ALPINE CHIROPRACTIC

Dr Leah McAlpine and Dr. James Hoffman

Name: ______________________ **Date:** ___/___/___

Neck / Upper Back ______________________ A=ACHE

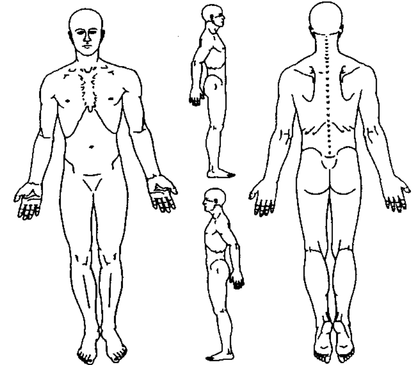
Mid / Low Back ______________________ B=BURNING

S=SHARP

N=NUMBNESS

Other ______________________ P=PINS & NEEDLES

Mark an "X" where you have pain.



PAIN SCALE
Please circle the number that best describes your pain
0 1 2 3 4 5 6 7 8 9 10
NONE LITTLE MEDIUM SEVERE

***Patient Signature:** ______________________

Objective Findings:

____

ASSESSMENT: Progress

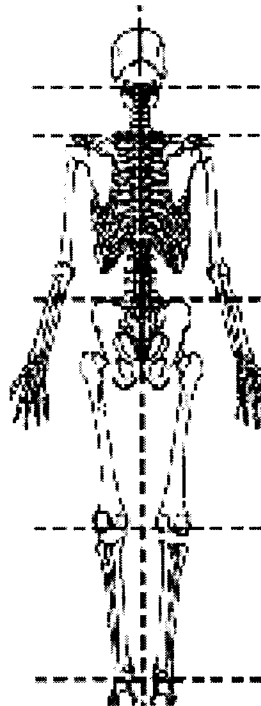
- ❑ Acute Sub-Acute Chronic
- ❑ Schedule - On Ahead Behind
- ❑ Exacerbation of ___/___/___
  Mild Moderate Severe

TREATMENT:

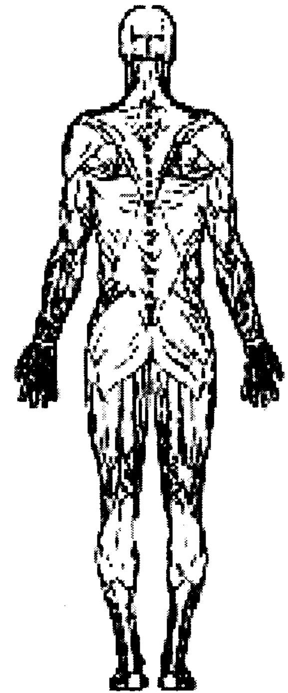
- ❑ 2. 99202 New Patient 15 min Exam
- ❑ 3. 99203 New Patient 30 min Exam
- ❑ 6. 99212 Re-Exam (Brief)
- ❑ 7. 99213 Re-Exam (Moderate)
- ❑ 10. 98940 Adjust / Manipulation1-2
- ❑ 11. 98941 Adjust / Manipulation 3-4
- ❑ 12. 98943 Extra Spinal Adjustment
- ❑ 13. 97010 Hot / Cold Packs
- ❑ 14. 97012 Mechanical Traction / IST
- ❑ 18. 97112 Manual Therapy / TPT
- ❑ 19. 97110 Therapeutic Exercises
- ❑ 47. 97530 Therapeutic Activity (SOT, F/D)
- ❑ 62. 97140 Cervical Traction
- ❑ 25. 99070 Supplies ____________
- ❑ 24. 72040 X-Ray Cervical AP & Lat
- ❑ 29. 72100 X-Ray Lumbar AP & Lat
- ❑ 135.72070 X-Ray Thoracic AP & Lat

Other: ______________________

C0
C1
C2
C3
C4
C5
C6
C7
L1
L2
L3
L4
L5
SAC
L-IL
R-IL



T1
T2
T3
T4
T5
T6
T7
T8
T9
T10
T11
T12



Notes: ______________________

Next Visit: ____________ **Payment:** ____________ **Dr's Initials:** ________

Alpine Chiropractic
11990 Colorado Blvd
Thornton, CO 80233

(PLEASE PRINT) DATE_______________

Name______________________________Address______________________________

City, State, Zip______________________________Home #______________________
Cell #______________________

Social Security #__________________ Birthdate______________ Age____ Height______ Weight_______

No. of Children__________ Marital Status – M S D W Spouse's Name or Parent____________________

Your Occupation____________________ Employer____________________ Work #______________

Address______________________________ City, State, Zip______________________________

Who may we thank for referring you to our office? ______________________________

Have you ever had Chiropractic Care before? ______________ If so when? ______________

