TRI HEALTH CLINIC, INC.
CHIRO. & REHAB.

PATIENT INFORMATION FORM

Name: _____
Last First M.I.

Date of Birth: _____ Age: _____ Sex: ____ S.S. Number: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Spouse's Name: _____ Work Phone: _____

Emergency Contact: _____Email:_____

Whom may we thank for referring you to us? _____

Who is responsible for this bill? _____

I hereby grant Tri Health Clinic Inc. the authority to give an initial examination to me/my dependent necessary to create a better understanding of my health status and to give an appropriate diagnosis and treatment schedule.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I agree to pay full payment upon receipt of a statement of an unpaid balance or I contact Tri Health Clinic Inc. to establish financial arrangements to ensure payment of any unpaid balance within 10 days of receiving a statement. I have read all the information and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above.

_____ _____
Signature **Date**

_____
Parent (if minor)

Also, I have received a copy of this office's Notice of Privacy Practices and acknowledge my understanding of its content. I understand that I may refuse to sign this portion of this agreement.

_____ _____
Signature **Date**

For Office Use Only. **Signature of acknowledgment could not be obtained because:**			
☐ Refuse to sign	☐ Communications barriers	☐ Emergency situation	☐ Other _____

INSURANCE AND ATTORNEY INFORMATION

INSURANCE INFORMATION

PATIENT INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Insured Name: _____

Claim Number: _____ Agent Name: _____

Do you have Medical Payments Coverage in your policy? _____ How much? _____

ADVERSE PARTY INSURANCE INFORMATION

Name of Adverse Party: _____ Phone Number: _____

Adverse Party Insurance: _____ Phone Number: _____

Claim Number: _____ Agent Name: _____

ATTORNEY INFORMATION

Have you retained an Attorney? ( ) Yes ( ) No

Name: _____

Address: _____

_____

Phone Number _____

Fax Number _____

MOTOR VEHICLE ACCIDENT/PERSONAL INJURY QUESTIONNAIRE

1. Date of Accident: _____ Time: _____AM/PM

2. Were you the: ( ) Driver ( ) Passenger **( )** Pedestrian
If passenger, were you in the ( ) Front seat ( ) Right rear seat ( ) Middle ( ) Left rear seat

3. What type of vehicle were you in? _____

4. What type was the other vehicle? _____

5. How many vehicles involved the accident? _____

6. Number of People in your Vehicle: _____ Name: _____ Relationship: _____

7. Where did the collision occur? Street: _____
City/Town: _____ State: _____

8. Please describe the collision in your own words:
_____
_____
_____
_____

9. What direction was your vehicle going? _____

10. Was the impact from: ( ) The front ( ) The rear ( ) The left side ( ) The right side

11. Was your vehicle in: ( ) Stopped: ( ) Traffic ( ) Red Signal Light ( ) Stop sign ( ) Yield sign
( ) Moving: Your vehicle _____mph Adverse vehicle _____ mph

12. How much is the damage of your car (estimate)? ( ) Mild ( ) Moderate ( ) Extreme $ _____

13. Did air bag deployed? ( ) No ( ) Yes

14. What was the weather at the time of the collision? ( ) Dry ( ) Wet ( ) Icy

15. Was there Police at the accident scene? ( ) No ( ) Yes From which City: _____

16. Was there Ambulance/Paramedic or Fire truck at the accident scene? ( ) No ( ) Yes
If ambulance, did the ambulance attendants place you in a: ( ) Neck brace ( ) Back brace
( ) Other _____

17. Did you go to the Hospital / Emergency department? ( ) No ( ) Yes
If yes, Please answer the following questions: When? ( ) Right after the accident ( ) Next day
If yes, how did you get there? ( ) Ambulance ( ) Other: _____

