Body In Balance Wellness Center

755 Heritage Rd, Unit 110
Golden, CO 80401
303-215-0390
www.bodyinbalancechiropractic.com

Welcome to Body In Balance Wellness Center

Welcome to our office! Rest assured that you will be provided the most appropriate and professional healthcare possible. Our most important goal is the constant improvement and enhancement of your health and wellbeing. In order to get started with your examination procedures, which will determine if we can help you, we want you to understand what we do and why we are going to do it, we need your consent to perform a history and physical evaluation. Our focus will be on testing procedures and questions that solely relate to quality of life, stress levels, body awareness, spinal cord tension, spinal subluxations, the loss of spinal and neural integrity and the overall function of your body.

Informed Consent

This office practices evidence-informed spinal care. This practice is based on nationally recognized practice guidelines as well as published research conducted at numerous universities and chiropractic colleges. Our commitment to you is to deliver the safest, highest quality of life changing care we can deliver, focused on the reduction of spinal cord tension and related spinal subluxations, as well as to develop and improve spinal and neural integrity.

For this reason, we constantly upgrade our techniques, procedures, and technology. While these procedures may meet the criteria of the state board of chiropractic examiners, due to the review process utilized to determine the effectiveness of a procedure, many of the procedures utilized in this office may fall into their designation of unproven. This includes but is not limited to para-spinal thermography.

When a person seeks our care and when we accept a patient for such care, it is essential that they are both working towards the same goals. This will prevent any confusion or disappointment. The goal of our office is to allow your body to function at its highest potential, free from interference and stress that causes dysfunction, disease, and eventually symptoms and sickness. We define health as a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Most importantly, you must understand that our care is not a substitute for medical treatment of any kind, in anyway, or for any reason. The medical approach treats symptoms and diagnoses conditions and diseases. Patients usually go to their medical doctors to get rid of whatever symptoms or conditions are bothering them. This is symptom, sickness and disease care and is necessary in emergency situations. Our approach recognizes that you get symptoms for a reason, attempts to find the cause of the symptoms, and addresses the function of the whole body. This is how we define healthcare; focusing on the optimum function of the individual, and it is what we do it in our office.

We provide various services in our office including Chiropractic care, massage therapy, exercise therapy and nutritional services. The purpose of Chiropractic care is to restore and enhance the integrity of the spine, spinal cord and its nerve roots. Vital nerve pathways are housed within and protected by the bones of the spine call vertebrae. Misalignments of one or more of those vertebrae, which interfere with transmission of normal nerve impulses, resulting in a lessening of the body's innate ability to express its maximum health potential, are called SUBLUXATIONS. Subluxations are the most common cause of nerve system interference and can potentially cause dysfunction to the tissue and organs that these nerves supply. Subluxations are corrected through an adjustment. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine.

With appropriate Chiropractic care, these subluxations can be reduced and corrected, which will restore normal nerve function. A properly functioning nerve system is the foundation to good health.

The information we get from you on the following pages is important. For this reason, please fill out our history forms completely and to the best of your ability so that we can quickly get you on the road to health. We look forward to a healthy relationship with you and your family.

I, _____ _____, have read the above, understand it.
Signature Date

PERSONAL INFORMATION

Name:_____
Address:_____
City:_____ State:____ Zip:_____
Home Phone:_____
Work Phone:_____
Cell Phone:_____
Age:_____ Date of Birth:____/____/_____
E-mail:_____

Sex: M / F Today's Date:_____
Employer: _____
Occupation: _____
Social Security #: _____
Marital Status: S / M / P / D / W
Name of Spouse: _____
Names and Ages of Children:
_____

We have the ability to send text messages for appointment reminders. Please fill out the following if you would like to receive this benefit. Phone number for text:_____ + Carrier Name _____

Preferred Language: _____ Ethnicity (Circle): Hispanic or Latino / Not Hispanic or Latino/ Decline

Race (Circle): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) / Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Emergency Contact:_____ Relationship:_____ Phone_____

How did you hear about us or who can we thank for referring you to our office? _____

ACCIDENT INFORMATION: Is condition due to an accident? Yes____ No____ Date of Accident _____
Type of Accident: Auto ____ Work ____ Home____ Other ____

