MOUNTAIN HEALTH

CHIROPRACTIC & NEUROLOGY CENTER

We would like to take this opportunity to welcome you as a member of Mountain Health Chiropractic & Neurology Center. During your first visit, we will perform a comprehensive evaluation of your neurological function. Our goal is to become acquainted with your body's current state of function. By understanding your body's function, we can better determine the underlying cause of your condition and design a method of care specific to your circumstances.

Enclosed is some important information for you to complete prior to your first visit. This information is essential for us to begin our assessment of your case.

- ***Confidential Case History Packet***
- ***Metabolic Assessment Form***
- ***Neurological Assessment Form***

These forms must be completely filled out prior to your visit. Please bring them with you on your scheduled appointment. In addition to the above documents, please bring in any recent diagnostic test results pertaining to your complaint (i.e. blood test, surgical report, X-Rays, CTs, MRIs w/ reports, etc.).

Again, we welcome and appreciate you choosing this office for your healthcare. If you have any questions please do not hesitate to call us at (303) 781-5617.

Respectfully,

Mountain Health Chiropractic & Neurology Center

Mountain Health
CHIROPRACTIC & NEUROLOGY CENTER

CONFIDENTIAL CASE HISTORY

(*PLEASE PRINT LEGIBLY*)

Patient Name ____ Date _____/_____/_____

SSN _______ / ______ / ________ (*for ID purposes*) DOB _____/_____/_____ Age _________ ❑ M ❑ F

Parent/Guardian Name (if minor) ____

Mailing Address ____ Apt./Ste. ____________

City ____ State _________ Zip _________________

Home (______)________________ Work (______)________________ Cell (______)________________

E-Mail Address ____

Work Address ____

City ____ State _________ Zip _________________

Occupation ____________________________ Company ____________________________________

Marital Status: ❑S ❑M ❑D ❑W Spouse's Name ______________________________

Spouse's Occupation & Employer ____

Name and phone # of Emergency Contact ______________________________________

Name(s) and age(s) of children ____

Who referred you to our office? ______________________________ Phone (______)________________

Have you ever had Chiropractic Care? ❑Yes ❑No How long ago? _______ Condition? ________________

Name and phone # of Chiropractor* ____

Name and phone # of General Practitioner (Primary)* ____________________________________

Name and phone # of Specialist(s)* ________________________________ Field ________________

Name and phone # of Specialist(s)* ________________________________ Field ________________

Please list all your reasons for visiting this office:

1. ______________________________________ 4. ______________________________________
2. ______________________________________ 5. ______________________________________
3. ______________________________________ 6. ______________________________________

*As part of our management of your case, we may periodically update your other caregivers on your progress in this office.

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PERSONAL HEALTH HISTORY

Name ______________________________________

Do you consume any of the following? ❑ Tobacco (packs/day) _____ or (cans/day) _____

❑ Coffee (cups/day) _____ (❑ Reg ❑ Decaf) ❑ Soft drinks (#/day)_____ (❑ Reg ❑ Diet ❑ Decaf)

❑ Tea (glasses/day) _____ ❑ Alcohol (drinks/day)_____ (1 drink = 1 oz. liquor, 12 oz. beer, or 6 oz. wine)

Do you use artificial sweeteners? ❑ No ❑ Yes If yes, please list? ______________________________

Level of exercise? ❑ None ❑ Moderate (days per week) _____ ❑ Strenuous (days per week) _____

Check any of the following you participate in: ❑ Yoga ❑ Pilates ❑ Aerobics ❑ Hiking ❑ Rock Climbing

❑ Backpacking ❑ Swimming ❑ Spinning ❑ Cycling ❑ Running ❑ Weights ❑ None

Are you wearing? ❑ Heel Lifts ❑ Sole Lifts ❑ Inner Soles ❑ Custom Orthotics ❑ None

Any rapid or unexplained weight changes in the past six (6) months? ❑ No ❑ Yes; _____lbs. – ❑ Loss ❑ Gain

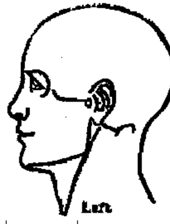
Do you eat unhealthy foods?	❑ No	❑ Yes	Do you use computer?	❑ No	❑ Yes
Do you have occupational stress?	❑ No	❑ Yes	Poor sleeping habits?	❑ No	❑ Yes
Do you have physical stress?	❑ No	❑ Yes	Sports injuries?	❑ No	❑ Yes
Do you have mental stress?	❑ No	❑ Yes	Slips and falls?	❑ No	❑ Yes
Do you sit for long hours?	❑ No	❑ Yes	Drugs?	❑ No	❑ Yes

Please mark the areas of complaint on the figures below as follows:

