Chiropractic - Physical Therapy - Massage
1360 S. Wadsworth Blvd Ste 104
Lakewood, CO 80232
(720) 440-3979

Thank you for choosing Denver Sports Medicine! Please complete this confidential patient form.

Patient Information **Date:** _____

Name: _____ Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Gender: _____
Preferred Phone: _____Email Address: _____
Emergency Contact: _____ Relationship: _____
Who may we thank for referring you to our office:
Google Facebook Yelp Friend/Family:_____ Other:_____

MEDICAL HISTORY

Have you RECENTLY noted any of the following (check all that apply)?

	Fatigue		Numbness or tingling		Constipation
	Fever/chills/sweats		Muscle weakness		Diarrhea
	Nausea/vomiting		Dizziness/lightheadedness		Shortness of breath
	Weight loss/gain		Heartburn/indigestion		Cough
	Falls		Difficulty swallowing		Fainting
	Difficulty maintaining balance or poor coordination		Changes in bowel or bladder function (i.e., urgency, color or incontinence)		Headaches
					Vision changes

Have you EVER been diagnosed with or are experiencing any of the following conditions (check all that apply)?

	Cancer		Bone or joint infection		Skin problems
	Heart disease		Osteoarthritis		Sinus problems
	Chest pain/angina		Osteoporosis/osteopenia		Jaw or dental problems
	High or low blood pressure		Rheumatoid arthritis		Parkinson's disease
	Circulation problems		Other bone or joint condition		Multiple sclerosis
	Blood clots		Abdominal pain		Epilepsy or seizures
	Stroke		Bladder/Urinary tract infection		Eye or vision problem
	Anemia		Kidney problem/infection		Concussion
	High cholesterol		Sexually transmitted infection/HIV		Head injury
	Lung problem/disease		Pelvic inflammatory disease		Depression
	Asthma		Liver problems/ infection		Anxiety
	Tuberculosis		Diabetes		Chemical dependency (i.e., alcoholism
	Pneumonia		Thyroid problems		

Other:_____
_____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

	Cancer		Stroke		Tuberculosis
	Heart disease		Diabetes		Thyroid problems
	High blood pressure		Autoimmune disease		Arthritis
	Blood clots		Epilepsy		Depression

WOMEN ONLY: Are you pregnant? ☐ Yes ☐ No

Please list all medications and supplements you are currently taking, including injections and skin patches:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Please list all allergies:

_____ _____ _____
_____ _____ _____

List all prior surgeries, hospitalizations and/or fractures and year:

_____ _____ _____
_____ _____ _____

LIFESTYLE

Occupation: _____
Activities that are performed during your work day: _____
Hours of sleep each night: _____
Recreational activities and sports:

☐ Golf	☐ Hockey	☐ Cycling	☐ Running	☐ CrossFit
☐ Tennis	☐ Basketball	☐ Mountain biking	☐ Marathon	☐ Martial Arts
☐ Volleyball	☐ Snowboard	☐ Hiking	☐ Triathlon	☐ Lifting
☐ Football	☐ Ski	☐ Walking	☐ Swimming	☐ Climbing

Other hobbies and activities: _____
Do you smoke? ☐ Yes ☐ No If yes, how many packs per day: _____
How many alcoholic drinks do you consume per week: _____

During the past month have you been feeling down, depressed or hopeless? ☐ YES ☐ NO
During the past month have you been bothered by having little interest or pleasure in doing things? ☐ YES ☐ NO
Is this something with which you would like help? ☐ YES ☐ YES, BUT NOT TODAY ☐ NO
Do you ever feel unsafe at home or has anyone tried to injure you in any way? ☐ YES ☐ NO

REASON FOR TODAY'S VISIT:

Please rank the health concerns you would like to address today, and how long have you had symptoms?
1: _____
2: _____
3: _____
4: _____
5: _____

Have you been treated by any other health care professional for the above concerns? ☐ Yes ☐ No
Name of facility or practitioner: _____
Treatment received:_____
_____

