Cherry Creek Wellness Center/Noel Chiropractic Patient Case History

Name:_____ Date of Birth:_____ Age:___ M:____ F:____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Email Address:_____ Social Security Number:_____

Marital Status:_____ Children, Ages:_____ Spouse:_____

Occupation:_____ Employer:_____

Emergency Contact Name:_____ Phone:_____

Who referred you to us?_____ How did you hear about us?_____

Referring physician:_____ Primary care physician:_____

What is your main complaint?_____

How long have you had this condition?_____

Have you had similar issues in the past?_____

Have you been treated by another healthcare provider for the current complaint?_____
If yes, who?_____

Are your symptoms related to a surgical procedure?_____

Is this condition getting better, staying the same, or getting worse?_____

When did your symptoms begin?_____

How did your symptoms begin?_____

What makes your symptoms worse?_____

What makes your symptoms better?_____

Patient/Guardian Signature:_____ **Date:**_____

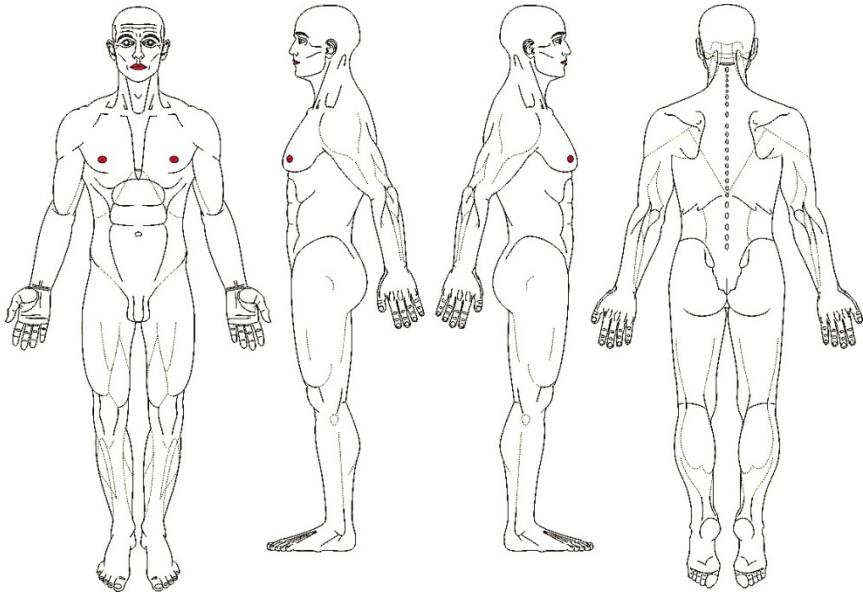
INITIAL SYMPTOMS QUESTIONNAIRE

Name _____ Date _____

Where is your pain now?

Mark the areas on your body where you feel the sensations described below. Include all affected areas and feel free to add any additional information!

- ☐ Aching **AAAA**
- ☐ Shooting **HHHH**
- ☐ Burning **BBBB**
- ☐ Stabbing **XXXX**
- ☐ Cramps **CCCC**
- ☐ Stiffness **FFFF**
- ☐ Dull **DDDD**
- ☐ Swelling **WWWW**
- ☐ Numb **NNNN**
- ☐ Throbbing **TTTT**
- ☐ Sharp **RRRR**
- ☐ Tingling **GGGG**
- ☐ Other _____



How severe is your pain?

No pain — Worst pain imaginable

(Mark a vertical line along the scale where you would describe your pain severity)

What 3 things are most difficult because of your symptoms?

1. _____
2. _____
3. _____

Which stage of recovery is your goal for treatment?

