



DR. KELLEN P. SCHWEITZER, DC
1732 Topaz Drive
Loveland, CO 80537
(970) 667-4062

CHIROPRACTIC CASE HISTORY/PATIENT INFORMATION

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.

PLEASE PRINT

Date _____
Full Name _____ Home Phone _____ Cell Phone _____
Preferred Name/Nickname _____ Fax Number _____
Address _____ City _____ State _____ ZIP _____
Age _____ Birth Date _____ Gender: M F Marital Status: S M W D Sep # of Children _____
Email _____ SS# _____ Driver's License # _____

Your Employer _____ Your Occupation _____ Years on Job _____
Employer Address _____ City _____ State _____ ZIP _____
Work Phone _____ Do **you** have health insurance at work? Yes No
Insurance Company _____ Plan/Group # _____ Cert # _____

Spouse _____ Occupation _____ Employer _____

How did you hear about our office? _____

Referring Doctor _____ Friend _____

Name & Phone Number of Emergency Contact _____

Family Medical Doctor _____ OB/GYN _____ Dentist _____

Reason for your visit today? (Please list areas of pain) _____

Is your condition due to an accident? Yes No Date of your Accident: _____

Please complete the following information only if your complaint was a result of an accident.

Accident Information

Did this injury occur as a result of a Car Accident, Fall or other Personal Injury? Yes _____ No _____

Did this injury occur at work (Workers' Compensation)? Yes _____ No _____

Please circle any and all insurance coverage that may be applicable in this case:

Health Insurance Medicare Worker's Compensation Auto Accident Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Financial Policy: Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, we will suggest the chiropractic care that we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Time of Service: If fees are paid in full within the same date of service, you will qualify for our Time of Service reduction in fees. Forms of payment accepted are check, MasterCard, Visa or Discover.

Insurance: Your health and accident insurance policies are an agreement between you and your insurance company. When possible, our office will call to verify benefits as a courtesy to you; however, the benefits quoted to us by your insurance company are not a guarantee of payment. Any co-pays or known deductible amounts will be collected at the time of service. Our office will complete any necessary insurance forms and file them with your insurance company at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

Medicare: We accept assignment from Medicare. The payment is generally sent to our office for services that Medicare will cover. Spinal manipulation is a covered service under Medicare. However, maintenance care is not considered by Medicare to be medically reasonable and necessary, and is not reimbursable by Medicare. All other services available are NON-COVERED and include but are not limited to, maintenance care adjustments, x-rays, examinations, therapies, orthotics, supports, and/or nutritional supplements. You are fully responsible for charges of non-covered services and are eligible for our Time of Service reduction in fees listed above. Our office completes and files the forms for Medicare at no charge. If there are any further questions, please let us know.

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any consequences thereof.

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I understand the above and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to immediately inform this office of any changes in my medical or account status.

I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I agree that a photostatic copy of this agreement shall serve as the original.

I have read and understand the payment policy of Front Range Family Health & Chiropractic. I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Front Range Family Health & Chiropractic and my insurance company. I request that Front Range Family Health & Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Front Range Family Health & Chiropractic that fees will be due and payable immediately. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

Past Medical History:

1. Have you been hospitalized or had any surgeries? Yes _____ No _____
If yes, when did it take place, for what condition, and what was the result? _____

2. Have you had any trauma or been involved in any accidents (*Car, Work, Falls, etc...*)? Yes ___ No ___
If yes, when, what type of trauma/accident, were you injured and what type of care did you receive? _____

3. Have you had any broken bones, dislocation or sprains? Yes _____ No _____
If yes, please describe the area of injury, when and how it happened: _____

4. Have you been diagnosed with any childhood illness(es) (*Measles, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Diabetes, Cancer, Birth Defects, etc...*)? Yes _____ No _____
If yes, which illness(es)? _____

5. Do you have any Congenital Conditions? Yes ___ No ___ If yes, please describe: _____

6. Have you been diagnosed with any illness(es) as an adult (*Shingles, Diabetes, Cancer, High Blood Pressure, etc*)? Yes _____ No _____
If yes, which illness(es)? _____
7. Have you been treated for any health condition by a physician in the last year? Yes _____ No _____
If yes, please describe: _____
8. Do you have any allergies to any medications? Yes _____ No _____
If yes, please describe: _____
9. Do you have allergies of any kind? Yes _____ No _____
If yes, please describe: _____
10. Have you ever had x-rays, MRI, or CAT Scan of your body? Yes _____ No _____
If yes, when and for what reason? _____
11. WOMEN ONLY: Please include information, if any, about childbirth (include date): _____