(P) Pain; (D) Discomfort; (T) Tingling; (N) Numbness; (R) Radiating; (B) Burning

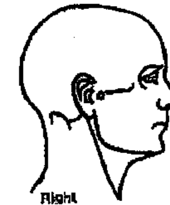
Left

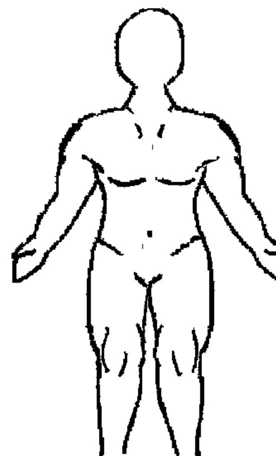
Right



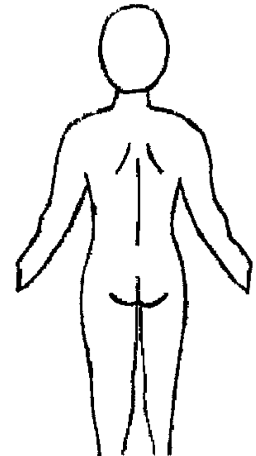
Left

Right





Front



Back

List any additional information here:

____

____

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Name ____

List *ALL* medications (prescriptions and over-the-counter) you take. (Use additional pages if necessary.)

Name of Prescription/OTC	Dosage	How **long** have you taken this and for **what condition?**

List *ALL* nutritional supplements you now take. (Use additional pages if necessary.)

Name of Supplements	Dosage	How **long** have you taken this and for **what condition?**

List *ALL* prior surgeries, hospitalizations, injuries, fractures, dislocations, and illnesses. (Use additional pages if necessary.)

Doctor Name	Date	Treatments / Procedures	Results
	____/____/____		
	____/____/____		
	____/____/____		

Please check all of the following conditions you have experienced in your lifetime.

❑ Cancer	❑ Stroke	❑ Mumps	❑ Measles	❑ Kidney infection	❑ Goiter
❑ Hepatitis	❑ Diabetes	❑ Anemia	❑ Ulcers	❑ ADD/ADHD	❑ Heart disease
❑ Pneumonia	❑ Alcoholism	❑ Chicken Pox	❑ Gout	❑ Depression	❑ Chronic Fatigue
❑ Seizures	❑ Asthma	❑ Fibromyalgia	❑ Appendicitis	❑ Thyroid disease	❑ Parkinson's
❑ Epilepsy	❑ Allergies	❑ Alzheimer's	❑ MS	❑ Gall Bladder Inflammation	

Please check all of the following conditions your family has experienced.

Father:	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Mother:	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Sisters:	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Brothers:	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Grandmother (M):	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Grandfather (M):	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Grandmother (P):	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS
Grandfather (P):	❑ Cancer	❑ Stroke	❑ Heart Disease	❑ Diabetes	❑ Parkinson's	❑ Alzheimer's	❑ MS

List any other health conditions you have had that are not listed:

____

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COMPLAINT HISTORY

Name ______________________________

Complaint 1

- When and how did your complaint first begin? ______________________________
- What makes your problem worse? ______________________________
- What makes your problem better? ______________________________
- Describe the type of pain/symptom you have? ______________________________
- Does your complaint travel into any other body part(s)? ______________________________
- Where exactly is the complaint area? ______________________________
- When do you notice the problem? ______________________________

Complaint 2

- When and how did your complaint first begin? ______________________________
- What makes your problem worse? ______________________________
- What makes your problem better? ______________________________
- Describe the type of pain/symptom you have? ______________________________
- Does your complaint travel into any other body part(s)? ______________________________
- Where exactly is the complaint area? ______________________________
- When do you notice the problem? ______________________________

Complaint 3

- When and how did your complaint first begin? ______________________________
- What makes your problem worse? ______________________________
- What makes your problem better? ______________________________
- Describe the type of pain/symptom you have? ______________________________
- Does your complaint travel into any other body part(s)? ______________________________
- Where exactly is the complaint area? ______________________________
- When do you notice the problem? ______________________________

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Informed Consent to Chiropractic Examination and Treatment

I hereby request and consent to the performance of examination, chiropractic adjustments, manual therapy and any other procedures, including, but not limited to, diagnostic tests, blood testing, salivary testing, diagnostic x-ray(s), physical therapy techniques, and/or neurological therapy techniques, on me, my child, or the person named below for which I am legally responsible, which are recommended by Dr. R. Shane Steadman, DC, DACNB, CCCN, Dr. David G. Arthur, DC, DACNB, CCCN, and/or other licensed doctors of chiropractic who now, or in the future, render treatment to me while employed by, working for, associated with, or serving as an on-call doctor for Mountain Health Chiropractic & Neurology Center, LLC.