- ☐ Relief (I want to feel better with the least amount of time/money)
- ☐ Correction (I want to stabilize my body and prevent a relapse)
- ☐ Wellness (I want to achieve my best level of health possible)

Signature _____

Name:_____ Date:_____

REVIEW OF SYMPTOMS Check only the ones you now have or have had in the past

GENERAL	NOW	PAST
Weakness	☐	☐
Fatigue	☐	☐
Fever	☐	☐
Chills	☐	☐
Night Sweats	☐	☐
Fainting	☐	☐
SKIN		
Color Changes	☐	☐
Nail Changes	☐	☐
Hair Changes	☐	☐
Moles	☐	☐
Rashes	☐	☐
Sores	☐	☐
HEAD		
Headaches	☐	☐
Injuries	☐	☐
Bumps	☐	☐
Last Eye Exam	_____	
Glasses	☐	☐
Contacts	☐	☐
Cataracts	☐	☐
EARS		
Hard of Hearing	☐	☐
Deafness	☐	☐
Ringing	☐	☐
Discharge	☐	☐
Earache	☐	☐
Itching	☐	☐
Dizziness	☐	☐
Room Spins	☐	☐
NOSE		
Decreased Smell	☐	☐
Bleeding	☐	☐
Pain	☐	☐
Discharge	☐	☐
Obstruction	☐	☐
Post Nasal Drip	☐	☐
Deviated Septum	☐	☐
Runny Nose	☐	☐
Sinus Congestion	☐	☐
MOUTH		
Bleeding Gums	☐	☐
Sores	☐	☐
Dental Problems	☐	☐
Bad Breath	☐	☐
Loss of Taste	☐	☐
Dry Mouth	☐	☐
Ulcers	☐	☐
Blisters	☐	☐

THROAT	NOW	PAST
Soreness	☐	☐
Bad Tonsils	☐	☐
Hoarseness	☐	☐
Pain	☐	☐
Trouble Swallowing	☐	☐
Recurrent Infections	☐	☐
NECK		
Neck Enlargement	☐	☐
Stiff Neck	☐	☐
Soreness	☐	☐
Lumps	☐	☐
Masses	☐	☐
BREASTS		
Discharge	☐	☐
Lumps	☐	☐
Pain	☐	☐
Bleeding	☐	☐
Nipple Changes	☐	☐
Skin Changes	☐	☐
Engorgement	☐	☐
LUNGS		
Cough	☐	☐
Phlegm	☐	☐
Blood	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Pain	☐	☐
Congestion	☐	☐
Inhalant Exposure	☐	☐
HEART		
Murmur	☐	☐
Palpitations	☐	☐
Rapid Heartbeat	☐	☐
Swollen Extremities	☐	☐
Cold Extremities	☐	☐
Chest Pain/Pressure	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Blue Extremities	☐	☐
BLOOD		
Anemia	☐	☐
Low Blood Iron	☐	☐
Easy Bruising	☐	☐
Easy Bleeding	☐	☐
Swollen Nodes	☐	☐
Painful Nodes	☐	☐
Sugar in Blood	☐	☐
Red Spots	☐	☐

GASTROINTESTINAL	NOW	PAST
Abdominal Pain	☐	☐
Nausea	☐	☐
Bloated	☐	☐
Belching	☐	☐
Heartburn	☐	☐
Indigestion	☐	☐
Irregular Bowel Habits	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Gas	☐	☐
Hemorrhoids	☐	☐
Poor Appetite	☐	☐
Food Intolerance	☐	☐
Bloody Stools	☐	☐
Black Stools	☐	☐
GENITOURINARY		
Urge Incontinence	☐	☐
Stress Incontinence	☐	☐
Straining	☐	☐
Back Pain	☐	☐
Frequent Voiding	☐	☐
Stones	☐	☐
Burning	☐	☐
Bed Wetting	☐	☐
Small Stream	☐	☐
Discharge	☐	☐
Impotence	☐	☐
Dribbling	☐	☐
Cloudy Urine	☐	☐
Urine Color	_____	
Spotting Between Periods	☐	☐
Menstrual Cramps	☐	☐
Itching	☐	☐
Painful Intercourse	☐	☐
Irregular Periods	☐	☐
Hot Flashes	☐	☐
Contraception Type	_____	
Age at First Period	_____	
Duration of Cycle	_____	Days
Duration of Flow	_____	Days
No. of Pregnancies	_____	
No. of Births	_____	
No. of Abortions	_____	
Menstrual Flow	Normal	Abnormal
Last Period	_____	
Last Pap Smear	_____	
Last Vaginal Exam	_____	
Last Mammogram	_____	
Last Prostate Exam	_____	