Habits and Social History:

1. Do you use: Caffeine: Cups per day ____ Tobacco/Packs per day ____
Alcohol: Drinks per month ____ Recreational Drugs (yes/no) ____ (If yes what kind)_____

2. Please describe your work:

- Type: __Professional __Physical Labor __Driver __Clerical __Factory
__Homemaker

- Physical Demands: __Heavy __Moderate __Mild
__Sedentary

- Stress Level: __High __Medium __Low

3. Exercise: None __ Moderate __ Vigorous__ Daily __ Type? _____

4. Your Diet is: __Balanced __Fair __Poor __Excessive __Restricted

5. Do you have: Family Pressures ____ Financial Pressures ____ Other Mental Stresses ____

6. In what position do you usually sleep, and how well?

7. Are you wearing (please circle) Heel Lifts, Sole Lifts, Inner Soles, Arch Supports?

8. Medications:

Please list all medications (prescription, non-prescription & vitamins/herbs) you are taking or take on an occasional basis:

- If not taking any medications please check here: _____

Review of Systems:

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

	N = Now	P = Previously	
Headaches _____ Frequency _____		Difficulty Breathing	_____
Neck Pain _____		Frequent Colds	_____
Stiff Neck _____		Sinus Problems	_____
Muscle Spasms _____		Fever	_____
Back Pain _____		Indigestion	_____
Tension _____		Unusual Bowel Pattern	_____
Shoulder/Arm Pain _____		Eating Disorder	_____
Leg Pain _____		Gallbladder Problems	_____
Joint Pain/Swelling _____		Ulcers	_____
Rheumatoid Arthritis _____		Irritability	_____
Osteoarthritis _____		Nervousness	_____
Numbness in Fingers _____		Sleeping Problems	_____
Numbness in Toes _____		Fatigue	_____
Weakness in Extremities _____		Weight Loss	_____
Dizziness _____		Weight Gain	_____
Loss of Balance _____		Depression	_____
Fainting _____		Loss of Memory	_____
Ears Ringing _____		Buzzing in Ears	_____
Loss of Smell _____		Seizures/Epilepsy	_____
Loss of Taste _____		Diabetes	_____
Light Bothering Eyes _____		Excessive Bleeding	_____
Chest Pain/Tightness _____		Osteoporosis	_____
Heart Disease _____		Broken Bones/Fractures	_____
High Blood Pressure _____		Difficulty Urinating	_____
Low Blood Pressure _____		Menstrual Difficulties	_____
High Cholesterol _____		Drug Addiction	_____
Pacemaker _____		Alcoholism	_____
Circulation Problems _____		HIV/Hep C Positive	_____
Cold Hands _____		Coughing up Blood	_____
Cold Feet _____		Cancer	_____
Asthma _____		Stroke	_____

Family History:

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problems									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Troubles									
Liver Problems									
Lung Disease									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									

If any of the above family members are deceased, please list their age at death and cause:

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Pain Drawing:

TELL US WHERE YOU HURT.

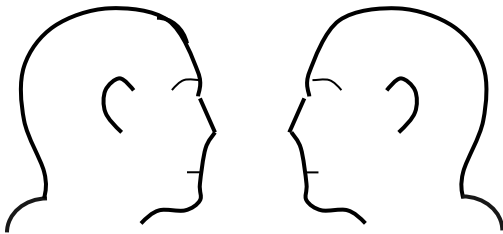
Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate letter(s) listed below. Place the letters and the corresponding pain in the proper place on the body below.