I understand that, as with any healthcare procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horner's syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains, and separations. Some types of manipulations of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. This very rare event occurs during manipulation with the head in a rotated and extended position – a method of adjusting that is not used in this clinic. I do not expect the doctors to be able to anticipate all risks and complications and I wish to rely on them to exercise judgment during the course of the procedure(s), which they feel at that time, based upon the facts then known, are in my best interest.

1. I hereby authorize Mountain Health Chiropractic & Neurology Center, LLC to examine and treat my conditions as they deem appropriate with chiropractic healthcare, and I give authority for performance of these procedures.
2. It is an understanding and agreed that the amount paid to Mountain Health Chiropractic & Neurology Center, LLC for x-rays, is for the procedure only and the x-ray films will remain in the property of the office, being on file where they may be seen at any time while I am a patient of this office. If I wish to receive care without x-rays, I must make this known at the time of examination.
3. Mountain Health Chiropractic & Neurology Center, LLC will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I affirm that I am not currently pregnant or trying to become pregnant. Should this condition change, I will notify Dr. Arthur, Dr. Steadman and/ or their staff as soon as possible.

Initials_______________ Date of last Menstrual Period _____/_____/_____

❑ **I have read** or ❑ **I have had read to me** the above explanation of the chiropractic adjustment and related treatments. By signing below, I state that I have weighed the risks involved in undergoing chiropractic care and have decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent for chiropractic treatment. I understand results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I understand the information above and guarantee all forms were completed correctly and to the best of my knowledge. I further understand it is my responsibility to inform this office of any changes in my medical status.

____ ______/______/______

Signature of Patient Date

____ ____________________

Signature of Patient's Representative (if minor or physically incapacitated) Relationship to Patient

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FINANCIAL POLICY

I understand that the policy of Mountain Health Chiropractic & Neurology Center, LLC requires payment in full for all services rendered at the time of my office visit, unless other arrangements have been made. If my account has not been paid within 30 days from the date of service and no financial arrangements have been made, I will be responsible for any expenses incurred in the collection of my account. **Initial**_____

I understand and agree that health and accident insurance are an arrangement between my insurance carrier and me. I authorize Mountain Health Chiropractic & Neurology Center, LLC to release any information required to process insurance claims. However, I clearly understand and agree that all services rendered are charged directly to me, and that I am ultimately responsible for payment of my account. **Initial**_____

I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will become immediately due and payable. **Initial**_____

I understand that regardless of my payment method, any nutritional supplements, supplies, equipment, or educational materials I purchase must be paid for in full. These items will not be charged to my account and there is no refund on opened or used products. Unopened or unused products may be returned for a credit. **Initial**_____

Any outstanding balances that are my responsibility will be billed to me, and will be due in full within 15 days from the date of the billing notice. Any accounts that become 45 days delinquent will be subject to a finance charge of 1.75% per month (21% APR). Any accounts that become more than 60 days delinquent will be referred for assignment to our collection agency. All additional charges equal to the cost of collection including agency and attorney fees and court costs incurred and permitted by laws governing these transactions will be added to the amount due. **Initial**_____

If your check is not paid on presentment, you agree to pay a charge of $20, or any higher amount allowed by law. We may electronically debit or draft your account for this charge. Also, if your check is returned for insufficient or uncollected funds, your check may be electronically re-presented for payment. Returned checks are subject to a $30 returned check fee in addition to any other bank fees accrued by this office in the collection of funds. **Initial**_____

There will be a missed appointment fee of $75 should you fail to provide this office with at least one (1) day advance notice of cancellation or to reschedule. **Initial**_____

I also understand that if this is a personal injury or auto accident case, my charges are not contingent based on my settlement. (See **'Personal Injury Financial Policy'** on next page) **Initial**_____

____ ______/______/______

Signature of Patient Date

____ ____________________

Signature of Patient's Representative (if minor or physically incapacitated) Relationship to Patient

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Health Insurance Portability and Accountability Act (HIPAA)

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

I, (Print Name) ________________________________, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected healthcare information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice would be available to me at any time in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice before signing this Consent, and has encouraged me to read the Privacy Notice carefully before my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following that will be used by the Practice: a) a postcard mailed to me at the address provided by me; and b) telephoning and leaving a message on my voice mail or with the individual answering the phone. I also understand my name may be viewed on a sign-in sheet, referral board, and/or clinic newsletter and may be called when the doctor is ready to see you.

4. The Practice may use and/or disclose my PHI (which includes information about my heath or condition and the treatment provided to me) in order for the practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations. This includes contacting my general physician, any specialists, and/or any other practitioners I have seen.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment, and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.

I have read, and understand, the foregoing notice and all of my questions have been answered to my full satisfaction in a way that I can understand.

____ ______/______/______

Signature of Patient Date

____ __________________________________

Signature of Patient's Representative Relationship to Patient

(if minor or physically incapacitated)

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