18. What was the reason you went to the hospital? _____
_____
_____

19. What was the name of the Hospital/Emergency Department? _____

20. What was the name of Doctor? _____

21. What was the diagnosis? _____

22. Any medication or medical supplies given? ( ) No ( ) Yes _____

23. Did you have X-rays / MRI / CT taken at the hospital? ( ) No ( ) Yes: Where? _____

Diagnosis from films? _____

24. Did you go to see any health care providers (MD, DO, DC, PT, Others) after the accident? ( ) No ( ) Yes

If yes, What was the Clinic and Doctor's name? ____

When was the date? _____ The reasons? _____

25. Please describes your injury from the accident? _____

_____

_____

26. Were you loss of consciousness from the accident? ( ) No ( ) Yes, How long? _____

27. Were you wearing a seat belt? ( ) No ( ) Yes

28. Did your seat have a head restraint (headrest)? ( ) No ( ) Yes

If yes, what was the head rest position? ( ) Low ( ) Mid position ( ) high

29. Did your head ride over the headrest? ( ) No ( ) Yes

30. Did any other part of your body hit the interior of the vehicle? ( ) No ( ) Yes

If yes, please specify: ( ) Seatbelt restraints ( ) Steering wheel ( ) Dashboard ( ) windshield

( ) Side door ( ) Side window ( ) Air bag ( ) Other _____

31. Which part of your body? ( ) Chest ( ) Head ( ) Chin ( ) Face ( ) R L knee ( ) R L shoulder

( ) R L hand ( ) Other _____

32. At the time of impact were you looking: ( ) Straight ahead ( ) Right ( ) Left ( ) Down ( ) Up

33. At the time of impact were you aware the accident? ( ) No ( ) Yes

34. Have you had any similar problems before? ( ) No ( ) Yes

If yes, explain_____

_____

35. Have you ever involved a previous motor vehicle accident? ( ) No ( ) Yes

If yes, When was the previous accident? _____

36. Were you injured from the accident? ( ) No ( ) Yes

If yes, Where did you injured from the accident? _____

37. Do you still have the ongoing complaints from the accident? ( ) No ( ) Yes

If yes, Where? _____

Are you still getting treatments? ( ) No ( ) Yes

PATIENT SIGNATURE _____ DATE_____

CONFIDENTIAL PATIENT CASE HISTORY

1.What is your major complain / Where does hurts?

_____

_____

USE THE INSTRUCTIONS BELOW TO RATE YOUR PAIN

(1-3 MILD PAIN) **(4-7 MODERATE PAIN)** **(8-10 SEVERE PAIN)**

CIRCLE THE NUMBER THAT DESCRIBES YOUR "FREQUENCY" PAIN AND YOUR "PAIN LEVEL"

HEADACHE FREQUENCY: 1 2 3 4 5 6 7 8 9 10 PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

Is your headache located in the: Front _____ Sides _____ Back _____ All over _____
Is your headache pain: Sharp _____ Dull _____ Throbbing _____ Muscle Tension _____
Is your headache pain today: Same _____ Better _____ Worse _____ than when it began.
Is you headache pain associated with: Dizziness _____ Vomiting _____
Double Vision _____ Confusion _____ Others _____
What is the timing of your pain: Constant _____ Intermittent _____ Worse with Activity _____

NECK PAIN FREQUENCY: 1 2 3 4 5 6 7 8 9 10 PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

Is your neck pain located in the: Front _____ Sides _____ Back _____ All over _____
Is your neck pain: Sharp _____ Dull _____ Throbbing _____ Muscle Tension _____
Is your neck pain today: Same _____ Better _____ Worse _____ than when it began.
Does pain increase with: Sitting _____ Job Duties _____ Turning ____ Bending _____ Lifting ____
Others _____
What is the timing of your pain: Constant _____ Intermittent _____ Worse with Activity _____
Have you injured your neck before? Yes ( ) No ( ) If yes, explain_____

- Is there a "pins & needles" sensation in your ARMS or HANDS associated with your neck pain? YES NO
- Is there a shooting pain into your ARMS or HANDS associated with your neck pain? YES NO
- Have you notice any weakness in your ARMS or HANDS associated with your neck pain? YES NO

