|For Office Use Only| Patient File # ______________________

Personal Injury Confidential Patient Information

GOLD Chiropractic & Rehab
1111 Washington Ave., Suite 117
Golden, CO 80401

phone: (720) 924- 6535
fax: (303) 273-0867
www.goldchiroandrehab.com

Date: _______/________/________

Patient's Full Name ____

Mailing Address:____ City:_________________ State:________ Zip:_____________

Home Phone: _______-________-________ Cell Phone: _______-________-________ E-Mail: ____________________________

☐ Male ☐ Female Date of Birth:_____/____/______ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:__________________________ Number of Children/Ages____

How Did You Find Us?	**What Insurance will be responsible for billing?**
☐ Existing Patient Who?____________________ ☐ Physician Who?____________________ ☐ Friend Who?____________________ ☐ Local Ad_________________ ☐ Google:_________________ ☐ Social Media (i.e. Facebook, Twitter, etc.____________________ ☐ Office Websit ☐ FAKTR Website ☐ Other:____________________ ☐ ART Website ☐ MPI Website ☐ ACA Website ☐ Other Website:_______________	• Name of Insurance Company: ______________________________ • Policy #: ______________________________ • Insurance Phone #: ______________________________ • Claim #: ______________________________ • Your Insurance Company: ______________________________

Social Security # __________ - ________ - __________(last four for file #)

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed Occupation:___________________

Employer:______________________ Employer Address:______________________________ Business Phone___________________

Emergency Contact:______________________________ Relationship:_____________________ Phone: ________-________-________

Family Physician: _________________________ City: ________________________ State:_______ Phone________________________

Previous Chiropractic Care: ☐ **Yes** ☐ **No** **If Yes, for what Problem:**

____

Chiropractic Dr.'s Name ____________________________________ **City:** _________________________ **State:** ____________

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No **Is Today's Visit Due To An Auto Accident:** ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date of Injury:______________________

Authorization and Assignment

In consideration of your undertaking to care for me, the patient, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement o charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to GOLD C &R the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to GOLD C & R for the charges made for service. I authorize GOLD C & R to prosecute said action either in my name. I further authorize GOLD C & R to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts GOLD C & R does not collect from insurance companies, whether it be all or part of what was due, **I personally owe to GOLD C & R**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (GOLD Chiropractic & Rehab) are **paid in full**.

Patient Signature:____ **Date:**______/________/_____________

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Dear Patient, Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Present complaint(s):____________________

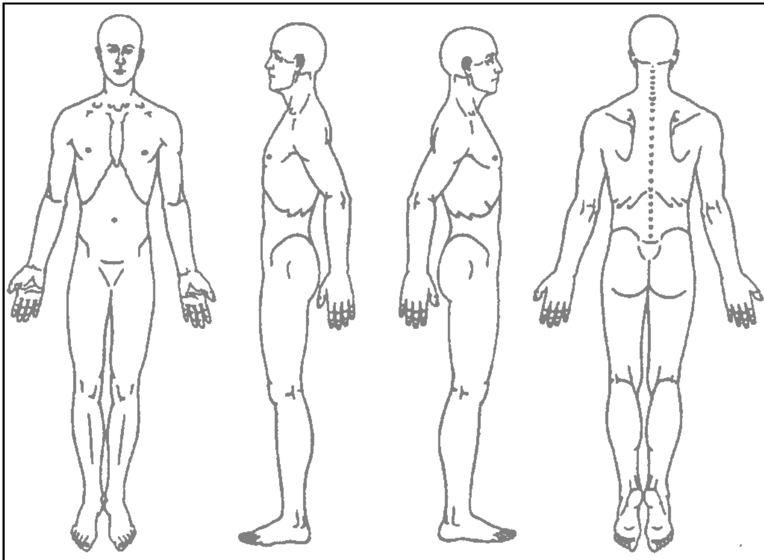
When did your symptoms begin? (Specific date if possible)____________________

How did your symptoms begin? (i.e. Lifting, bending, ect.)____________________

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain____________________

PAIN CHART

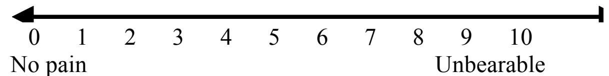
Please Mark the Areas of Pain *On The Diagram* Below, then Describe Your Pain(s) seperately in each box.



