Appointment Date/time_____

Welcome to Carefree Chiropractic! Please take your time completing the following information so we can serve you to the best of our ability.

Is your condition related to an accident in a car or at work? Yes No
If yes: notify front desk immediately.

Do you have health insurance that might cover this treatment? Yes No
If yes: notify front desk immediately.

Patient Information

Title: Mr. Mrs. Miss Ms. Dr. (circle one) DATE_____
Last Name_____ First_____ Middle Initial____
EMAIL_____
Address_____ City_____ State_____ Zip_____
Phone: Home_____ Work_____ Cell_____
Gender: MALE FEMALE Birthdate_____
Status: Married Single Widowed Divorced Child Other Spouse's Name_____
Children's names_____
How were you referred to this office? (circle all that apply) Yellow pages Newspaper Flyer Radio TV Friend/ Relative (Name_____) Other _____
Your occupation_____ Employer_____
Employer's address_____ City_____ State_____ Zip_____
Nearest Relative not living with you_____ Relative's phone_____
Address_____ City_____ State_____ Zip_____
Other doctors seen for this condition? MD DC DO DDS Doctor's name_____
Diagnosis_____ X-rays? YES NO Length of time under care_____
Off work? YES NO If yes, how long?_____ Have you returned to the same job? YES NO
Treatment received: Medication Physiotherapy Adjustments Surgery Other_____
Results_____
Ever seen another chiropractor/DC? YES NO Name_____ Date(s)_____
Who is the person responsible for payment on this account?_____

Height_____ Weight_____ Blood pressure_____(front desk can take your BP for you)
Smoking status: (circle one) Current every day, current some days, former smoker, never smoker
Race:(circle one)African American, American Indian, Asian, Black, Native Hawaiian, Pacific Islander, White, decline, Unknown
Ethnicity: (circle one) Hispanic/Latino, Not Hispanic/Latino

PLEASE ANSWER THOROUGHLY FOR BEST EVALUATION

Primary area of discomfort_____
How long have you had this condition? _____ Days _____ Weeks _____ Months _____ Years
As far as you know, the cause was_____
If condition is due to any injury, what day did the injury occur?_____
Place injury occurred: ( ) Home ( ) Work ( ) Other_____
Intensity of discomfort: ( ) Mild ( ) Moderate ( ) Severe
Frequency of discomfort: ( ) Constant ( ) Daily ( ) Intermittent __times per Day / Week
How would you describe the pain: ( ) Sharp ( ) Dull ( ) Achy ( ) Stiff ( ) Throbbing
( ) Tingling Other_____
Pain is getting: ( ) Better ( ) Worse ( ) Staying the same
What aggravates the discomfort: ( ) Lifting ( ) Bending ( ) Lying ( ) Sitting ( ) Walking
( ) Standing Other_____
Time of day discomfort is most noticeable: ( )Morning ( )Afternoon ( )Evening ( )Increases during day
Discomfort decreased when/with: ( )Resting ( )Lying ( )Sitting ( )Standing ( )Ice ( ) Heat ( )Other
Names of other doctors seen for this condition?_____
I have tried: ( )Aspirin ( ) Muscle Relaxers ( ) Pain Medication ( )Cortisone ( )Other_____
Results_____
Have you had any surgical operations? ( ) Yes ( ) No What kind?_____
Are you taking any **prescription** medication? ( ) Yes ( ) No
What kind?_____
What **prescription** medication are you **actively** allergic to: _____
_____

PLEASE NOTE THE LOCATION OF YOUR DISCOMFORT

Headaches
____ Back of head
____ Top of head
____ Side(s) of head
____ Front of head
____ Behind the eyes
____ Other _____

Neck Pain
____ Left side ____ Right Side ____ Both sides

Pain travels to:
Upper back ____ Left ____ Right
Shoulders ____ Left ____ Right
Arms ____ Left ____ Right
Hands ____ Left ____ Right
Fingers ____ Left ____ Right
Other _____

Low Back Pain
___ Left side ___Right side ___Both sides

Pain travels to:
Legs ____ Left ____ Right
Buttocks ____ Left ____ Right
Thighs ____ Left ____ Right
____ Left ____ Right
Knees ____ Left ____ Right
Ankles ____ Left ____ Right
Feet ____ Left ____ Right
Other _____

Mid Back Pain
___ Left side ___Right side ___Both sides

Pain travels to:
Neck ____ Left ____ Right
Shoulders ____ Left ____ Right
Arms ____ Left ____ Right
Around Rib Cage ____ Left ____ Right
Through chest ____ Left ____ Right
Other _____

Other areas of discomfort:_____
Other health issues:_____

I hereby authorize the Doctor to care for me as he deems appropriate. I will not hold him responsible for any pre-existing medically diagnosed condition(s), nor any medical diagnosis. The information I have given is accurate and true.

