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: _____

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 INFORMATION

INSURANCE INFORMATION

PATIENT INSURANCE INFORMATION

Insurance Company: _____ Phone Number: _____

Policy Number: _____ Insured Name: _____

Group Number: _____ Member ID Number: _____

Effective date: _____ Deductible: $_____ Co-Pay: $_____

Claim Address: _____

_____

For office use only

COVERAGE

Chiropractic:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr
P.T:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr
Acupuncture:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr
M.D:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr
X-ray:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr
MRI:	Insurance: _____%	Patient: _____%	Max: $/Visits:_____Yr

ADDITIONAL NOTES

_____
_____
_____
_____
_____
_____
_____
_____

PATIENT NAME:_____ DATE:_____

CONFIDENTIAL PATIENT CASE HISTORY

Please fill out the following questions in as much detail as possible.

What is your major complaint and symptoms?

_____
_____
_____

How do you believe your complaint began? (Please describes your injury or trauma) _____
_____
_____
_____

When did your first notice this complaints/pain? _____

What positions or activities aggravate your conditions? _____

What positions or activities relieve your conditions? _____

Can you describe your pain? (Ex: Sharp pain, Dull pain, Throbbing pain, Muscle tension)

_____
_____

Does the pain radiate to arms or legs? No Yes, Please describes? _____

Have you lost any work because of your conditions? No Yes, How many days? _____

Have you ever had this condition before or a similar condition? No Yes, When? _____
Please, describes your conditions: _____
_____
Have you been treated by a provider for this conditions? No Yes, When?_____
Where? _____ Doctor's Name? _____
Describes the type of treatment: _____
Length of time under care: _____

Do you have a family physician? No Yes, Your doctor's name: _____
Address: _____ Phone Number: _____
_____ Fax Number: _____
(Please send a report to my family doctor: No Yes)

Have ever been in any accidents such as a motor vehicle accident or work injury? No Yes, When? _____
Please describes your accident: _____
_____
Have you ever injured from this accident? No Yes Where? _____
Please describes your injury: _____
_____
Have you been treated by a provider for this conditions? No Yes, When?_____
Where? _____ Doctor's Name? _____
Describes the type of treatment: _____
Length of time under care: _____

Any comments/concern before examination: _____

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 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 _____

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_____
AlcoholBeer/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

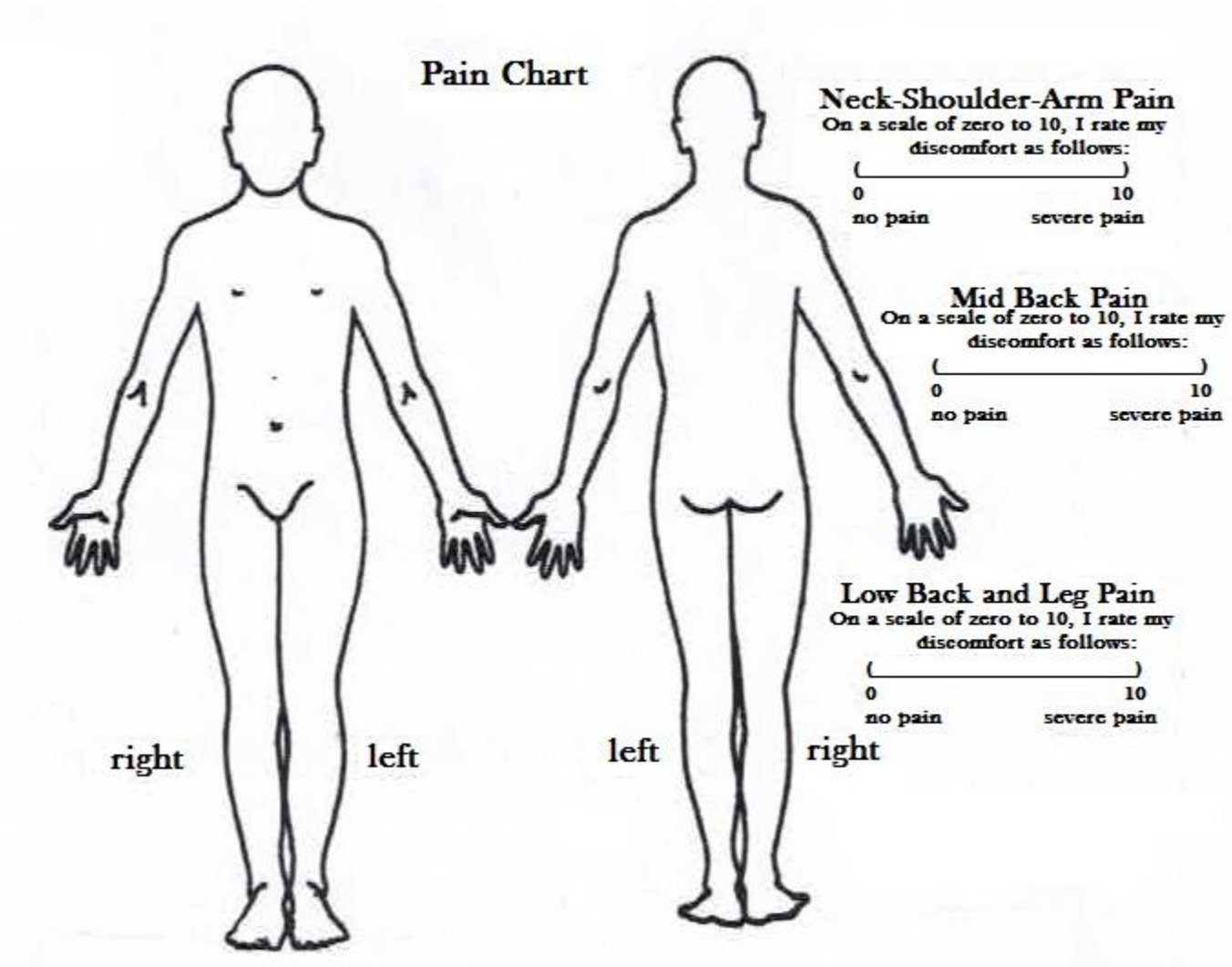
When was your last menstrual period? _____ weeks ago.
Are you or could you be pregnant? YES ( ) NO ( ) If yes, # weeks__

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

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

OFFICE FINANCIAL POLICY

Our policy is to extend to you're the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expense and allows you to place your family under care.

1. **If you do not have insurance:** All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed $100 at any time or care may be terminated. Our payment plans make care an affordable part of your family budget.

2. **If you have insurance:** All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary and reasonable by most companies and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard and of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once per month or longer, you will not be eligible for insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

_____ _____

Patient's Printed Name Date

_____ _____

Signature Date