BACK PAIN FREQUENCY: 1 2 3 4 5 6 7 8 9 10 PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

Where is your pain located? Upper Back ____ Middle Back ____ Lower Back ____ All over ____
Is you back pain: Sharp _____ Dull _____ Throbbing _____ Muscle Tension _____
Is your back pain today: Same _____ Better _____ Worse _____ than when it began.
Does pain increase with: Sitting _____ Job Duties _____ Turning ____ Bending ____ Lifting ____
Others _____
Does the pain wake you up at night? YES ( ) NO ( ) Explain _____
What is the timing of your pain: Constant _____ Intermittent _____ Worse with activity _____
Does SNEEZING ( ) or COUGHING ( ) increase your NECK ( ) or BACK ( ) pain?
Do you have full control of you bladder and/or bowels? YES ( ) NO ( )

- Is there a "pins and needles" sensation in your CHEST or ABDOMEN associated with your pain? YES NO
- Is there a "shooting pain" in your CHEST or ABDOMEN associated with this pain? YES NO
- Is there a 'pins and needles" sensation in your LEGS or FEET associated with your back pain? YES NO
- Is there a "shooting pain" into your LEGS or FEET associated with your low back pain? YES NO
- Have you noticed any WEAKNESS in your legs associated with your low back pain? YES NO

OTHER PAIN FREQUENCY: 1 2 3 4 5 6 7 8 9 10 PAIN LEVEL: 1 2 3 4 5 6 7 8 9 10

Where is your pain located? Chest /Rib Cage _____ Shoulder (RT/LT) _____ Elbow (RT/LT) _____
Arm (RT/LT) _____ Wrist (RT/LT) _____ Fingers (RT/LT) _____ Knee (RT/LT) _____
Ankle (RT/LT) _____ Toes (RT/LT) _____ Others (RT/LT) _____
Is your back pain today: Same _____ Better _____ Worse _____ than when it began.

PATIENT NAME:_____ DATE:_____

FUNCTIONAL CAPACITY / ACTIVITIES OF DAILY LIVING

Describes of your functional capacity and ADL such as duty of working, exercise etc.

_____

_

Check if you have pain or discomfort with any of the following:

( ) washing, dressing, or grooming
( ) walking
( ) sitting for prolonged periods
( ) social or recreational activities
( ) getting in and out of bed or car
( ) lifting involved in household chores
( ) driving a car
( ) sleeping
( ) reading or concentrating
( ) carrying groceries or children

PAST MEDICAL HISTORY

( ) No major medical history ( ) Yes, I do have a past medical condition(s)

Describes your past medical conditions: _____

_____

PAST SURGICAL HISTORY

( ) No major surgical history ( ) Yes, I do have a past surgical history

Explain your surgical history: _____

_____

MEDICATION

( ) No medication taking ( ) Yes, I am taking a medication currently.

Name of medication? _____

_____

FAMILY HISTORY

Relative	Age if Living	Age at Death	Cause of Death	Illnesses
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Brother (s)	_____	_____	_____	_____
Sister (s)	_____	_____	_____	_____

SOCIAL HISTORY

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work ( ) Heavy ( )Moderate ( )Light Hours per day _____

Physical Work ( ) Heavy ( )Moderate ( )Light Hours per day _____

Exercise ( ) Heavy ( )Moderate ( )Light Hours per day _____

Smoking ( )Current ( )Previous Packs/Day_____ No.of Years_____

Alcohol Beer/Week_____ Liquor/Week____Wine/Week_____ No.of Years_____

OCCUPATIONAL HISTORY

Are you working currently? Yes ( ) No ( )

Work Times: Full Time ( ) Part Time ( ) _____hrs/day _____days/week

Describe your present job requirements:_____

_____

FEMALE PATIENT

When was your last menstrual period? _____ weeks ago.

