SCOTT FAMILY HEALTH

Chiropractic | Massage | Acupuncture | Physical Therapy

Today's Date:_____

Patient Information:

Patient First Name:	**Middle Initial:**	**Last Name:**
Patient Address:		
Patient City:	**Patient State:**	**Patient Zip:**
Home Phone:	**Mobile Phone:**	**E-mail:**
Date Of Birth:	**Gender:**	**Marital Status:**
How did you hear about us?		

Pregnant ❑ Yes ❑ No **How many weeks** _____

Race *(check one)*

❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian/Alaskan Native
❑ Vietnamese ❑ Asian Indian ❑ Chinese ❑ Filipino ❑ Japanese ❑ Korean
❑ Asian ❑ Native Hawaiian or other Pacific Island ❑ Samoan ❑ Guamanian or Chamorro
❑ Other_____ ❑ I choose not to specify

Multi-Racial *(check one)* ❑ Yes ❑ No ❑ Unknown

Ethnicity *(check one)* ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ I choose not to specify

Preferred Language *(check one)*

❑ English ❑ Spanish ❑ American Sign Language ❑ Chinese
❑ French ❑ German ❑ Tagalog ❑ Vietnamese ❑ Italian
❑ Korean ❑ Russian ❑ Polish ❑ Arabic ❑ Portuguese ❑ Japanese
❑ French Creole ❑ Greek ❑ Hindi ❑ Persian
❑ Urdu ❑ Gujarati ❑ Armenian ❑ I choose not to specify

Accident information:

Date of accident: _____ _____T- Boned _____ Rear-ended _____ Head- on

How many cars were involved: _____ Did the air bags deploy? _____ Yes _____ No

Speed of Accident: _____ Did you ride in an Ambulance? _____ Yes _____ No
Did you wear your seatbelt? ____ yes _____ No Did you go to the ER? _____ Yes _____ No

Symptom 1_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
  - Bending neck forward/backward Tilting head to left/right turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
  - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
  - Morning Afternoon Evening Night Unaffected by time of day

Symptom 2_____

- On a scale from 0-10, with 10 being the worst, please circle the number that best describes the symptom most of the time: 0 1 2 3 4 5 6 7 8 9 10
- What percentage of the time you are awake do you experience the above symptom at the above intensity:
  5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100
- When did the symptom begin?_____
  - Did the symptom begin suddenly or gradually? (circle one)
  - How did the symptom begin?_____
- What makes the symptoms worse? (circle all that apply)
  - Bending neck forward/backward Tilting head to left/right turning head left/right Bending forward/backward at waist Tilting left/right at waist Sitting Standing Getting up from sitting position Lifting Any movement Driving Walking Running Nothing Other_____
- What makes the symptoms better? (circle all that apply)
  - Rest Ice Heat Stretching Exercise Massage Pain Medication Nothing Other_____
- Describe the quality of the symptom (circle all that apply):
  - Sharp Dull Achy Burning Throbbing Piercing Stabbing Deep Nagging Other _____
- Does the symptom radiate to another part of your body? (circle one) Yes No
  - If yes, where does the symptom radiate? _____
- Is the symptom worse at certain times of the day or night? (circle one):
  - Morning Afternoon Evening Night Unaffected by time of day

Medications:

Current medications, including frequency and dosage if known. If there are no current medications, check here: ❑

NAME	Start Date	Frequency	Dosage		NAME	Start Date	Frequency	Dosage

List any vitamins, herbs or nutritional supplements that you are taking:

Vitamin/Mineral Name	Year Started (yyyy)	Year Stopped (yyyy)	Dosage (amount/# daily)

Allergies:

List any known allergies you have had to any medications. If no allergies are known, check here: ❑

1) _____ **5)** _____

2) _____ **6)** _____

3) _____ **7)** _____

4) _____ **8)** _____

Surgical History:

Please list any surgeries you have had:

1) _____

2) _____

3) _____

4) _____

5) _____

_____

Social History:

Have you ever used Tobacco: _____ Yes ____ No If Yes, what type? _____

Frequency: _____

Have you tried to quit using tobacco: _____ Yes ____ No

Do you Drink Alcohol: _____ Yes ____No If Yes: Type of alcohol: _____

Frequency: _____ Amount:_____

Do you drink/consume caffeine: ____ Yes _____No If Yes: Type of caffeine: _____

Frequency: _____ Do you exercise: ____ Yes__ No

Type: _____ Frequency: _____

Special Diet (ex. Gluten free): _____

Have you ever used recreational drugs: ____ Yes ____ No If Yes, please list: _____

_____

_____

Family History:

Family History: Do any Family Members have any of the following? Please Indicate who has the condition:

ADD/ADHD_____

Alcoholism _____

Allergies _____

Arthritis _____

Asthma _____

Blood Disorder _____

Cancer _____

Cardiovascular Disease _____

Coronary Artery Disease _____

Depression_____

Developmental Delay _____

Diabetes _____

Eczema _____

Elevated Lipids _____

Genetic Disease _____

Hearing Deficiency _____

Hypertension _____

Irritable Bowel Disease _____

Learning Disability _____

Mental Illness _____

Migraines_____

Obesity _____

Osteoporosis _____

Peripheral Vascular Disease_____

Renal Disease _____

Seizure Disorder _____

Stroke _____

Thyroid Disorder _____

Other _____

Review of Systems: Please Check all the Apply:

