Colorado ActiveHealth
Dr. John Hamilton D.C. Chiropractic PLLC

2323 South Troy Street, Suite 6-200, Aurora, CO 80014
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(303) 766-2357

PATIENT CASE

Name _____ Birth Date ___/____/____ Social Security # _____-___-_____

Age _____ Height ____'_____ Weight _____lbs Occupation _____ Employer _____

Address _____ City _____ State ____ Zip_____Phone ( )_____

Email_____@_____ Any Previous Chiropractic Care? Y N _____ Referred by _____

PERSONAL HEALTH HISTORY

All information will be kept strictly confidential. Please check the degree of all conditions you currently have, or have had.

N = Never N/A O=Occasional F = Frequent C= Constant

Muscle / Joint				
N	O	F	C	Low back pain
N	O	F	C	Neck pain, stiffness
N	O	F	C	Pain between shoulders
N	O	F	C	Other

Pain or Numbness in				
N	O	F	C	Hands
N	O	F	C	Arms
N	O	F	C	Shoulders
N	O	F	C	Hips
N	O	F	C	Legs
N	O	F	C	Feet
N	O	F	C	Other _____

Eye, Ear, Nose, Throat				
N	O	F	C	Eye pain
N	O	F	C	Near/Far sighted
N	O	F	C	Ear problem
N	O	F	C	Nose problem
N	O	F	C	Sinus problem
N	O	F	C	Sore throat

General				
N	O	F	C	Fever
N	O	F	C	Fatigue
N	O	F	C	Malaise
N	O	F	C	Unexplained weight loss
N	O	F	C	Headache
N	O	F	C	Migraine
				Nervous
				Depressed

				Moodiness
				Allergy
				Sleeping Problems
				Asthma
				Light headed arising
				Other _____

Cardiovascular				
N	O	F	C	High/Low blood pressure
N	O	F	C	Pain over Heart
N	O	F	C	Poor circulation
N	O	F	C	Rapid heart beat

Genitourinary				
N	O	F	C	Blood/pus in urine
N	O	F	C	Frequent urination
N	O	F	C	Painful urination
N	O	F	C	Lack of kidney control

Skin				
N	O	F	C	Bruise easily
N	O	F	C	Varicose veins
N	O	F	C	Dryness/itching

Gastrointestinal				
N	O	F	C	Liver trouble
N	O	F	C	Gallbladder trouble
N	O	F	C	Constipation/Diarrhea
N	O	F	C	Digestive problems
N	O	F	C	Pain over stomach
N	O	F	C	Vomiting
N	O	F	C	Blood in Vomit
N	O	F	C	Other _____

Respiratory				
N	O	F	C	Difficult deep breathing
N	O	F	C	Chest pain
N	O	F	C	Spitting up phlegm/blood
N	O	F	C	Chronic cough

Women Only				
N	O	F	C	Irregular cycle
N	O	F	C	Menopausal
N	O	F	C	PMS
N	O	F	C	Painful menstruation
N	O	F	C	Pain over stomach
N	O	F	C	other_____
YES		NO		Are you pregnant?
IF YES				How many months ___

Check any of the following conditions that apply:	
Yes	Arthritis
Yes	Appendicitis
Yes	Cancer
Yes	Diabetes
Yes	Edema
Yes	Epilepsy
Yes	Heart disease
Yes	HIV / AIDS
Yes	Pacemaker
Yes	Stroke
Yes	Other:_____
Yes	Other:_____
Yes	Other:_____

DAMAGE TO YOUR HEALTH EXPRESSION

For many, birth or childhood traumas cause the first damage to the nervous system and the journey of ill health begins.

Response			Explanation	Chiropractor's Notes
Birth				
Y	N	Long/difficult birth		
Y	N	Forceps/Vacuum		
Y	N	C-Section		
Y	N	Breach		
Y	N	Induced labor		
Y	N	Premature		
Childhood and Growth				
Y	N	Breast-fed		
Y	N	Taught to care spine		
Y	N	Used good posture		
Y	N	Falls:bed/stairs		
Y	N	Accidents;bike, auto		
Y	N	Discipline:spanked		
Y	N	Childhood sickness		
Y	N	Allergies		
Y	N	Stiches/Surgery		
Y	N	Drugs		
Y	N	Fighting		
Y	N	Childhood sports		
Y	N	Traumas (what,when)		

PERSONAL BEHAVIORS / SOCIAL HISTORY

Y	N	Water_____oz/day	Y	N	Tobacco (type)____	Y	N	Mental Stress
Y	N	Coffee_____cup/day	Y	N	Medication	Y	N	Exercise___min/day
Y	N	Soda_____can/day	Y	N	Sleep_____hrs/night	Y	N	Work_____hr/day
Y	N	Alcohol_____oz/day	Y	N	Physical Stress	Y	N	Accident/Trauma

ABOUT YOUR CARE

Chiropractic provides three types of care. Initial Intensive Care corrects the most recent damage, usually relieving or reducing the symptoms. Reconstructive Care continues the healing by re-training the soft tissues and correcting deeper layers of damage. Once you have reached your optimum level of correction, Chiropractic provides true Wellness Care. I hereby state that the information I have given is true and correct to the best of my knowledge. I authorize Colorado Active Health Chiropractic PLLC to examine, request x-rays, adjust and do whatever is deemed necessary in accordance with state statutes for the care I receive in this office. I authorize release of information required to process insurance claims and payment of insurance benefits directly to the clinic for services received.

Patient Signature _____ **Date** _____

CONSENT TO GIVE TREATMENT TO A MINOR (If patient is a minor)

I hereby authorize Colorado Active Health Chiropractic to examine and administer care as needed for my child.