Name:_____ Date:_____

NEUROLOGIC	NOW	PAST
Seizures	☐	☐
Vertigo	☐	☐
Dizziness	☐	☐
Hand Trembling	☐	☐
Loss of Sensation	☐	☐
Discoordination	☐	☐
Weak Grip	☐	☐
Facial Weakness	☐	☐
Paralysis	☐	☐
Difficult Speech	☐	☐
Tingling	☐	☐
Loss of Memory	☐	☐
Numbness	☐	☐

PSYCHIATRIC	NOW	PAST
Hyperventilation	☐	☐
Insecurity	☐	☐
Depression	☐	☐
Troubled Sleep	☐	☐
Irritable	☐	☐
Undecidedness	☐	☐
Timid	☐	☐
Hallucinations	☐	☐
Loss of Memory	☐	☐
Alcoholism	☐	☐
Drug Addiction	☐	☐
Suicidal Thoughts	☐	☐
Extreme Worry	☐	☐
Sexual Problems	☐	☐

MUSCULOSKELETAL	NOW	PAST
Muscle Pain	☐	☐
Muscle Weakness	☐	☐
Muscle Cramps	☐	☐
Muscle Twitching	☐	☐
Joint Stiffness	☐	☐
Joint Pain	☐	☐

ENDOCRINE

	NOW	PAST
Weight Loss	☐	☐
Weight Gain	☐	☐
Extremely Thin	☐	☐
Heat Intolerance	☐	☐
Hair Changes	☐	☐
Breast Changes	☐	☐

IMMUNIZATION

DPT	☐
Mumps	☐
Smallpox	☐
Typhoid	☐
Tetanus	☐
Measles	☐
Pneumococcal	☐
Influenza	☐
Polio	☐
MMR	☐

BLOOD TYPE

A+/-	☐
B+/-	☐
AB+/-	☐
O+/-	☐

PAST MEDICAL ISSUES: Check only if you have had these in the past

Hay Fever	☐	Epilepsy	☐		
Mumps	☐	Paralysis	☐		
Rheumatic Fever	☐	Polio	☐		
Allergies	☐	Mental Illness	☐		
Angina	☐	Alcoholism	☐		
Cancer	☐	Depression	☐		
Tumor	☐	Nervous Breakdown	☐		
Blood Disease	☐	Migraine	☐		
Leukemia	☐	Gout	☐		
Heart Trouble	☐	Prostate Problems	☐		
Varicose Veins	☐	Sexually Transmitted Disease	☐		
Phlebitis	☐	Diabetes	☐		
Hypertension	☐	Bladder Trouble	☐		
Stroke	☐	Kidney Infections	☐		
Ulcers	☐	Dysentery	☐		
Jaundice	☐	Blood Transfusions	☐		
Skin Trouble	☐				
Gallstones	☐	Date of Last Chest X-Ray	_____		
Liver Trouble	☐	Date of Last TB Test	_____		
Hepatitis	☐	Allergies_____	_____		
Parasites	☐				
Osteoporosis	☐				

SOCIAL HISTORY

Current Weight	_____		Have you recently lost/gained weight?		Y/N	If Yes, how many pounds?	_____
Mental Work	Heavy	Moderate	Light	Hours/Day	_____		
Physical Work	Heavy	Moderate	Light	Hours/Day	_____		
Exercise	Heavy	Moderate	Light	Hours/Wk	_____		
Smoking	Current	Previous	Packs/Day _____	Years	_____		
Alcohol	Beer	Wine	Liquor	Drinks/Wk	_____	Years _____	
Caffeine	Cups/Day _____		Years _____				
Aspirin	Pills/Day _____		Years _____	Others	_____	_____	

FAMILY HISTORY

Relative	Age	Death Age	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Grandparents					

OFFICE STAFF ONLY

VITALS	
BP	_____
HR	_____
O2%	_____
Initials	_____

Cherry Creek Wellness Center and Noel Chiropractic
Policies and Informed Consent for Examination and Treatment

Cancellation Policy

Our goal is to provide you with the most advanced, effective chiropractic, massage therapy, and physical therapy care available at one-on-one appointments. As a result, we reserve space and staff time for your appointment. Except for emergency situations, anyone who does not give us 24 hours notice of a cancellation will be charged a $25 cancellation fee.