Have you ever seen a chiropractor / physical therapist before? ☐ Yes ☐No
If yes, when was your last appointment? _____

Please list any imaging or special tests performed for this problem (X-ray, CT scan, MRI, labs, etc.):
_____
_____

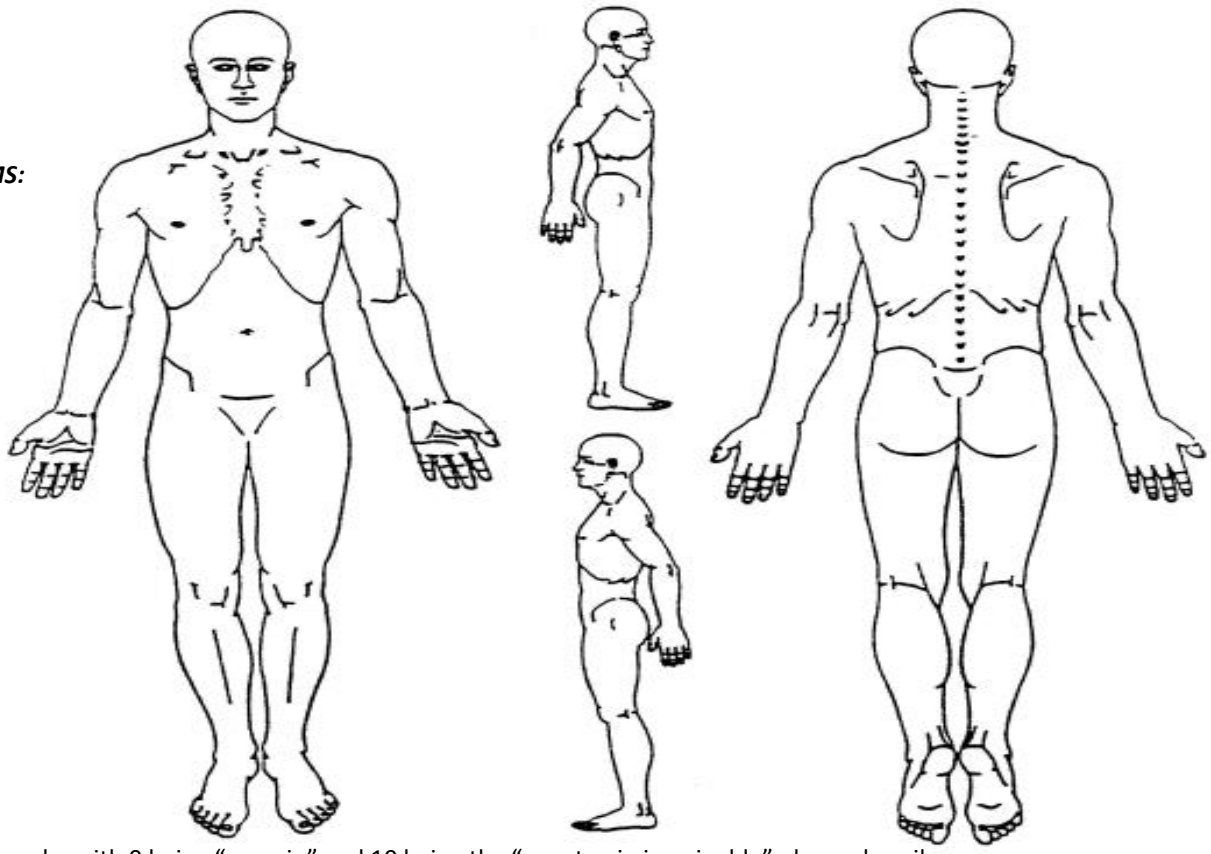
CURRENT SYMPTOMS:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/sharp pain