Constituional		Cardiovascular		Reproductive	
	Chills		Chest Pain		Erectile Dysfunction
	Fatigue		Claudication		Penile Discharge
	Malaise		Edemda		Sexual Dysfunction
	Night Sweats		Papatations		Abnormal Pap
	Weight Gain		Other:		Dysmenorrhea
	Weight Loss				Hot Flashes
	Other:	Musculoskeletal			Irregular Menses
			Back Pain		Vaginal Discharge
Neurological			Joint Pain		Other:
	Extremity Numbness		Joint Swelling		
	Extremity Weakness		Muscle Weakness	HEENT	
	Gait Disturbance		Neck Pain		Ear Drainage
	Headache		Other:		Ear Pain
	Memory Loss				Eye Discharge
	Seizures	Integumentary			Eye Pain
	Tremors		Breast Discharge		Hearing Loss
	Other:		Breast Lump		Nasal Drainage
			Brittle Hair		Sinus Pressure
Gastrointestinal			Brittle Nails		Sore Throat
	Abdominal Pain		Hair Loss		Visual Changes
	Blood In Stool		Hirsutism		Other:
	Change in Stool		Hives		
	Constipation		Pruritus	Phsyciatric	
	Diarrhea		Mole Changes		Anxiety
	Heartburn		Rash		Depression
	Loss of Appetite		Skin Lesion		Insomnia
	Nausea		Other:		Other:
	Vomiting	Respiratory			
	Other:	Chronic Cough		Genitourinary	
Hematologic/ Lymphatic			Cough		Dribbling
	Easy Bleeding		Known TB Exposure		Dysuria
	Easy Bruising		Shortness of Breath		Hematuria
	Lymphadenopathy		Wheezing		Polyuria
	Other:		Other		Slow Stream
		Immunologic			Urinary Frequency
Metabolic/ Endocrine			Contact Allergy		Urinary Incontinence
	Cold Intolerance		Environ Allergy		Urinary Retention
	Heat Intolerance		Food Allergies		Other:
	Polydipsia		Seasonal Allergies		
	Polyphagia		Other:		
	Other:				

Cancellation Policy

We value your time and our provider's time here at Scott Family Health. Therefore, we are strictly enforcing the 24-hour cancellation policy. You may opt-in for e-mails or text reminders that will be given 24 hours in advance. Any appointments must be cancelled at least 24 hours prior to your scheduled appointment to avoid the cancellation fee. The cancellation fee is $35 for all services. We appreciate your understanding.

Patient: _____ Date: _____/_____/_____

Credit Card Authorization for Cancellation

We provide secured methods of accepting your payment if a cancellation is made with less than 24 hours' notice or if an appointment is missed.

We will automatically charge the card on file for $35.00 for any missed appointments or appointments cancelled with less than 24 hours' notice.

I, _____ authorize Scott Family Health to keep my signature and credit card information on file to charge my account $35.00 if signed cancellation policy is violated.

I am authorizing the use of this card for the Scott Family Health cancellation fee when applicable.

*If you choose not to leave a card on file, a bill for $35 will be sent to the address we have listed and will need to be resolved prior to your next visit. Unresolved late fees may result in cancellation of future appointments.

Name of Patient(s):_____ Card #: _____

Card Holder Name:_____ Exp:_____ Security Code:_____

Card Holder Address:_____

Type of Credit Card: VISA _____ MC_____ AMEX _____ DISC _____

Signature: _____

By signing below, I am stating that all of the information above is completed to the best of my knowledge and belief true, correct and complete.

_____ _____

Patient or Guardian Signature Date

_____ _____

Print Name Relationship

HIPAA Privacy Authorization Form/ Notice of Privacy Practices

Authorization of use or disclosure or protected health information

(Required by the Health Insurance Portability and Accountability Act -45 CFR Parts 160 and 164)

Please read the following and sign at the bottom:

I hereby authorize Integrative Health to view radiology studies that are necessary for my treatment and/ or evaluation through the PAC system provided by Banner Health System, Poudre Valley Hospital, and related affiliates. Requests for other studies and medical information will require a separate request form and my signature. *I understand that these studies may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Hum Immunodeficiency Virus (HIV) and other communicable diseases. Behavioral Health Care/ Psychiatric Care, Treatment of alcohol and/or drug abuse and genetic testing; my signature authorizes the release of any such information.*

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, and/ or other purposes as I may direct.

This authorization shall be in force and in effect until I sign a written request to terminate this agreement. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re- disclosed by the person or organization that received the information.

I release Integrative Health, its employees, staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

By signing below, you agree to the statements presented.

If you would like us to disclose your medical records, upon request, to any additional parties (i.e.; spouse, parent, providers) please provide Name, Date of Birth, and Relationship:

_____

_____

_____

_____

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE DATE

_____

PRINT NAME OF PATIENT OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

_____

WITNESS SIGNATURE DATE