



Please Answer All Questions

1 PATIENT INFORMATION

Date _____

Patient Name _____

Mailing Address _____

City _____ State _____ Zip _____

Sex: M F Age _____ Birth Date _____

Occupation _____

Employer _____

How did you hear about our office?

2 PHONE NUMBERS

Home _____ Cell _____

In Case of Emergency Contact:
Name _____ Relation _____
Phone _____

E-Mail-for appointment reminders:
_____ @ _____

Communication Preference:
Email Home Phone Cell Phone Text

6 PATIENT CONDITION

3 INSURANCE

Insurance Co. _____

Policy Holder: Self Other

If "Other"—Name _____
Date of Birth: _____

Please present card for us to copy

4 ACCIDENT INFORMATION

Is your condition due to an accident? Yes No

Type of accident Auto Work Home Other

Date of accident _____

5 PAST TREATMENT

Who is your family doctor? _____

When was the last time you saw him/her? _____

Have you ever seen a Chiropractor Physical Therapist or
Acupuncturist?

Who? _____

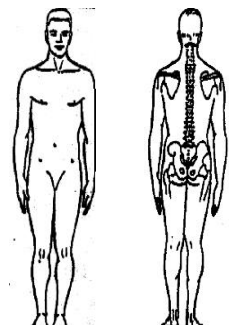
When did you last see him/her? _____

How did you respond to their treatment?
Excellent Results Good Results Fair Results

Any other comments about your treatment with the health care
provider noted above? _____

What is your **major reason** for being here? _____

When did your symptoms begin? _____



Please mark on the
pictures where you
have pain.

Is your condition getting: Worse Better Staying the same? Height _____ Weight _____

On a scale from 1 (least pain) to 10 (severe pain), what is the pain level in the area(s) that hurts you most? _____

Is your pain: Sharp Dull Stabbing Aching Radiating Burning Throbbing?

Are your symptoms: Occasional Intermittent Frequent Constant? Are they: Slight Moderate Severe?

What increases your symptoms? Sitting Standing Walking Bending Moving from one position to another
Other _____

What makes your symptoms better? Moving Rest Medication Ice Walking Nothing
Other _____

Do your symptoms interfere with your: Work Sleep Recreation Daily Activities?

Do you have: Weakness Numbness Tingling Stiffness?

What type(s) of treatment do you desire or would you consider? Chiropractic Physical Medicine Acupuncture

Simone Physical Medicine

1111 1st St.
Fort Lupton, CO 80621

Patient Name: _____

Health Questionnaire--All information is strictly confidential.

How often do exercise?

- ☐ Every day
- ☐ 4 or 5 times a week
- ☐ 3 or fewer times a week
- ☐ I don't really exercise

What is your work activity?

- ☐ Sitting
- ☐ Standing
- ☐ Light Labor
- ☐ Heavy Labor

Habits?

- ☐ Smoking—If yes ____/day
- ☐ Alcohol—If yes ____/week
- ☐ Caffeine Drinks
- ☐ High Stress Level

Have you had any of the following?:

- ☐ Falls _____
- ☐ Head Injuries _____
- ☐ Broken Bones _____
- ☐ Surgeries _____

Medical Illnesses

Please note age of onset?

- ☐ Diabetes _____
- ☐ Hypertension/High Blood Pressure _____
- ☐ Heart Disease _____
- ☐ Asthma _____

- ☐ Cancer _____
- ☐ Headaches _____
- ☐ Arthritis _____
- ☐ Bleeding Disorder _____
- ☐ Severe Infections _____

- ☐ Herniated Disc _____
- ☐ Liver Disease _____
- ☐ Epilepsy _____
- ☐ HIV/Aids _____
- ☐ Tumors/Growths _____
- ☐ Lung Disorder _____
- ☐ Other _____

- ☐ Osteoporosis _____
- ☐ Pacemaker _____
- ☐ Prostate Disorder _____
- ☐ Psychiatric Care _____
- ☐ Stroke _____
- ☐ Hepatitis _____
- ☐ Hysterectomy _____

List Any Allergies Below:

What Health Issues Do or Have Your Parents/Brothers or Sisters Had?:

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

List Any Vitamins/Herbs You Are Currently Taking Below:

List All Current Medications Below:

If you have low back pain, please answer (circle) the following: Do you have numbness and/or tingling in your leg(s)? Y N Do you have pain in your leg(s)? Y N Do you have pain when at rest? Y N Does your pain get better when you bend forward (like pushing a shopping cart) or after you rest 10-20 minutes? Y N Do you feel better if you sit or lay down? Y N Do you also have pain in your buttocks and/or thighs? Y N



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INFORMED CONSENT---OFFICE POLICIES---PAYMENT OPTIONS

As with any health care procedure, there are certain complications that may arise during treatment. Even though the following complications are **very rare**, we do want you to be aware of the most common: muscle strains, rib fractures, first or second degree burns from heat pads, and disc herniations. An **extremely rare** complication of an upper neck adjustment is a Vertebrobasilar Incident (which could cause a stroke in progress to worsen). The most recent research suggests this occurs about 1 in 1,000,000 times. Dr. Simone uses tests during his examination that are designed to identify if you may be susceptible to that kind of injury. ***None of these complications has occurred while Dr. Simone has been in practice. You may also experience pain or discomfort during the initial examination.*** This is very common since the diagnostic tests we use are designed to mildly stress the joints and other tissues. Treatment options available outside this office include self-administered (over the counter) medications, prescription drugs and surgery. Complications from these treatment options often exceed possible complications of treatments used in this office.

Our office charges a \$45 fee if an appointment is not canceled within 24 hours. Making scheduled appointments is very important to insure you receive the care you need. It is the policy of this office to discharge you from care if you miss two consecutive scheduled appointments. We will refer you to another provider for further care.

A \$25 charge is added to any fees our bank charges us when a check is returned for insufficient funds.

I have read the above and have had any questions answered to my satisfaction. Having been informed of the risks and after having any of my questions answered, I hereby give permission for Simone Physical Medicine to treat my condition.

Signature of Patient or Guardian

Date

Printed Name of Patient or Guardian

MY RESPONSIBILITY FOR PAYMENT OF FEES

I fully understand and agree that I am directly and fully responsible to pay Simone Physical Medicine in full for all professional services and /or products provided to me and/or my dependents. I further understand and agree that such payment to Simone Physical Medicine is not contingent upon any settlement, claim, judgement or verdict by which I may eventually recover said fee. I also agree to pay all reasonable costs of collection, attorneys' fees and interest at the ANNUAL PERCENTAGE RATE OF 21% (1.75% PER MONTH) on any PAST DUE BALANCE (over 60 days old). I authorize insurance companies, attorneys or other third party payers to directly pay Simone Physical Medicine for services provided to me in this office.

Patient or Guardian Signature

Date

Patient or Guardian Name Printed Name

(Please make sure you signed both areas and printed your name in the space below)

Simone Physical Medicine

Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, “I” and “my” refer to the patient.

I consent to the use or disclosure of my protected health information by Simone Physical Medicine for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Simone Physical Medicine. I understand that analysis, diagnosis or treatment of me by Simone Physical Medicine may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Simone Physical Medicine is not required to agree to the restrictions that I may request. However, if Simone Physical Medicine agrees to a restriction that I request, the restriction is binding on Simone Physical Medicine. I have the right to revoke this consent, in writing, at any time, except to the extent that Simone Physical Medicine has taken action in reliance on this Consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Simone Physical Medicine. The Notice of Privacy Practices for Simone Physical Medicine is available at 1111 1st. Street, Ft. Lupton CO 80621. This Notice of Privacy Practices also describes my rights and duties of Simone Physical Medicine with respect to my protected health information.

Simone Physical Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Simone Physical Medicine and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I authorize Simone Physical Medicine to share information concerning appointment times (not medical information) with those who answer the phone connected to the number I have given, see text messages we send, view emails sent to the email I have provided, and/or listen to voice messages.

☐ Yes ☐ No

Signature of Patient or Personal Representative

Printed Name of Patient

Date of Signing

Description of Personal Representative's Authority