Assignment of Benefits Policy – THIS SECTION WILL BE COMPLETED BY OUR OFFICE STAFF

To _____ (insurance company), I hereby release payment to Cherry Creek Wellness Center (CCWC) and/or Noel Chiropractic for medical services rendered to me. Furthermore, I understand that CCWC and/or Noel Chiropractic has agreed to accept the contracted amount as payment in full.

Insurance Policy Benefits

In Network		Out of Network	
Deductible_____	Out of Pocket Max: _____	Deducible: _____	Out of Pocket Max: _____
Co-Insurance:_____	Co-Pay_____	Co-Insurance:_____	Co-Pay:_____
Visit Limits: _____		Visit Limits: _____	
Pre-Cert/Referral #_____		Spoke To: _____	

Comments: _____

While we believe that this information is correct, we have often been given incorrect or incomplete information when verifying insurance benefits. As a result, we recommend that you also confirm your benefits with your insurance company. Your policy with your health/auto insurance company is a contract between **them and you**. If your insurance company fails to pay or only pays part of your bill, you will be responsible for any balance left over.

Consent to Treat

I have had the opportunity to discuss with the provider or other clinic personnel the risk and benefits of chiropractic, massage therapy, and/or physical therapy procedures. I understand that neither chiropractic, massage therapy, and/or physical therapy is an exact science, and that my care may involve judgments based upon facts and information known to the providers. The provider uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected, but rather I wish to rely on the provider to choose and recommend a best course of treatment, based on scope of practice and facts known, that is in my best interest. I further understand that there are certain degrees of risk associated with chiropractic, massage therapy, and physical therapy care, and while rare, complications can occur including but not limited to fractures, disc injuries, strains/sprains, infection, bleeding, pneumothorax, nerve injury, and stroke. By signing below, I agree to accept and consent to the risk associated with the care that I am about to receive.

Female Patients: □ I am not pregnant □ I am or may be pregnant **PLEASE TELL US IF YOU BECOME PREGNANT**

Email Policy

We strive to protect ALL patient information, including your email address. By providing your email address to us you are giving us permission to send you occasional (not more than once a month) email newsletters, coupons, informative articles, etc., and have access to communication with your provider. We will NEVER sell or give out your email address and you will always reserve the right to unsubscribe from our email list.

Patient/Guardian Name_____ Date:_____

Patient/Guardian Signature:_____

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Cherry Creek Wellness Center, Inc.'s and/or Noel Chiropractic Notice of Privacy Practices.

Patient Name:_____ Date of Birth:_____

Patient Signature:_____ Date:_____

Cherry Creek Wellness Center, Inc.'s/Noel Chiropractic's LEGAL DUTY

Healthcare providers are required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use your personal health information primarily for treatment of your injury; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.
We may also use and disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law, such as in cases of suspected abuse or neglect, law enforcement or national security issues, or for coroners, funeral directors, or medical examiners.
In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with written authorization to release your information, you may revoke that authorization to stop future disclosures at any time.
We may change our policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.
You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. We will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS
If you are concerned that Cherry Creek Wellness Center, Inc. or Noel Chiropractic may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact the individual(s) listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices of if you have a complaint, please contact the following person(s):

Cherry Creek Wellness Center, Inc. Noel Chiropractic
R. Dean Hasse, P.T., A.N.M.T. Patrick Noel, DC

Effective September 16, 2011

Documentation of Good Faith Efforts to Obtain Patient's acknowledgement that they received Notice of Privacy Practices

The patient presented to the office on _____ and was provided with a copy of Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of hi/her receipt of the Notice. However, such acknowledgment was not obtained because:

- ○ **Patient refused to sign**
- ○ **Patient was unable to sign or initial because:_____**
- ○ **The patient had a medical emergency, and an attempt to obtain the Acknowledgment will be made at the next available opportunity**
- ○ **Other reason_____**

_____

_____ _____
Signature of employee completing form Date