DESCRIBE YOUR PAIN

#2 Complaint (if applicable)____________________

(Rate your level of Pain, Scale 0-10)



0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #2 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

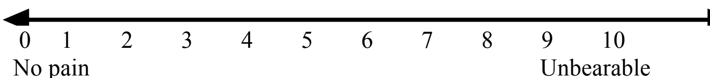
☐ Other____________________

How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#1 Complaint ____________________

(Rate your level of Pain, Scale 0-10)



0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

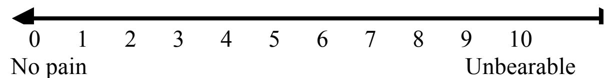
☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other____________________
How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#3 Complaint (if applicable) ____________________

(Rate your level of Pain, Scale 0-10)



0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #3 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other____________________
How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

* Check each following box that applies to your pain(s), and place the **Complaint #** next to its corresponding box :

Is your Pain:	Was the Onset:	Pain is aggravated by:	Pain is improved by:
☐ Increasing ☐ Decreasing ☐ Not Changing ☐ Varies	☐ Gradual ☐ Sudden	☐ Walking ☐ Lifting ☐ Sitting ☐ Bending ☐ Riding in a car ☐ Stretching ☐ Standing ☐ Twisting ☐ Other____________	☐ Medication ☐ Chiropractic Adjustment ☐ Rest ☐ Exercise ☐ Other____________ ☐ Therapy ____________

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Family Doctor / Primary Care Physician(PCP)?____________________
We normally keep your family doctor and/or referring physician informed regarding your care at this office.

☐ Yes ☐ No Is it okay to inform your PCP?

☐ Yes ☐ No Is pain affecting your ability to work or be active? **If Yes** explain:____________________

____

☐ Yes ☐ No Any change in bowel or bladder (bathroom) function? **If Yes** explain:____________________

☐ Yes ☐ No Any fever or chills? **If Yes** explain:____________________

☐ Yes ☐ No Any dizziness associated with symptoms? **If Yes** explain:____________________

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? **If Yes** explain:____________________

____

☐ Yes ☐ No Are your complaints affecting your sleep? **If Yes** explain:____________________

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. X-rays, MRI, CT) **If Yes** explain:____________________

☐ Yes ☐ No Any past or recent falls / accidents / surgeries / broken bones?
If Yes explain:____________________

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? **If Yes** explain:____________________

____

☐ Yes ☐ No Have you had any prior treatment for this or a related complaint, including any physical therapy?
If Yes, who?____________________

What treatment?____________________

☐ Yes ☐ No Have you ever been in the hospital or had surgery for any reason? **If Yes** explain:____________________

____

☐ Yes ☐ No Have you ever been in an accident? **If Yes** explain:____________________

☐ Yes ☐ No Do you smoke? **If Yes** how much?:____________________

If you have quit smoking, when did you quit?____________________

☐ Yes ☐ No Do you consume alcohol?

☐ Yes ☐ No Do you exercise? **If Yes** what is your routine?____________________

What type of care are you interested in?
☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

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What **non-prescription** medication are you currently taking?	What **Prescription** medication are you taking?
☐ Tylenol ☐ Aspirin ☐ Ibuprofen ☐ None ☐ Other___________________________ How often? ☐Daily ☐Weekly ☐Other:_______________	☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills ☐ Pain Killers ☐ Cholesterol Meds ☐ Nerve Pills ☐ Muscle Relaxers ☐ Insulin ☐ HRT ☐ Blood Pressure Meds ☐ Tranquilizers ☐ Sleeping Aid ☐ Blood Thinners ☐ Other_______________________________________ ☐ None Specific names if possible:_____________________________________

FAMILY HISTORY AND HEALTH STATUS: List any diseases, disorders, or major illnesses. If deceased, from what?
(This information may help determine your familial susceptibilities to illness, disorders, etc, and help me better treat your condition.)

Mother:_______________________________________ Father:____

Brother(s):____________________________________ Sister(s):____

Other:____ Other:____

Do you have any other health concerns or diseases? (eg: heart disease, hypothyroidism, asthma, alergies, etc.)_________________________

____

Do you have any specific dietary guidelines you follow? ☐ Gluten Free ☐ Dairy Free ☐ Vegetarian / Vegan
☐ Other: ____

☐ **Yes** ☐ **No** **Do you consume artificial sweeteners? If so, please specifiy:** ☐Sweet N' Low/Sugar Twin/Sacchrine ☐Splenda/Sucralose ☐Equal/NutraSweet/Aspartame ☐Sweet One/Swiss Sweet/cesulfame-K ☐Other_______________________________________

☐ **Yes** ☐ **No** **Do you consume diet beverages such as soda, sports drinks, tea, or others?**
If so, please specify type(s): ____

☐ **Yes** ☐ **No** **Do you belong to a local gym, sports team/ league, etc.?**
If so, please specify: ____

☐ **Yes** ☐ **No** **Would you like more information on Nutrition and/or Supplement recommendations?**