HEALING TOUCH CHIROPRACTIC OF BOULDER, PLLC
Dr. Joanie De Bever
3005 47th St., Suite F-2, Boulder, CO. 80301 (303) 447-0036

"If you don't take care of yourself today, someone else may have to take care of you tomorrow!"

WELCOME, and thank you for choosing Healing Touch Chiropractic. In order to provide you with the best chiropractic care possible, please complete BOTH sides of this form. All information is CONFIDENTIAL and required for your care.

NAME:____DATE:__________________________

ADDRESS:____EMAIL:______________________________

CITY:__________________________STATE:_________ ZIP: ______________ BIRTHDAY:________________

CHECK BEST CONTACT # ☐ HOME:______________________ ☐ WORK/CELL:______________________

SOCIAL SECURITY#:_______________________ OCCUPATION:______________________________

EMPLOYER:_________________________ADDRESS:__________________________________

MARITAL STATUS:________________SPOUSE/PARTNER'S NAME:____________________________

THEIR OCCUPATION:________________________EMPLOYER:___________________________

EMERGENCY CONTACT:____________________________TELEPHONE: ________________________

MAY WE CONTACT YOU THROUGH EMAIL? (WE NEVER SHARE OR GIVE OUT YOUR INFO)__________________

WHO MAY WE THANK FOR REFERRING YOU?____

PRESENT COMPLAINTS

IS YOUR VISIT DUE TO AN ACCIDENT? _____ NO (SKIP TO #1) _____ **IF YES: DATE OF INJURY**:______________

TYPE OF ACCIDENT:_____***AUTOMOBILE ________WORK-RELATED _______OTHER ______________________

(Describe)____

*****IF THIS IS AN AUTO ACCIDENT, INSURANCE COMPANY:**______________________________Phone#:____________________

Claim#:___________________________ Billing Address:____

Name of the Insured:______________________________ Contact/Claim Agent: ____________________________

1) HAVE YOU EVER HAD CHIROPRACTIC CARE ______NO ______YES; FOR? ______________________________

2) DESCRIBE ***TODAY'S*** SYMPTOMS, ***LOCATION AND TYPE***____

____

3) LIST OTHER PROFESSIONALS SEEN FOR THIS CONDITION____________________________________

4) HAVE YOU HAD TREATMENT FOR ANY HEALTH CONDITION IN THE LAST YEAR? NO ____________ YES ____________

*** DESCRIBE CONDITION(S)____

5) DATE OF LAST PHYSICAL EXAM__________ MEDICATIONS CURRENTLY TAKING?______________________

6) FOR WHAT CONDITION(S)?____

7) ANY PREVIOUS SIGNIFICANT TRAUMAS/ ACCIDENTS? _______________________________________

8) DESCRIBE GOALS YOU HAVE FOR OBTAINING CARE: _______________________________________

____

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CONFIDENTIAL HEALTH HISTORY

All information is kept strictly CONFIDENTIAL. Your responses help determine how effective chiropractic treatment will be for your case. We only proceed with chiropractic treatments if we sincerely believe you will obtain MAXIMUM BENEFIT FROM OUR CARE.

NAME: ______________________________ **AGE:** __________ **BIRTHDATE:** ____________ **TODAY'S DATE:**__________

CHECK (√) ANY OF THE FOLLOWING SYMPTOMS/CONDITIONS experienced _CURRENTLY OR PAST and note with "C" OR "P" respectively_.

- ❑ Allergies
- ❑ Anemia
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arthritis (where?)
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Bleeding disorders
- ❑ Breast lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer (type?)
- ❑ Cataracts
- ❑ Cold sores
- ❑ Concussion
- ❑ Disc herniation (level?)
- ❑ Diabetes
- ❑ Eczema
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fractures
- ❑ Glaucoma
- ❑ Gout
- ❑ Headaches
- ❑ Heart disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ High cholesterol
- ❑ High blood pressure
- ❑ Liver disease
- ❑ Miscarriage
- ❑ Multiple sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate enlargement
- ❑ Rheumatoid Arthritis
- ❑ Stroke
- ❑ Thyroid disorders
- ❑ Tremor
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal disease
- ❑ Whooping cough
- ❑ Other______________

____
____
____
____
____

Have you ever had x-rays taken? NO ☐ YES ☐ Body part(s)? ______________________________

What MEDICATIONS are you currently taking and for what? (List DRUG NAME, DOSING, HOW OFTEN, HOW MUCH? Etc.)