Females: If we determine X-Rays are necessary, are you currently pregnant? Yes / No

CURRENT HEALTH CONCERNS

Please indicate the main reason you are seeing us today: _____

What describes your health concern? (circle all that apply)
Sharp / Dull / Achy / Shooting / Burning / Other: _____

Is there any radiating pain into the arms or legs? _____ **Is there any numbness or tingling?** _____

How long have you been suffering with this problem, has it been more than a month or two? _____

When was the first time you EVER recall having a problem in this area? _____

Please explain the event or process in which you feel this problem started. _____

_____

How often have you suffering with this problem? (Please indicate for each of the body area of concern)

Constant (75 – 100% of the time) _____Frequent (50 – 75% of the time)_____

Occasional (25 – 50% of the time) _____ Intermittent (0 – 25% of the time) _____

What makes your problem <u>worse</u>? Sitting / Standing / Changing Position / Walking / Bending / Lifting / Twisting / Reaching / Driving / Sleeping / Cough or Sneeze / Computer Work / Telephone / Going From Sit to Stand / Other_____

What have you already tried for this problem? Anti-inflammatory / Pain Meds / Muscle Relaxers / Injections / Physical Therapy / Chiropractic / Massage / Exercise / Other _____

What tests have you already had for this problem? X-rays / MRI / C.T. Scan / Myelogram / EMG or NCV / None / Other _____

What activity does this problem prevent you from doing, either partially or totally, that you would really like to be able to do again? _____

What area of your life has this problem affected the most? Family / Relationships / Work / Exercise / Recreation

List any MD's, Chiropractors, or other health care professionals you've already seen for your current problem:

_____

On a scale of 1 to 10, with 10 being the highest, rate your level of commitment to get rid of this problem: _____

Do you have any other health conditions, regardless of whether you think it's related to your spine:

_____

_____

_____

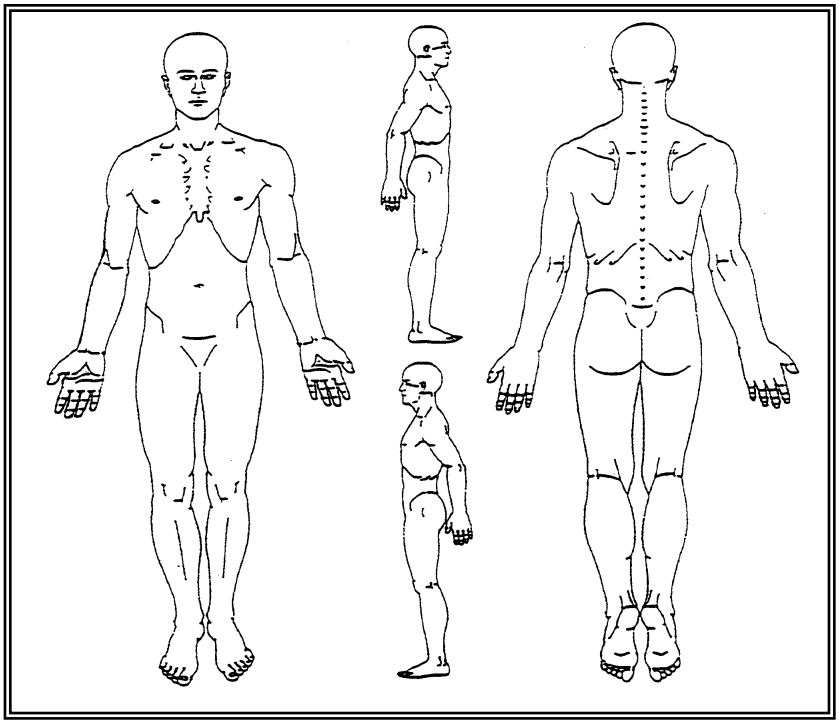
Please list any concerns you may have about getting this problem corrected such as time or transportation:

_____

Name: _____ Date: _____

If you are seeing us for a pain related issue, use the symbols to show what type of pain you feel on the diagram.

XXXXXXXXX	/ / / / / / / / / /	o o o o o o o o o	s s s s s	- - - - - - - -
DULL/ACHY	**SHARP/STABBING**	**NUMBNESS/TINGLING**	**STIFF/TIGHT**	**BURNING**



Using the pain scale below, circle the pain level you experience when this problem is at its very worst:

.