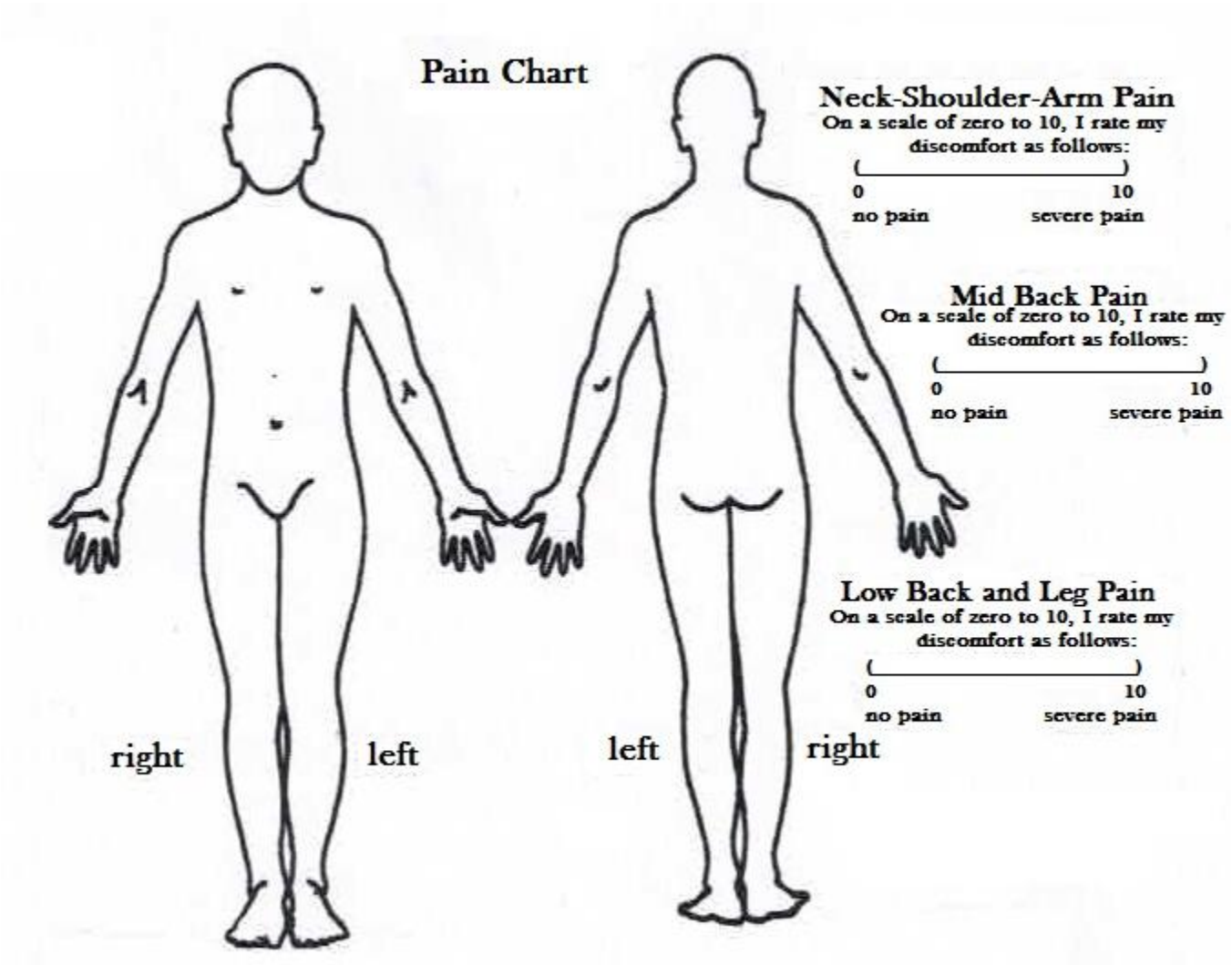
Are you or could you be pregnant? YES ( ) NO ( ) If yes, # weeks____

SHOW AREA (S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols.
Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	0 0 0 0 0	X X X X X	+ + + + +	/ / / / /
- - - - -	0 0 0 0 0	X X X X X	+ + + + +	/ / / / /
- - - - -	0 0 0 0 0	X X X X X	+ + + + +	/ / / / /

Please mark on the pain scale from zero to 10 the pain you feel with this condition. 10 being the worst pain you have felt with this condition and zero being the least.