____
____

What VITAMIN, MINERAL OR HERBAL SUPPLIMENTS do you currently take? (List for CONDITION, DOSAGE, AMOUNTS, etc.)

____
____
____

HABITS: (_these practices influence your body's ability to heal and respond favorably to care_)

								none	some	moderate
☐**Alcohol**	Drinks/week__________		**Exercise**	☐Daily	☐Weekly	☐Other	**Salty foods**	☐	☐	☐
☐**Coffee**	Cups/day__________		**Sleep**	☐ <4hrs	☐ 5-7hrs.	☐ >8 hrs.	**Water**	☐	☐	☐
☐**Tobacco**	Pack/day__________		**Meals**	☐ <3/day	☐ 3/day	☐ >3/day	**Sugar foods**	☐	☐	☐
☐**Drugs/Recreational**	☐Yes	☐No	**Sodas**	☐ none	☐ 1-2/day	☐ >3/day	**Artificial--sweeteners**	☐	☐	☐

HAVE YOU EVER:	**NO**	**YES**	**BRIEFLY EXPLAIN ANY "YES" ANSWERS…**
Broken bones?	☐	☐	______________________________
Been hospitalized?	☐	☐	______________________________
Had sprains/strains?	☐	☐	______________________________
Been struck unconscious?	☐	☐	______________________________
Had surgeries? What? When?	☐	☐	______________________________
Self adjust your joints?	☐	☐	

FAMILY HISTORY: **Some health conditions are influenced by family GENETICS. _Please list family members and health conditions below_:**

FAMILY MEMBER	**PRESENT AND PAST HEALTH CONDITIONS (example: heart disease, diabetes, cancer, arthritis, stroke, etc.)**
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________
______________	______________________________

"OPTIMIZING LIFE EXPRESSION ONE SPINE AT A TIME!"

Healing Touch Chiropractic of Boulder, PLLC

GENERAL SYMPTOM AND DISABILITY QUESTIONNAIRE

Name: ______________________ **Age:** ______ **Today's Date:** ______________________

Is this your first episode of this/these symptoms: ☐**Yes** ☐**No** **When did you first feel or experience these symptoms?**

____

Please circle below, in each category, the number by which your symptoms interfere with activities of daily living. . .

KEY: 0= "I FEEL GREAT!" To 10= "WORST SYMPTOM/PAIN EVER HAD!"

FAMILY RESPONSIBILITIES**:** How well can you handle family responsibilities; duties; chores; errands, etc:

0 1 2 3 4 5 6 7 8 9 10

RECREATION**:** Participation in sports, hobbies, leisure activities:

0 1 2 3 4 5 6 7 8 9 10

SOCIAL ACTIVITIES**:** With friends, others to places such as movies, theater, parties, concerts, etc:

0 1 2 3 4 5 6 7 8 9 10

OCCUPATION: How well can you do your job, duties, volunteer work, etc:

0 1 2 3 4 5 6 7 8 9 10

SELF CARE: How well you can complete showering, dressing, basic hygiene habits, driving, etc:

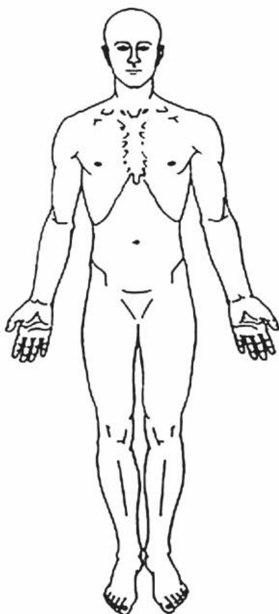
0 1 2 3 4 5 6 7 8 9 10

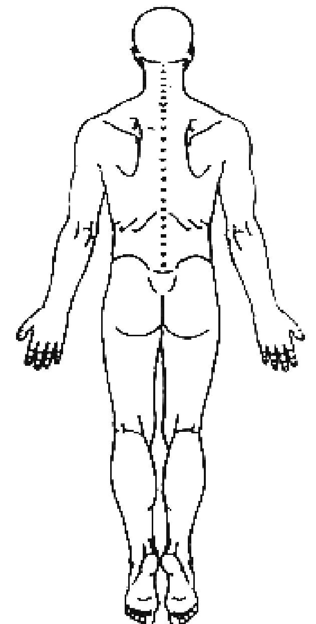
LIFE SUPPORT**:** How well you can comfortably eat, drink, sleep, perform easily in your daily habits:

0 1 2 3 4 5 6 7 8 9 10

Please use the following letters to indicate the type and location of your symptoms using the diagrams below

A=ACHE B=BURNING P=PINS/NEEDLES S=STABBING O=OTHER (and describe)





_______/60= _______%

Healing Touch Chiropractic of Boulder, PLLC Dr. Joanie DeBever D.C.

GENERAL SYMPTOM AND DISABILITY QUESTIONNAIRE

Name:____ **Age:**_________**Today's Date:** _________________

Main symptom(s) and/or reason for your visit? (list if more than one symptom)______________________________________
____
____
____

Is this your first episode of this/these symptoms? ☐ **YES** ☐ **NO:** **When did you first experience symptoms?**
____
____

What is your goal for this visit? ____

How long have the symptoms lasted? ____

Symptoms are getting? ☐ **Better** ☐ **Worse** ☐ **Same**

What makes symptoms worse? ____

What makes symptoms better/relieves? ____

Does it refer to other areas? ☐ **No** ☐ **Yes, describe** ____
____

What best describes your symptoms? ☐ **Sharp** ☐ **Dull ache** ☐ **Shooting** ☐ **Burning** ☐ **Throbbing** ☐ **Tingling** ☐ **Numb** ☐ **Other (describe)** ____

Symptoms are present in: ☐ **morning** ☐ **afternoon** ☐ **evening** ☐ **night** ☐ **constant** ☐ **wakes me up**

How often do you have symptoms? ☐ **Constant (76-100% of day)** ☐ **Frequent (51-75% of day)** ☐ **Occasional (26-50% of day)** ☐ **Intermittent (0-25% of day)**

Are you restricted in your ability to perform job/work duties as a result of your symptoms? ☐ **No** ☐ **Yes, describe limitations:**
____
____

Are you restricted in your ability to perform your activities of daily living (sports, family, recreation, home tasks, self-care) due to your symptoms? ☐ **No** ☐ **Yes, describe limitations:** ____
____

Have you seen other health care professionals for THIS episode of symptoms? ☐ **No** ☐ **Yes, I have seen the following:**
☐ **Other chiropractor** ☐ **Medical doctor** ☐ **Physical therapist** ☐ **Acupuncturist** ☐ **Massage therapists** ☐ **Other**

What type of treatment did you obtain? ____

Have you had any other diagnostic tests or lab work for these symptoms or similar symptoms in the past? ☐ **No** ☐ **Yes**
If yes: ☐ **X-ray** ☐ **CT scan** ☐ **MRI scan** ☐ **Bone scan** ☐ **Blood/urinalysis** ☐ **Other:** ___________________

RATE SYMPTOM INTENSITY BY CHECKING THE NUMBER AT THE: (0=NO SYMPTOMS/BEST: 10= WORST EVER EXPERIENCED)

	0	1	2	3	4	5	6	7	8	9	10
WORST	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
AT BEST	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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NOTICE OF PATIENT PRIVACY RIGHTS AND OUR OFFICE PRIVACY PRACTICES

EFFECTIVE: April 1, 2014

This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations and for other purposes permitted or required by law. It describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health condition and related health care services. You have a right to review our complete Notice of Privacy Practices (NPP) before signing this notice summary and before services are provided to you through our office. By signing this form, you acknowledge that you have been given the opportunity to read the clinic's full NPP and obtain a copy of this notice summary.

USES AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

TREATMENT: We use and disclose your PHI to provide, coordinate, or manage health care and any related services, including coordination and management of your health care with a third party, other referring health specialists assisting in your treatment, or hospital staff where you may hospitalized to assist in proper diagnosis and treatment of your condition.

PAYMENT: Your PHI may be disclosed for billing and collection of payment for our services rendered to you. Example: information on or accompanying a bill identifying you, your diagnosis, supplies, procedures and services provided to you in order to obtain payment.