List your chief complaints in order of severity:

(1)______________________________ For how long? ______________

(2)______________________________ For how long? ______________

(3)______________________________ For how long? ______________

List other doctors consulted for these conditions:

(1)______________________________ Address ______________________________

(2)______________________________ Address ______________________________

Is this injury or illness work related? ______________ Have you reported it to your employer? ______________

Is this injury or illness related to an automobile accident? ______________ (if yes, name of:)

Your Auto Ins. Co______________________ Policy #______________________ Claim #______________

Address______________________________ Agent's Name______________________________

Agent's Phone #______________________________

List any previous auto accidents:

____

NOTICE: Not all patients require X-rays to determine or verify diagnosis, type of treatment or length of treatment if your examination warrants X-ray analysis the following office policy prevails:

(1) All first visit charges with or without X-rays are payable when service is rendered

(2) The fee paid for treatment X-rays is for analysis only. The film itself is the property of this office and remains part of your permanent records.

Method of payment you plan to use to take care of today's charges.

☐ Check ☐ Cash ☐ Mastercard ☐ Visa

List any medications currently taking

______________________ ______________________

______________________ ______________________

Surgery (Please include all surgery)

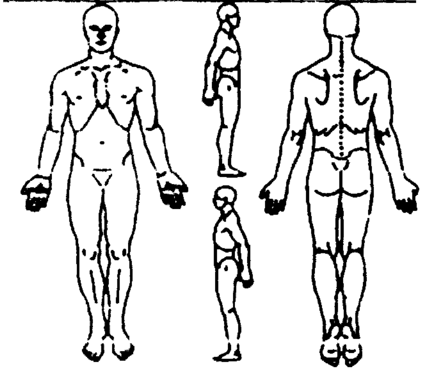
(1)Type____ When ______________________________

(2)Type____ When ______________________________

(3)Type____ When ______________________________

ARE YOU NOW OR HAVE YOU SUFFERED FROM ANY OF THE FOLLOWING:

- ☐ Stroke
- ☐ Fatigue
- ☐ Migraine
- ☐ Nervousness
- ☐ Arthritis
- ☐ Numbness or pain in arms/legs/hands
- ☐ Pregnant at this time
- ☐ Pain between shoulders
- ☐ Spinal curvature
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Headache
- ☐ Shingles
- ☐ Dizziness
- ☐ Heart Attack
- ☐ Cancer
- ☐ Diabetes
- ☐ Sinus
- ☐ Stiff neck
- ☐ Backache
- ☐ Swollen joints



Please mark your areas of pain on the figures

0__________________5__________________10

Please rate your pain: 0 Absent to 10 Extreme

Are symptoms

☐ Getting worse ☐ Getting better ☐ Staying the same

X-RAY CONFIRMATION: This is to confirm that I have been advised by this office that x-rays can be hazardous to an unborn child. At this time, to the best of my knowledge, I am not pregnant, and I consent to spinographic pictures.

Signature____ Date____________________

CONSENT TO TREAT A MINOR CHILD: I hereby authorize this office to administer chiropractic as deemed necessary for my child.

Signature____ Date____________________

NOTES:

Privacy Acknowledgement

The Privacy Policies and Procedures are effective as of April 14, 2003. This notice will expire seven years after the date upon which the record was received. By signing below, I acknowledge that I have read and may request a copy of these Privacy and Policies at any time.

____________________________ ______________________

Patient Name Printed | Date

____________________________ ______________________

Patient Signature | Authorized Provider Representative

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Privacy notices, but acknowledgement could not be obtained because

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from
- Other (Please Specify)____________________________

Office Personnel (signature)____________________________ Date:________________

Assignment

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered by this clinic.

A photocopy of this assignment shall be considered as effective and valid as the original.

____________________________ ______________________

Patient Signature | Date

Release of Information

I authorize this clinic to release any information pertinent to my case to any insurance company, adjustor, and attorney involved in this case; and hereby release this clinic of any consequence thereof.

____________________________ ______________________

Patient Signature | Date

Financial Responsibility

I agree to be financially responsible for any and all charges incurred at this clinic including but not limited to my insurance deductible, copayment, any services rejected by my insurance company, as well as any collection costs. **In addition all missed appointments will be charged a $25.00 fee.**

____________________________ ______________________

Patient Signature | Date

Alpine Chiropractic
11990 Colorado Blvd
Thornton, CO 80233
Phone 303-920-9486

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of the findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________	______________________	______________
Print Name	Signature	Date

Consent to evaluate and adjust a minor child:

I,__________________________ being the parent or legal guardian of __________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Date of last menstrual cycle: ______________________

______________________________	____________________
Signature	Date