CONSENT TO TREAT FORM

DATE: _____

PATIENT NAME: _____

The diagnosis, treatment schedule, and payment plan have been explained to me and I have had my questions answered to my satisfaction. I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended I hereby grant TRI HEALTH CLINIC INC. the authority to treat and examine me/my dependent and to order the examination and test. I understand that the practice of chiropractic is not an exact science and that there are no guarantees. Also, I understand that every individual may respond differently to a particular treatment regimen. I understand that there are certain risks associated with any examination or treatment and those risks have been presented and explained to me. I hereby authorize TRI HEALTH CLINIC INC. and/or its clinical staff to perform examinations and treatment as necessary for my care.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time. Date of last menstrual period _____.

_____

Signature

_____

Printed Name

_____

Signature of Parent or Guardian (if a minor)

CASE INFORMATION RELEASE FORM

DATE: _____

TO:

_____

_____

_____

I hereby request and authorize you, your employees, and agents to furnish to the person(s) listed below or anyone designated in writing by him/her/them, all the records and reports, including the disbursement statement, and any other information he/she/they may request relating to my case, treatment, or opinion concerning my case.

Please forward the reports and information requested to:

Tri Health Clinic
11275 E. Mississippi Ave. 2-S-2
Aurora, CO 80012

_____
Signature

_____
Print Name

_____
Street Address

_____
City, State, and Zip Code

TRI-HEALTH CLINIC, INC
CHIROPRACTIC & REHABILITATION

LIEN, ASSIGNMENT & AUTHORIZATION

This agreement, entered into this date between _____ called "PATIENT" and Tri Health Clinic, Inc. Patient desires to receive health care services from Tri Health Clinic, Inc. and agrees to provide a lien, assignment and release to the Tri Health Clinic, Inc. as consideration for Tri Health Clinic, Inc.'s services. Accordingly, it is agreed:

A. Patient agrees to have a lien placed on any settlement, judgment or payment from any legally responsible party or insurance company arising from the Patient's injuries related to a legal claim for damages from an incident that occurred on or about _____, including, but not limited to, a bodily injury liability claim, an uninsured or underinsured motorist claim or any other insurance or other claim damages. This lien is granted to the Tri Health Clinic, Inc. **Patient agrees and instructs any insurance company or other responsible party making payment, that any check or draft payable to Patient on this matter will be made payable jointly to Patient and to the Tri Health Clinic, Inc.** Patient understands that Patient is directly and fully responsible to the Tri Health Clinic, Inc. for treatment rendered and this agreement is made solely for additional protection and consideration to Tri Health Clinic, Inc. Patient further understands that such payment is not contingent on any settlement, claim, judgment or verdict which Patient may eventually recover. In the event of non-payment or reduced payment by any insurance company, health care benefit plan or any other party liable to Patient for payment of health care costs incurred by Patient as a result of services rendered by the Tri Health Clinic, Inc., Patient agrees to be responsible for any such outstanding balance, including interest at a rate of 9% per year compounded annually.

B. Patient fully understands and agrees that this lien, assignment and authorization are irrevocable.

C. Patient agrees and directs any attorney representing Patient to honor this lien and make payment in accordance with this lien directly to the Tri Health Clinic, Inc. from the attorney's COLTAF trust fund account. In the event that there is a dispute on payment of all or a part of Tri Health Clinic, Inc.'s bills, Patient agrees to instruct Patient's attorney to hold the full amount of the Tri Health Clinic, Inc.'s bills in the attorneys COLTAF trust fund until an agreement is reached on payment or a court decides the matter.