0 = No Pain. No Discomfort
1 = Minimal Discomfort. Minor stiffness or tightness.
2 = Discomfort. Stiff, tight, sore. Muscle fatigue.
3 = Minimal Pain. More than just sore. Uncomfortable.
4 = Mild Pain. Noticeable pain but tolerable.
5 = Moderate Pain. Aggravating. Still allows movement.
6 = Strong Pain. Quite aggravating. Movement slightly limited.
7 = Very Strong Pain. Very aggravating. Movement definitely limited.
8 = Very, Very Strong Pain. Extremely aggravating. Movement very limited.
9 = Severe Pain. Brings tears. Almost impossible to move.
10 = Excruciating Pain. Agony. Unbearable. Cannot move. ER.

Name: _____ Date: _____

Part II

HEALTH AND WELLNESS CARE

The human body is designed to function properly. Throughout life, stresses and traumatic events can harm the body and alter your life expression. Our objective in this office is to help your body not only function properly, but also develop new strategies for living with vibrant health and wellness. In our analysis, we want to identify any potential stress to which your body cannot adapt. These stresses may be ***Physical***, ***Chemical***, or ***Emotional*** in nature. We are assisted in serving you by understanding the stresses that have acted upon your spine and nervous system. Please be as specific and thorough as possible when completing the following information regarding the past and current stresses and traumas of your life. Each question is important for us and will provide us with the information needed to deliver exceptional care to you.

HEALTH HISTORY

Have you ever had your spine and/or nervous system professionally evaluated by a chiropractor? Y / N

Have you ever been adjusted by a chiropractor? Y / N - Date of your last adjustment? __/__/____

If yes, how often did you go? What techniques did he or she use?

_____

ILLNESS HISTORY

Research has shown that many of the health challenges that occur later in life have their origins during the developmental years, some starting at or before birth. Please answer the following questions to the best of your ability.

Date of last automobile accident: __/__/____ Speed: _____ Injuries: _____

Date of automobile accident before that: __/__/____ Speed: _____ Injuries: _____

Physical, Chemical, & Emotional Stress:

Every trauma is recorded in the spine. Please give a brief description of any additional injuries or accidents over the course of your life (slips, falls, knocked unconscious, broken bones, or sports injuries), whether or not you think they are related to your spine: _____

_____

_____

Did you go to the hospital for any of these injuries? _____

Did you get any X-rays for any of these injuries? _____

Did you get checked by a Chiropractor after any of these injuries?_____

What do you do most of the day in your job postures, positions and repetitive movements:_____

_____

_____

Name: _____ Date: _____

PAST MEDICAL HISTORY

Do you have a family medical doctor? Y / N Name:_____
Do you consult with him or her regularly? Y / N If yes, why?_____
Please list any significant conditions that you've been diagnosed with or been treated for over the course of your life: _____

_____

Please list any surgeries you have had over the course of your life: _____

_____

MEDICATIONS & ALLERGIES

Are you allergic to any medications? Yes / No **If yes, please list:** _____

Are you currently taking any drugs (prescription or over-the-counter)?
Please list each drug with the specific reason that you are taking it:_____

_____

In the past, have you taken any medication regularly (for example, long-term use of antibiotics or an inhaler)? Please list each drug with the specific reason that you took it: _____

_____

Are you currently taking any supplements, homeopathic formulas, or herbal remedies?
Please list each supplement with the specific reason that you are taking it: _____

_____

Do you have any know food allergies or sensitivities?_____

FAMILY HISTORY

Mother: □Living □Deceased - List any medical problems: _____

Father: □Living □Deceased - List any medical problems: _____

List any problems common in your family: Cancer / Diabetes / Heart disease / High blood pressure / Stroke / Arthritis / Scoliosis / Thyroid disease / Osteoporosis / Other _____

SOCIAL HISTORY

Do you have any children? Yes / No If yes, how many? _____

Do you drink alcohol? Yes / No If yes, how much & how often? _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