O Dull/aching pain

= Numbness or tingling



Using the 0 to 10 the scale, with 0 being "no pain" and 10 being the "worst pain imaginable" please describe:
Your current level of pain while completing this survey: _____
The best your pain has been during the past 24 hours: _____
The worst your pain has been during the past 24 hours: _____
Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:
_____
_____
Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:
_____
_____
How are you currently able to sleep at night due to your symptoms?
☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

When are your symptoms worst?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise or activity

When are your symptoms the best?
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise or activity

I should not do physical activities that might make my pain worse:
☐ Agree ☐ Disagree ☐ Unsure
What do you think is the cause of your current symptoms? _____

I certify that I have read and understood the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that my chiropractic, physical therapy insurance carrier may cover only a portion of or not cover all of the services rendered. I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

_____ _____

Patient/Guardian Signature **Date**

HIPAA Privacy Practices – Patient Form

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent(s) during the period of such chiropractic, physical therapy, and massage care to third party payers and or health practitioners. I understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially initiated care at this office on my first visit, whenever that may have occurred. I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Patient Name

I allow the doctors and staff at Denver Sports Medicine to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name, Title

_____ _____

_____ _____

Informed Consent to Treat

I consent to the performance of chiropractic , physical therapy, and massage treatments; including any diagnostic tests performed by the physicians employed by Denver Sports Medicine, who now or in the future treat me.

I understand and am informed that in the practice of medicine there are risks to treatment; including, but not limited to: fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains, and muscle soreness. I do not expect the physicians to be able to anticipate and explain all risks and complications, and I wish to rely on the physicians to exercise judgement during the treatment based upon the facts then known, in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

_____ _____

Patient/Guardian Signature **Date**

Appointment Cancelation Policy

At Denver Sports Medicine, our goal is to provide quality treatment for all our patients. We have implemented a cancelation policy which enables us to better utilize available appointments for our patients in need of medical care.

Cancellations of Appointments

Please be courteous and call Denver Sports Medicine promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment.

If it is necessary to cancel your appointment, we require that you give at least **24 hours notice**. Available appointments are in high demand and your early cancellation will give another person the ability to have access to timely care.

Remember, your attendance will directly impact your recovery. Research shows that patients who are compliant with their appointments will recover faster.

Any appointments that are not cancelled within our 24 hour notice policy will be subject to a **fee of $45**. This fee will not be billed to insurance.

How to Cancel Your Appointment:

To cancel and/or change appointments call Denver Sports Medicine at 720-440-3979.

No Show Policy:

A "no show" is someone who misses an appointment without canceling within one (1) working day in advance. No shows inconvenience those individuals who need access to medical care in a timely manner. A failure to be present at the time of a schedule appointment will be recorded in the patient's' chart as a "no show". Three "no shows" may result in the suspension of services.

Appointment and Cancelation Policy Acknowledgement:

I acknowledge that I have received and understand the appointment and cancelation policy. Should I have any questions about the policy, I will notify a Denver Sports Medicine staff member immediately.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Patient Name

Auto Accident Form

ACCIDENT HISTORY

Date of accident:_____

Have you retained an attorney? ☐Yes ☐ No
Attorney name, address, and phone number: _____
_____

Where were you located at the time of the accident?
☐ Driver ☐ Front passenger ☐ Rear passenger ☐ Pedestrian ☐ Cyclist ☐ Other:_____

Where did the accident occur?
☐ Intersection ☐ Parking lot ☐ In Town ☐ Highway ☐ Interstate ☐Other:_____

How many vehcicles were involved: _____

Where was **YOUR** vehicle impacted?
☐ Front ☐ Rear ☐ Driver side (left) ☐ Passenger side (right) ☐ Other:_____

How fast was **YOUR** vehicle going, and what were you doing, at time of impact? _____ mph
☐ Stopped ☐ Slowing down ☐ Speeding up

How fast was **THE OTHER** vehicle going, and what were you doing, at time of impact? _____ mph
☐ Stopped ☐ Slowing down ☐ Speeding up