D. Patient agrees that in the event Patient or Patient's attorney receives any check or draft from an insurance company, paying any bills of Tri Health Clinic, Inc., such as a Med-Pay or medical insurance company payment, Patient or Patient's attorney agrees to act a s fiduciary agent for the Tri Health Clinic, Inc and will immediately deliver the check or draft to the Tri Health Clinic, Inc. to be applied to Patient's debt for services rendered.

E. Patient authorizes and directs Patient's attorney to disclose any settlement or collected judgment amounts, distribution sheet and final accounting by Patient's on the Patient legal case to the Tri Health Clinic, Inc. and waives any attorney/client privilege as it relates to any terms, distribution and final accounting of any funds collected and monies paid from a settlement or payment on a judgment.

F. Patient authorizes and directs any third party insurance company to disclose the settlement amounts, dates of settlement and terms to the Tri Health Clinic, Inc.

G. Patient assigns to the Tri Health Clinic, Inc. any and all benefits and payments payable from the Patient's medical insurance company or by a Med-Pay insurer for services provided by the Tri Health Clinic, Inc. Patient also assigns to the Tri Health Clinic, Inc. all contractual rights and legal causes of action Patient has against Patient's medical insurance company or a Med-Pay insurer that fails to properly pay the Patient's bills with Tri Health Clinic, Inc.

H. Patient authorizes Tri Health Clinic, Inc. to receive a complete copy of Patient's insurance policy, including any declaration pages, endorsements, conditions, limitation, benefits, exclusions and policy limits.

I. In the event of a breach of this agreement, the prevailing party is entitled to its reasonable attorney fees and costs incurred to enforce this agreement.

Patient Signature: _____

(NAME) (DATE)

Responsible Party Information

Name of Party at Fault: _____

Insurance Company Name: _____

Insurance Address and Phone Number: _____

Claim Number: _____ Adjusted: _____

Date of Injury: _____

Attorney Information

Name of Patient's Attorney: _____

Attorney's Address: _____

Attorney's Phone Number: _____

Attorney's Fax Number: _____

Attorney Acknowledgement and Agreement to Honor Lien

I, _____, the attorney for _____,
Acknowledge receipt of this lien and agree to withhold from any settlement payments, judgment payments, uninsured or underinsured motorist payments or other monies received on this patient amounts equal to the health care provider(s) outstanding balances unless an agreement has already been reached with the provider(s) for a lesser amount prior to any distribution of monies received.

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

THE GOALS OF THE REHABILITATION PROGRAM INCLUDE:

1. Determining the cause and extent of your problem.
2. Providing a therapeutic exercise program to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

THE EQUIPMENT USED TO TEST YOU AND THE PROCESS WE WILL BE USING WILL BE EXPLAINED TO YOU.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and DVR manager, if it is applicable.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified. Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider. The "team" approach has the best chance of attaining your Goals, so please ask as many questions as necessary for you to gain the maximum benefit from your rehabilitation program.

Since the process of strengthening and conditioning are a form of "controlled strain", there is a chance of aggravation or injury. It is therefore imperative that you communicate to your provider any aggravation or injury that you may observe during the rehabilitation process. For example, the best exercise for you, if performed too early in your condition, may be your worst enemy if performed too soon. Communication with your provider will help put into perspective problems that may occur. Failure to discuss problems may only foster additional problems down the road.

I HAVE READ THE ABOVE AND UNDERSTAND THE RISKS AND BENEFITS OF THE REHABILIATION PROGRAM. I AGREE TO PARTICPATE AND HAVE MY REHABILTATION INFORMATION RELEASE TO MY DOCTOR, INSURANCE CARRIER, ATTORNEY, OR DVR PERSONNEL IF REQUESTED.

_____ _____

SIGNATURE OF PARTICPANT DATE