SIGNATURE_____ **DATE**_____

Professional fee Schedule

Our experience has shown that it is wise to have an understanding with our patients regarding our office policies and fees. Our main concern is your health and well-being. The following fees are general. Your specific cost will be discussed once Dr. Johnson has an understanding of your needs.

Consultation	**No Charge**
Chiropractic Examinations	**$40 - $140**
Spinal Adjustment (1 to 5 areas)	**$60 - $70**
Extremity Adjustment	**$40**
Manual Therapies	**$40 - $115**
Chiropractic X-ray studies	**$65 - $365**
Patient / Doctor Conference	**$40 - $70**

Yours will be a PRE-PAY CASH PLAN

I qualify, understand, and elect to participate in a pre-pay cash plan.

Signature _____Date _____

Explanation of professional Fees

Consultation: No charge
The consultation takes place subsequent to the New Patient Examination. The Doctor will discuss with the patient any current complaints. The Doctor will also give the patient a brief explanation of Chiropractic and the care they will be receiving.

New Patient Examination: $50-$140
The Doctor will review the Patient History form describing the patient's chief complaints. At that time, a postural exam, range of motion study, and any necessary orthopedic tests will be performed.

Established Patient Examination: $40-$60
Periodically the Doctor will monitor percent improvement and will obtain additional information on a visit related to progress or aggravation from initial findings.

Chiropractic Adjustment: $60-$70
Generally an adjustment will be performed each visit to address the individual's subluxation patterns. There are up to four areas of the spine that may be involved.

Extremity Chiropractic Appointment: $40
Additional areas outside the spine such as knees, wrists, etc. that may require care.

Manual Therapies: $40-115
Manual therapies consist of services such as, but not limited to, lymphatic drainage, manual traction, and myofascial trigger point.

Chiropractic X-ray Studies: $65-$360
Subsequent to the consultation, and after careful review of the patient's complaints. The Doctor will determine if x-rays are necessary for the proper care of the patient.

Patient/Doctor Conference: $40-$70
The patient/Doctor conference is a specific office visit at which time the Doctor reviews with the patient their examination finding, including physical examination and X-ray examination study, lending itself to aid the patient in understanding and participating in the health findings and care.

Signature _____**Date** _____

Carefree Chiropractic
3365 N. Academy Blvd.
Colorado Springs, CO 80917

FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Carefree Chiropractic uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws.), for administrative purposed, and to evaluate the quality of care that you receive,

Carefree Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Carefree Chiropractic may use your information to provide appointment reminders, information about treatment alternatives or other health-related issues.

Carefree Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records.

You may complain to Dr Johnson and to the Department of Health and Human Services if you believe you r privacy rights have been violated. You will not be retaliated against for filing a complaint.

Carefree Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, notify you if it was unable to agree to the requested restriction on how your information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

If you have any questions of complaints please contact Dr. Doug Johnson at (719) 572-0211.

_____ _____

Patient Signature Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic healthcare, and when a chiropractor accepts a patient for such care, it is essential that both are seeking and working for the same goals. Chiropractic does NOT diagnose or treat disease. Chiropractic has only one Goal:

TO LOCATE, ANALYZE, AND CORRECT SPINAL INTERFERENCE TO THE NERVOUS SYSTEM

The purpose of the nervous system is to control and coordinate all bodily function. Interference to this master system automatically produces improper function of the body. The SUBLUXATION (spinal misalignment producing nerve interference), in and of itself, is a detriment to life and health. Correction of the subluxation through a specific chiropractic adjustment allows the body to function at its optimum level. This allows the innate healing power of the body to work at maximum efficiency to restore, maintain, and promote natural health.

WE DO NOT DIAGNOSE CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.

WE OFFER NO TREATMENT OF CONDITION(S) OR DISEASE(S) OTHER THAN VERTEBRAL SUBLUXATIONS.

WE PROMISE NO CURE FROM ANY CONDITION(S) OR DISEASE(S).

THE CHIROPRACTIC ADJUSTMENT RESTORES LIFE AND HEALTH TO ITS FULLEST POTENTIAL!

I, _____, having read the above statements, and understanding them fully, do undertake chiropractic health care on this basis.

Date: _____

Signature: _____