Did your vehicle hit another object, barrier, or vehicle after impact:? ☐Yes ☐No
Was your vehicle hit by another vehicle after impact? ☐Yes ☐No
If yes to either of the above, please describe:_____

Did any part of your body strike anything in the vehicle?
☐ Head ☐ Face ☐ Shoulder ☐ Elbow ☐ Chest ☐ Hips ☐ Legs ☐ Knees ☐ Shins ☐ Feet

Which hands were on the steering wheel? ☐ Both ☐ Left ☐ Right ☐ None
Which foot was on the brake? ☐ Both ☐ Left ☐ Right ☐ None
Where were you looking at the time of impact? ☐ Straight ahead ☐ Left ☐ Right ☐ Up ☐ Down
Where you wearing a seat belt? ☐ Yes ☐ No
Did you have a headrest? ☐ Yes ☐ No
What air bags deployed? ☐ Front ☐ Side ☐ None

Did you go to a hospital? ☐ No ☐ Yes: Hospital name and location:_____
Where you taken by ambulance? ☐ Yes ☐ No
Please list all procedures performed and treatments received **AT THE HOSPITAL**, including braces, medications, life-saving procedures, etc.: _____
_____
_____

Please list any imagaing (MRI, X-ray, CT scan, etc) you have received SINCE the accident, including what part of the body was imaged: _____
_____
_____

CONDITIONS:

Please check the symptoms you had **IMMEDIATELY FOLLOWING** the accident:

	Head pain		Cold hands or feet		Constipation
	Neck pain or stiffness		Muscle spasm		Diarrhea
	Jaw or facial pain		Loss of conciousness		Shortness of breath
	Shoulder pain or stiffness		Dizziness/lightheadedness		Cough
	Arm pain		Disorientation		Heartburn/indigestion
	Chest pain		Impaired concentration		Difficulty swallowing
	Mid-back pain		Nausea		Loss of balance
	Low-back pain		Headaches		Fatigue
	Hip pain		Fainting		Sleep problems
	Leg pain		Vision changes		Depression
	Numbness or tingling in arm or hand		Sensitivity to light		Nervousness or anxiety
	Numbness or tingling in leg or foot		Sensitivity to noise		Changes in bowel or bladder (i.e.,
	Muscle weakness		Loss of smell or taste		urgency, incontinence, or color)

Please check the symptoms you have experienced **SINCE** the accident:

	Head pain		Cold hands or feet		Constipation
	Neck pain or stiffness		Muscle spasm		Diarrhea
	Jaw or facial pain		Loss of conciousness		Shortness of breath
	Shoulder pain or stiffness		Dizziness/lightheadedness		Cough
	Arm pain		Disorientation		Heartburn/indigestion
	Chest pain		Impaired concentration		Difficulty swallowing
	Mid-back pain		Nausea		Loss of balance
	Low-back pain		Headaches		Fatigue
	Hip pain		Fainting		Sleep problems
	Leg pain		Vision changes		Depression
	Numbness or tingling in arm or hand		Sensitivity to light		Nervousness or anxiety
	Numbness or tingling in leg or foot		Sensitivity to noise		Changes in bowel or bladder (i.e.,
	Muscle weakness		Loss of smell or taste		urgency, incontinence, or color)

Please describe the treatment you have received SINCE your accident, including medications, braces, and visits with health care providers:

_____

_____

_____

Are you reposding to treatment so far? ☐ Getting better ☐ Getting worse ☐ Feel the same ☐ Other: _____

Have you missed work due to the accident? ☐ Yes ☐ No

If yes, how many days did you miss? _____

Are you back to work? ☐ Yes ☐ No ☐ Yes, but only part time or light duty. Explain:_____

I certify that I have read and understood the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that my chiropractic, physical therapy insurance carrier may cover only a portion of or not cover all of the services rendered. I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

_____ **_____**

Patient/Guardian Signature **Date**