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_______________

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:

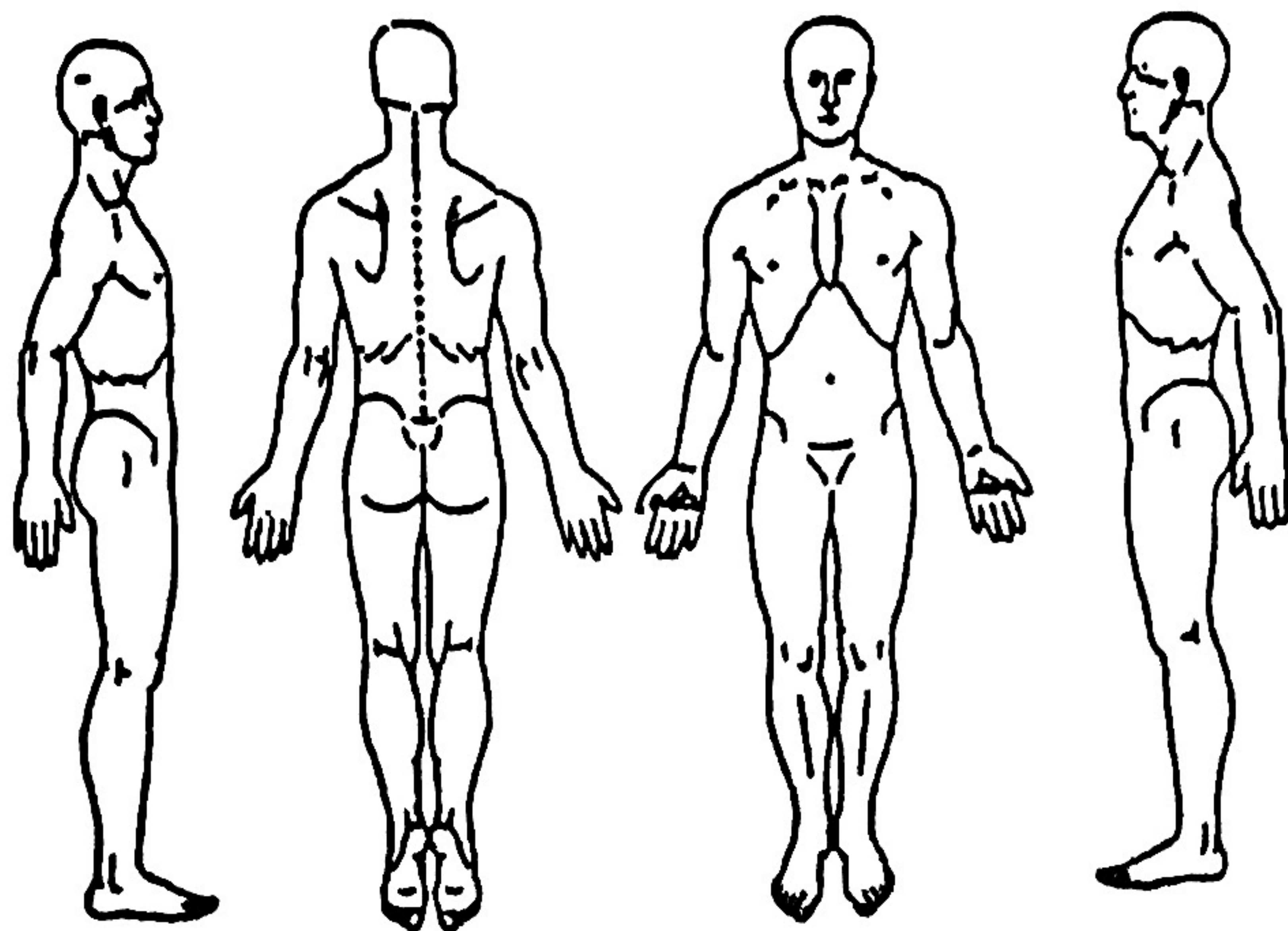
___Massage Therapist ___Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist
___Personal Trainer ___Nutritionalist ___Rolfer ___Pilates ___Other________________

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.****



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

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

	Activity				
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________________________

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

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

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 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?

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

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: ___________

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______________

IN CASE OF EMERGENCY

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

NAME	PHONE	RELATIONSHIP