Child's name _____

Parent/Guardian Signature _____ Dated ___/____/_____Location (City) _____ (State) ___

PRESENTING COMPLAINT

NAME _____ DATE _____/_____/_____

Major Complaint _____

1. Location and Symptoms_____
_____
_____
_____

2. When did it start _____
_____

3. What were you doing _____
_____

4. Prior Episodes of Similar Problem _____
_____

5. Describe what the problem feels like_____
_____

6. Is it Mild/Moderate/Severe _____
_____

7. What activities has it affected _____
_____

8. What has made it feel better _____
_____

9. What has made it feel worse _____
_____

10. Other associated problems _____
_____

11. Have you been treated for this problem before?
_____

12. X-Rays of the region _____
_____

13. Anything else you feel is pertinent to your care that you feel is important for us to know _____
_____
_____

14. What are your goals of care _____
_____
_____

Chiropractor Notes:

Please use a dot(s) or a circle(s) to help us identify your specific areas.

Additional Chiropractor Notes:

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OFFICE POLICIES and TERMS OF ACCEPTANCE

Welcome…
In order to provide you with the optimum in gentle, precise chiropractic care, it is important that we are both working toward the same goals. Chiropractic has only one objective. It is necessary that each patient understand this objective and the method used to obtain it. That way we will avoid any confusion or disappointment.

Our Purpose is to provide you with specific, scientific chiropractic care in a relaxed professional setting, while helping you to learn to participate in and take control of your health. Working together, we can help you achieve your optimum health potential as you increase your knowledge of what health really is and how to obtain it.

Important Definitions
Vertebral Subluxation: A misalignment or malfunction of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of nerve impulses, resulting in decreases in the body's innate ability to express its maximum health potential.
Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxations. Our chiropractic method is correction is by specific adjustments to the spine.
Health: A state of optimum physical, mental and social well being, not merely the absence of disease or infirmity. We do not offer to diagnose of treat any disease or condition other than vertebral subluxation and underlying causes. However, if during the course of a chiropractic spinal examination, 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 another health care provider.

Office Hours – We reserve the right to alter office hours when necessary and will do all we can to avoid any inconveniences.
All Treatments are **BY APPOINTMENT** however, we offer window and days for our typical available hours.

Aurora Office - Monday, Wednesday, Friday, Saturday (Mornings)
2323 S. Troy Street Bldg. 6 Suite 200, Aurora, CO 80104
Castle Rock Office - Tuesday, Thursday, Saturday (Afternoons)
210 Fifth Street, Castle Rock, CO 80104

Missed Appointments Policy
Please keep your scheduled appointments. Missed appointments disrupt your progress and office flow, and reduce the effectiveness of care. Missed Appointments or Tardiness may result in dismissal from care. We understand that unforeseen circumstances arise; in that case a phone call to reschedule is appreciated at least **24-hours in advance** for non-emergencies and prior to your scheduled appt. for emergencies.

Our office runs on what is known as the law of fair exchange. This principle states that for balance and harmony in any type of relationship, there must be an equal exchange for what is given and what is received. We feel we provide an extremely valuable service, and in return we expect prompt and courteous payment for that service. There are several ways in which payment for services may be made. We have designed programs to enable most everyone, regardless of whether you have insurance or not, to be able to afford care. Remember, we will work with you, as our goal is your improved health. All charges must be paid in full each visit, unless other arrangements have been made in advance. Insurance Patients: Our office will be glad to call your insurance company to verify coverage limits. We will also file your claims for you, with a signed assignment of benefits. Or, you may choose to file your own claims, and we will provide a superbill for that purpose. Since coverage and limitations vary greatly for chiropractic care, please be sure to work with our office manager to fully understand your situation.
Cash Patients: Cash patients may pay on a per visit basis, or you may take advantage of our discount packages. No refund is available for discount packages, so please consider carefully your payment options prior to purchasing care in advance. Inquire with Dr. Hamilton for more details. If these terms are inconvenient, speak with the office manager so suitable arrangements can be made.
Auto and Personal Injury Patients: If you were involved in an accident or personal injury, which may have caused your symptoms, you may be covered for care. Please present proof of insurance immediately so that we can verify coverage and obtain a claim number. If an attorney is involved in your case, please let us know. It may be necessary in some cases to have a doctor's lien on file in order to render care. If you are unsure of your situation please let us know.
Workers Compensation Patients: You are responsible to report on the job injuries to your employer, and follow their procedures regarding where care may be received. Once you have information from your company, we will verify coverage. If you have questions regarding your situation please let us know.
PLEASE NOTE: All payments for care are due at the time of service. Any balances past 30 days will accumulate interest charges of 1.5% per month and a collection fee equal to 25% of the balance owed, should your account become over 120 days past due, from the date services were first rendered. All questions regarding the doctor's objectives pertaining to my care in this office have been fully answered to my satisfaction. I therefore accept and wish to begin chiropractic care on this basis.

Printed Name _____

Signature _____ **Date** ____/____/____

HIPAA NOTICE OF PRIVACY PRACTICES OF ACTIVE HEALTH CHIROPRACTIC PLLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry outtreatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law. Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission. Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, FuneralDirectors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization. Your Rights: Following is a statement of your rights with respect to your protected health information. You have the right to inspect and copy your protected health information. Under federal law, however, you may notinspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of or in use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, if you have agreed to accept this notice alternatively i.e. electronically. You may have the right to have your physician amend your protected health information. If we deny your request foramendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statementand will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before April 14, 2003. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have read this Notice of our Privacy Practices.

Printed Name: _____

Signature: _____ **Date:** ____/____/____