



In an effort to provide a higher quality of care to you and your family, we are updating to electronic health records in our office. To help us on our way, we ask that you please fill out the health history form below as completely as possible. Thank you from our entire team.

Chiropractic Registration and History

Contact Information Date: / /

Name: _____
First Middle Last

Address: _____

City State Zip

Email: _____
 Sign up for Team DC newsletter

Pref. Phone:

Home: - -

Work: - - Ext. _____

Cell: - -

Sign up for text reminders

Cell Carrier: _____

How did you hear about us? _____

Who referred you to our office? _____

Date of Birth: / / Age: _____

S.S. #: - - Sex: M F

Marital Status: Married Divorced Live w/ partner
 Minor Separated Widowed

Race: _____ Ethnicity: _____
(Caucasian, Asian, Latino etc.) (Mexican, German, French etc.)

Preferred Language: _____

Spouse Name: _____

Parents/Guardians: _____
(Only if patient is a minor)

Lives with: Alone Spouse Children
Check all that apply Parents Siblings Other

Emergency Contact: _____

Relationship: _____

Phone: - -

Employment Information

Employed Unemployed Retired In-School

Occupation: _____ Start: / / End: / /

Company/School Name: _____

Insurance Information **For Medicare, Worker Comp., and Auto Accident patients ONLY

Medicare Workman's Comp. Auto Accident

Who is responsible for this account? _____ Relationship to patient: _____

Insurance Company: _____ Secondary Insurance: _____

Please present your insurance card to the front desk for copying.

ID#: _____ Group #: _____ Deductible Met: Y N

Symptom Information

Date: / /

Reason for visit: _____ Date you first noticed symptoms: / /

Please explain your condition: _____

Have you seen another doctor for this condition? Y N If Yes, who? _____

Please explain any prior treatment you have received for this condition: _____

Is this condition getting progressively worse? Y N Rate the severity of your pain: **1 2 3 4 5 6 7 8 9 10**

Is the pain constant? Y N OR does it come and go? Y N

Which activities are difficult to perform? Sitting Standing Walking Bending | Laying down OtherType of pain: Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other: _____

Health History

*Please answer the rest of these questions as completely as possible.***ALLERGY INFORMATION** Are you allergic to anything? Y N *If yes, please continue filling out the allergy portion.*

What are you allergic to? _____

(please list all)

What is your reaction? _____ Is your reaction currently active? Y N

Do you take medicine for your allergy? Y N Have you had any adverse reaction to the medication? Y N

If yes, Please Explain: _____

MAJOR ILLNESSES

Do/Have you have/had a major illness? Y N *If yes, please check all that apply.*

Previously	Presently	Previously	Presently	Previously	Presently	Previously	Presently		
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Allergy Shots	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Migraine Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Anorexia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>	Suicide Attempt
<input type="checkbox"/>	<input type="checkbox"/>	Appendicitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Tumors, Growths
<input type="checkbox"/>	<input type="checkbox"/>	Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Typhoid Fever
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Parkinson's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pinched Nerve	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Infections
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	Chemical Dependency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prostate Problems	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prosthesis	<input type="checkbox"/>	<input type="checkbox"/>	

Please list the dates of all checked: _____

FAMILY HISTORY

Relationship	Arthritis	Alzheimer's	Back Pain	Blood Pressure	Cancer	Cholesterol	Diabetes	Headaches	Heart Attack	Joint Pain	MS	Osteoporosis	Scoliosis	Stroke	Deceased		Cause of Death
															Y	N	
Any other family conditions?															Y	N	

SOCIAL HISTORY

Smoking	<input type="checkbox"/> Never	<input type="checkbox"/> Former	<input type="checkbox"/> Current	How many years?		Comments:
Alcohol	<input type="checkbox"/> Never	<input type="checkbox"/> Former	<input type="checkbox"/> Current	Drinks p/week		
Caffeine	<input type="checkbox"/> Never	<input type="checkbox"/> Former	<input type="checkbox"/> Current	Drinks p/week		
Drug Use	<input type="checkbox"/> Never	<input type="checkbox"/> Recreational	<input type="checkbox"/> Addiction			
Exercise	<input type="checkbox"/> Never	<input type="checkbox"/> Everyday	<input type="checkbox"/> Weekly			
<i>all that apply</i>	<input type="checkbox"/> Walks	<input type="checkbox"/> Runs	<input type="checkbox"/> Swims	<input type="checkbox"/> Other		