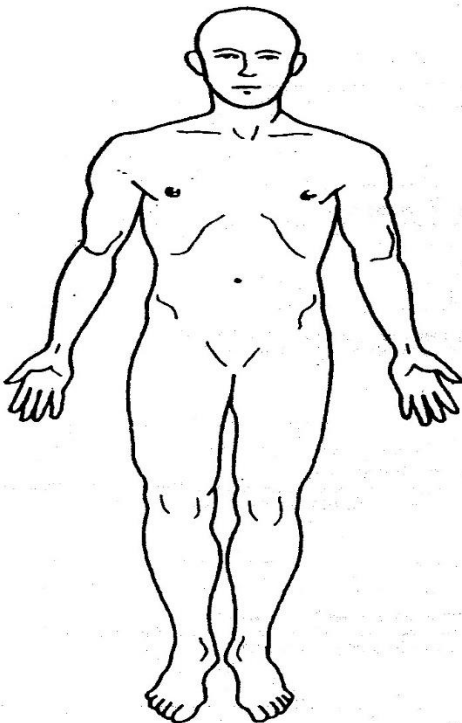
SUBJECTIVE PAIN ASSESSMENT

Right

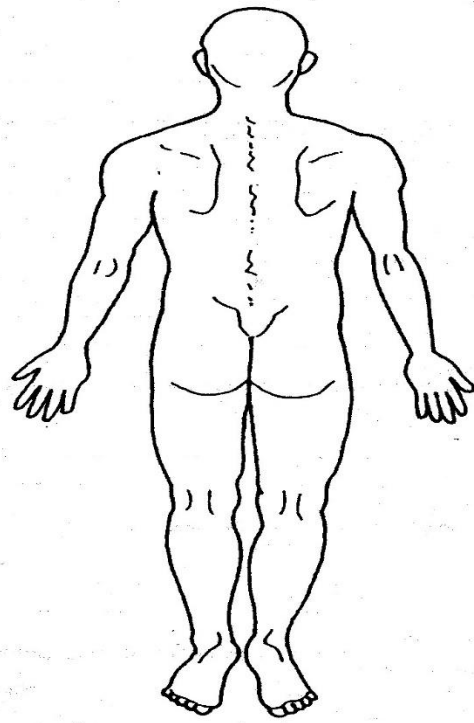
Left



Front



Back



RATE YOUR PAIN

A=Aching
B=Burning
SH=Sharp
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

1. Have you ever had any previous chiropractic experience?
Manual Adjustments _____ Instrument Adjustments _____ None _____
Acupuncture _____ Rehabilitation Therapy _____ Other: _____
2. What is your major symptom(s)?

3. How and when did it happen?

4. What does this prevent you from doing or enjoying?

5. What are your primary goals you hope to achieve with chiropractic care?

6. If this is a reoccurrence, when was the first time you noticed the problem?

 - How did it originally occur? _____
7. Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
If yes, when and how? _____
8. How frequent is the condition? Constant ___ Daily ___ Intermittent ___ Night Only ___
How long does it last? All Day ___ A Few Hours ___ Minutes ___
9. Are there any other conditions or symptoms that may be related to your major symptom?
Yes ___ No ___ If Yes, please describe _____
10. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___ Throbbing ___
Tight/Stiff ___ Burning ___ Stabbing ___ Other: _____
11. Is there anything that you can do to relieve the problem? Yes ___ No ___
If yes, please describe: _____
If no, please let us know what you have tried that didn't work: _____
12. What makes the problem worse? Bending ___ Lifting ___ Lying ___ Sitting ___
Standing ___ Twisting ___ Other: _____
13. WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?
Yes _____ No _____ Uncertain _____

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE	LITTLE		MEDIUM			SEVERE			EXCRUCIATING		

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed to what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Front Range Family Health & Chiropractic include but may not be limited to:

The Staff of Front Range Family Health & Chiropractic. This includes:

Dr. Kellen P. Schweitzer, DC

All Chiropractic Assistants

Necessary health care providers or family members who may need to be consulted if related to the patient's condition. This includes:

Your Primary Care Physician

Name: _____

Medical Group/Office: _____

City: _____ State: _____ ZIP _____

Patient or Authorized Representative Signature

Date

Informed Consent for Chiropractic Care

In coming to Dr. Schweitzer, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. Dr. Schweitzer is licensed in chiropractic and is available to work with other types of providers in your health care regime. Dr. Schweitzer will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. Dr. Schweitzer will not give any treatment or health care if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known should they be aware of any conditions they may have. There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Dr. Schweitzer is aware of these complications, and in order to minimize their occurrence he will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell Dr. Schweitzer when he takes your clinical history. I understand that if I am accepted as a patient by Dr. Schweitzer at Front Range Family Health & Chiropractic, I am authorizing him to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

DATE _____

Printed Name

Patient or Authorized Representative Signature

Photo/Announcement Release:

I, Patient Name (please print) _____, give Front Range Family Health & Chiropractic permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized the appointment time.

Our office does reserve the right to charge for missed appointments without 24 hour notice. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Initial _____