month or 18% per annum, until paid in full.

I have read, or have had read to me the Informed Consent to Chiropractic Adjustments and Care. I have also had an opportunity to ask questions about its content, and my signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition.

Name (Printed) Date Signed

Signature: **Patient** or Legal Representative (Atty., Guardian, Parent) Witness to Patients signature