HOSPITALIZATION

Date	Reason	Hospital	Surgery	Results
/ /			Y N	
/ /			Y N	
/ /			Y N	
/ /			Y N	

MEDICATIONS

Please include supplements where applicable

/ /	Name: _____	Active: Y N	Strength: _____	Dosage/Frequency: _____
Prescribed by: _____	Rx #: _____	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Other		
/ /	Name: _____	Active: Y N	Strength: _____	Dosage/Frequency: _____
Prescribed by: _____	Rx #: _____	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Other		
/ /	Name: _____	Active: Y N	Strength: _____	Dosage/Frequency: _____
Prescribed by: _____	Rx #: _____	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Other		
/ /	Name: _____	Active: Y N	Strength: _____	Dosage/Frequency: _____
Prescribed by: _____	Rx #: _____	Route: <input type="checkbox"/> Oral <input type="checkbox"/> Injection <input type="checkbox"/> Topical <input type="checkbox"/> Other		

If you are currently taking more than 4 medications, please append a separate list.

IMMUNIZATIONS

Date	Vaccine	Administered by	Date	Vaccine	Administered by
/ /			/ /		
/ /			/ /		

Please Sign the Authorization on the back.



AUTHORIZATION

I certify that I have read and understood the above information. The above questions have been accurately answered to the best of my knowledge. I understand that providing incorrect or incomplete information can be dangerous to my health. I authorize and request my insurance company to pay directly to the chiropractor insurance benefits otherwise payable to me. I certify that I have read, understood and received a copy of the financial policy, and I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent/guardian)

/ /

Date



TEAM DC FINANCIAL POLICY

Welcome to Dunnagan Chiropractic! Our primary mission is to deliver the finest and most comprehensive health care available today. Our experience shows that it is wise to have an understanding with our patients as to our office policies and fees. We offer several methods of payment for your chiropractic care at our office. You may choose the plan which best fits your needs. Please read over the options carefully and choose the plan you prefer. This information enables us to better serve you. Our main concern is your health and well-being.

A. CASH: Includes checks, Debit, or Credit (Visa, Mastercard, and Discover)

1. Payment in full is expected at the time services are rendered.
2. You may make a single payment in full at the beginning of the week for multiple visits during the week.

B. PROMPT PAYMENT AGREEMENT (For patients without insurance) Medicare, Medicaid, Personal Injury and Worker's Compensation do not qualify.

1. A billing savings will be given with payment of cash, check or credit card at the time of service, if there is no outstanding balance on your account.
2. Accounts that carry a balance will be charged the regular fee until the balance is paid off.

C. INSURANCE

WE ARE NOT ENROLLED IN ANY MANAGED CARE INSURANCE PLANS.

It is important that you understand your insurance policy is a contract between you and your carrier. These days, many policies reimburse for at least some chiropractic care. Coverage varies greatly from policy to policy and constantly changes. Our goal is to help you get well and stay well. Sometimes this is at odds with the profit motives of an insurance company. Our office will supply you with a bill to submit to your insurance company on your own.

1. We will bill Personal Injury, Auto Accident claims, and Worker's Compensation cases and accept payment upon settlement if necessary.
2. A signed agreement is required in these cases stating you agree to pay your bill in full if, for any reason, any charges are denied.
3. We are also a Medicare provider. Deductible and co-payments are accepted at time of service.

YOU are responsible for the full amount of your bill if, for any reason, your insurance claim is denied.

Emergency / After hours information:

In case of an emergency, please call (970) 596-5105 for instructions.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE INFORMATION. Please Initial _____



INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on (or the patient named below, for whom I am legally responsible, by the doctor of chiropractic named below and/or his preceptor and/or other licensed doctors of chiropractic who now or in the future treat me while employed by, working or associated with, or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocation and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

Chiropractic treatment involves the science, philosophy and art of locating the correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use his hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which he feels at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plan for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised to the address I've provided or forward a copy in via e-mail at my request. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information is used or disclosed to carry out treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Chiropractic Adjustments and Care. 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. This includes any and all use of the three (3) Power Vibe machines (see contraindications page).

L. Darin Dunnagan DC
Dunnagan Chiropractic LLC

Name (Printed)

Date Signed

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

Witness to Patient's Signature