HEALTHCARE OPERATIONS: We may use your PHI to assist in the operation of our practice. Example: assist in quality assessment of our practice's treatment, care, patient progress, and customer satisfaction of business operations. This may include a patient sign in sheet, greeting you by first name, phone calls to set appointments or remind you of appointments.

OTHER PERMITTED AND REQUIRED USES/DISCLOSURES: *Will be made* ***ONLY*** *with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use/disclosure indicated in the authorization.*
EXCEPTIONS BY LAW*: We may use/disclose your PHI* ***WITHOUT YOUR CONSENT*** *in situations required by law. Examples: Public Health Issues; Abuse/Neglect cases; Communicable Diseases; Law Enforcement; Coroners; Criminal Activity; Military Activity; National Security; and Worker's Compensation.*

PATIENT HEALTH INFORMATION RIGHTS:

The following are statements of your rights with respect to your protected health information (PHI).

- **RIGHT TO OBTAIN A PAPER COPY** OF THIS NOTICE PRIVACY PRACTICES (NPP) at any time.
- **RIGHT TO INSPECT AND COPY PHI**: You have the right to inspect and copy your medical and billing records used to make decisions about your care. You must submit your request, in writing to our privacy officer, Dr. Joanie DeBever. Per allowance by HIPPA, we may charge $.75 per page. By law, psychotherapy notes are NOT included under this right.
- **RIGHT TO AMEND**: If you feel that the medical information we have is incorrect or incomplete, you may submit a written request for amendment to Dr. Joanie DeBever. We may deny your request in certain circumstances. You may submit a written statement of disagreement that becomes part of your medical record and may also include our rebuttal statement.

- **RIGHT TO ACCOUNTING OF DISCLOSURES**: You have the right to request an accounting of certain disclosures we have made, if any of your PHI. You request must be in writing and provided to our privacy officer, Dr. Joanie DeBever and include a period of time which may not exceed 6 years.

- **RIGHT TO REQUEST RESTRICTIONS:** You have the right to request restrictions or limitations on the PHI we use/disclose about you for treatment, payment or health care operations. You may limit the medical information we can provide to family, friends, relatives or others involved in your care or payment of your care . You may also restrict PHI to a health plan where you have paid out of pocket in full for your care or healthcare items. You must submit a written request for limiting our use, disclosure or both and to whom you want the limits to apply* (OPTIONAL: Please complete the preference section below as written preferences for Dr. DeBever, privacy officer). We will comply unless the restricted information is needed for your care such as under emergency medical situations.

- **RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS:** You have the right to request that we communicate with you about PHI in certain ways and locations. Example: You may request that we contact you only at home or work and only through a phone call, email or text messaging** (OPTIONAL: Please check options below as written preferences for Dr. DeBever to document as the privacy officer.)

- **RIGHT TO RECEIVE NOTICE OF BREACH:** We are required to notify you by first class mail (or your preferred method of information communication checked below) of any breaches of Unsecured PHI as soon as possible but no later than 60 days following the discovery of a breach. *"Unsecured PHI" is information not secured through the use of technology/methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users.*

- **COMPLAINTS:** If you believe your privacy rights have been violated, you may file a complaint with us or the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, please submit in writing to Dr. Joanie DeBever at the address letterhead.

- ***We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any questions in reference to this form, please contact and speak with Dr. Joanie DeBever in person or by telephone.***

  **I authorize Dr. Joanie DeBever/staff of Healing Touch Chiropractic of Boulder, PLLC to release specific protected health information pertaining to my condition and/or care to the individuals named below:*

  Name(print): ______________________ *Relationship:*______________

  *Name(print):*______________________ *Relationship:*______________

**I authorize Dr. Joanie DeBever/staff at Healing Touch Chiropractic of Boulder, PLLC to contact me in the following ways:

HOME PHONE#: ______________________ **CELL#:** ______________________

☐ OK to leave detailed message on answer machine. ☐ OK to leave detailed message on voice mail.
☐ OK to leave message with call-back number only. ☐ OK to leave message with call-back number only.
☐ OK to leave message with family/who? ______________________

WRITTEN COMMUNICATION: ☐ OK to email me at: ______________________
☐ OK to fax me at: ______________________ ☐ Mail home ☐ Mail to Work

By signing this Agreement you are only acknowledging that you've received or been given the opportunity to obtain a copy of our Notice of Privacy Practices.

Signature: ______________________ Printed name: ______________________

Date: ______________________