PERSONAL HEALTH GOALS

□Improve Nutrition/Eating Habits	□Lower Cholesterol	□Get off Medications
□Weight Loss/Fat Loss	□Lower Blood Pressure	□Improved Sleep
□Increase Lean Muscle Mass	□Start Exercising	□Improved Energy
□Increase Bone Density	□Look Better	□Improved Posture
□Reduce Stress	□Feel Better	□Improved Outlook/Happiness

On a scale of 1 to 10 with 1=Poor and 10=Excellent, please rate how well you think you are doing in the following categories:

Exercise_____ Sleep _____ Diet _____ Stress Level _____ Water Intake _____ Energy Level _____

Do you take: Omega 3 (Fish Oil)? Yes / No Vitamin D3? Yes / No Probiotics? Yes / No

Who is your Family Physician or Primary Doctor that monitors you? _____

When was the last time you had blood work done? _____

Name: _____ Date: _____

REVIEW OF SYMPTOMS

Please rate each of the symptoms, using the 0 to 4 guide below, according to your health status over the past 30 days.

Point Scale 0 - Never or almost never have the symptom
1 - Occasionally have it, effect is not severe
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD Headaches_____ Faintness_____ Dizziness_____ Insomnia _____ **Total_____**	**HEART** Irregular or Skipped Heartbeat_____ Rapid or Pounding Heartbeat_____ Chest Pain_____ **Total_____**	**EMOTIONS** Mood Swings_____ Anxiety, Fear, Nervousness_____ Anger, Irritability, Aggressiveness_____ Depression_____ **Total_____**
EYES Watery or Itchy Eyes_____ Swollen, Reddened or Sticky eyelids_____ Bags or Dark Circles_____ Blurred or Tunnel Vision_____ **Total_____**	**LUNGS** Chest Congestion_____ Asthma, Bronchitis_____ Shortness of Breath_____ Difficulty Breathing_____ **Total_____**	**OTHER** Frequent Illness_____ Frequent or Urgent Urination_____ Genital Itch or Discharge_____ **Total_____**
EARS Itchy Ears_____ Ear Aches/Infections_____ Drainage from Ear_____ Ringing in Ears_____ Hearing Loss_____ **Total_____**	**DIGESTIVE TRACT** Nausea/Vomiting_____ Diarrhea_____ Constipation_____ Bloated Feeling_____ Belching/Passing Gas_____ Heartburn_____ Intestinal/Stomach Pain_____ **Total_____**	**WEIGHT** Binge Eating/Drinking_____ Craving Certain Foods_____ Excess Weight_____ Compulsive Eating_____ Water Retention_____ Underweight_____ **Total_____**
NOSE Stuffy Nose_____ Sinus Problems_____ Hay Fever_____ Sneezing Attacks_____ Excess Mucus_____ **Total_____**	**JOINTS/MUSCLE** Aches or Pain in Joints_____ Arthritis_____ Stiffness or Limitation of Movement_____ Pain or Aches in Muscles_____ Feeling of Weakness or Tiredness_____ **Total_____**	**MIND** Poor Memory_____ Confusion, Poor Comprehension_____ Difficulty Making Decisions_____ Learning Disabilities_____ Stuttering/Stammering/Slurred Speech_____ **Total_____**
MOUTH/THROAT Chronic Coughing_____ Gagging/Frequent Need to Clear Throat_____ Sore Throat/Hoarseness/Loss of Voice_____ Swollen or Discolored Tongue, Gums, or Lips_____ Canker Sores_____ **Total_____**	**ENERGY/ACTIVITY** Fatigue/Sluggishness_____ Apathy/Lethargy_____ Hyperactivity_____ Restlessness_____ **Total_____**	**Grand Total_____**

Is there anything else not covered on this form that you feel is relevant for the Dr. to know about you?

_____

Name: _____ Date: _____

Body In Balance Wellness Center - 755 Heritage Rd Units 110/130 Golden, CO 80401

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Our Legal Duty
We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures
There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information,
most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**:
Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

(continued on next page)

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to: Privacy Officer, The Body In Balance Chiropractic, P.C. 755 Heritage Rd Unit 110 Golden, CO 80401

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

Patient Name	Patient Signature	Date

Name of Personal Representative	Signature of Personal Representative	Date

Legal Authority of Personal Representative

EFFECTIVE DATE OF NOTICE: 6/21/2016