

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_  
 Resident & Mailing City State Zip Code

Home Telephone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Birth date: \_\_\_\_\_ Social Security #: \_\_\_\_\_ Driver's License # \_\_\_\_\_

Occupation/Employer's Name & Address: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Spouse's Occupation/Employer \_\_\_\_\_

No. of Children \_\_\_\_\_

Reason for consulting our office? \_\_\_\_\_

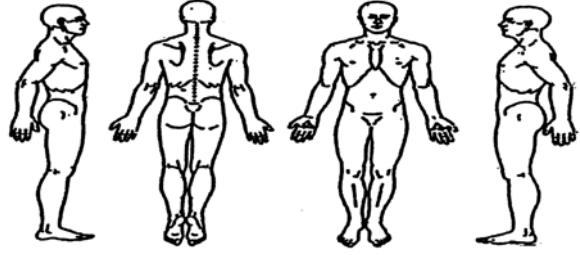
Who may we Thank for referring you to our office? (If phone book ad please let us know which one).  
 \_\_\_\_\_

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are to address the issues that brought you to this office, and to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential. If you have no symptoms or complaints and are here for wellness services, please check here \_\_\_\_\_, "I wish to have Chiropractic WellnessServices" and skip to "Health Profile."

**Addressing The Issues that Brought You to Our Office**

1. Is today's problem caused by:  Auto Accident  Workman's Compensation

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?  
 Constantly (76-100% of the time)  Occasionally (26-50% of the time)  
 Frequently (51-75% of the time)  Intermittently (1-25% of the time)

4. How would you describe the type of pain?  
 Sharp  Numb  
 Dull  Tingly  
 Diffuse  Sharp with motion  
 Achy  Shooting with motion  
 Burning  Stabbing with motion  
 Shooting  Electric like with motion  
 Stiff  Other: \_\_\_\_\_

Practice Member Name \_\_\_\_\_

5. How are your symptoms changing with time?

- Getting Worse       Staying the Same       Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (Please circle)

7. How much has the problem interfered with your work?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

8. How much has the problem interfered with your social activities?

- Not at all       A little bit       Moderately       Quite a bit       Extremely

9. Who else have you seen for your problem?

- Chiropractor       Neurologist       Primary Care Physician  
 ER physician       Orthopedist       Other: \_\_\_\_\_  
 Massage Therapist       Physical Therapist       No one

10. How long have you had this problem? \_\_\_\_\_

11. How do you think your problem began?  
 \_\_\_\_\_

12. Do you consider this problem to be severe?     Yes       Yes, at times       No

13. What aggravates your problem?  
 \_\_\_\_\_

14. What concerns you the most about your problem; what does it prevent you from doing?  
 \_\_\_\_\_

**HEALTH PROFILE**

15. What is your: Height \_\_\_\_\_ Weight \_\_\_\_\_

16. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

- | Past                     | Present                                       | Past                     | Present  | Past                     | Present  |
|--------------------------|---|--------------------------|--|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> Headaches            | <input type="checkbox"/> | <input type="checkbox"/> High Blood Pressure         | <input type="checkbox"/> | <input type="checkbox"/> Diabetes                |
| <input type="checkbox"/> | <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> | <input type="checkbox"/> Heart Attack                | <input type="checkbox"/> | <input type="checkbox"/> Excessive Thirst        |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Back Pain      | <input type="checkbox"/> | <input type="checkbox"/> Chest Pains                 | <input type="checkbox"/> | <input type="checkbox"/> Frequent Urination      |
| <input type="checkbox"/> | <input type="checkbox"/> Mid Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Stroke                      | <input type="checkbox"/> | <input type="checkbox"/> Smoking/Tobacco Use     |
| <input type="checkbox"/> | <input type="checkbox"/> Low Back Pain        | <input type="checkbox"/> | <input type="checkbox"/> Angina                      | <input type="checkbox"/> | <input type="checkbox"/> Drug/Alcohol Dependence |
| <input type="checkbox"/> | <input type="checkbox"/> Shoulder Pain        | <input type="checkbox"/> | <input type="checkbox"/> Kidney Stones               | <input type="checkbox"/> | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> | <input type="checkbox"/> Elbow/Upper Arm Pain | <input type="checkbox"/> | <input type="checkbox"/> Kidney Disorders            | <input type="checkbox"/> | <input type="checkbox"/> Depression              |
| <input type="checkbox"/> | <input type="checkbox"/> Wrist Pain           | <input type="checkbox"/> | <input type="checkbox"/> Bladder Infection           | <input type="checkbox"/> | <input type="checkbox"/> Systemic Lupus          |
| <input type="checkbox"/> | <input type="checkbox"/> Hand Pain            | <input type="checkbox"/> | <input type="checkbox"/> Painful Urination           | <input type="checkbox"/> | <input type="checkbox"/> Epilepsy                |
| <input type="checkbox"/> | <input type="checkbox"/> Hip Pain             | <input type="checkbox"/> | <input type="checkbox"/> Loss of Bladder Control     | <input type="checkbox"/> | <input type="checkbox"/> Dermatitis/Eczema/Rash  |
| <input type="checkbox"/> | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> | <input type="checkbox"/> Prostate Problems           | <input type="checkbox"/> | <input type="checkbox"/> HIV/AIDS                |
| <input type="checkbox"/> | <input type="checkbox"/> Knee Pain            | <input type="checkbox"/> | <input type="checkbox"/> Abnormal Weight Gain/Loss   | <input type="checkbox"/> | <input type="checkbox"/> Cold Sweats             |
| <input type="checkbox"/> | <input type="checkbox"/> Ankle/Foot Pain      | <input type="checkbox"/> | <input type="checkbox"/> Loss of Appetite            | <input type="checkbox"/> | <input type="checkbox"/> Mood Swings             |
| <input type="checkbox"/> | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> | <input type="checkbox"/> Abdominal Pain              | <input type="checkbox"/> | <input type="checkbox"/> Constipation            |
| <input type="checkbox"/> | <input type="checkbox"/> Joint Pain/Stiffness | <input type="checkbox"/> | <input type="checkbox"/> Ulcer                       |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> | <input type="checkbox"/> Hepatitis                   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> | <input type="checkbox"/> Liver/Gall Bladder Disorder |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Cancer               | <input type="checkbox"/> | <input type="checkbox"/> General Fatigue             |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Tumor                | <input type="checkbox"/> | <input type="checkbox"/> Muscular Incoordination     |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Asthma               | <input type="checkbox"/> | <input type="checkbox"/> Visual Disturbances         |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Chronic Sinusitis    | <input type="checkbox"/> | <input type="checkbox"/> Dizziness                   |                          |  |
| <input type="checkbox"/> | <input type="checkbox"/> Other: _____         |                          |  |                          |  |

- For Females Only**
- Birth Control Pills  
  Hormonal Replacement  
  Pregnancy

Practice Member Name \_\_\_\_\_

17. On a scale of Poor, Good, Excellent describe your:  
 Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

18. On a scale of 1-10 describe your stress level: (1=none/10=extreme)  
 Occupational  Personal

19. What type of exercise do you do?  
 Stenuous  Moderate  Light  None

20. Indicate if you have any immediate family members with any of the following:  
 Rheumatoid Arthritis  Diabetes  Lupus  
 Heart Problems  Cancer  ALS

21. List all prescription medications you are currently taking:  
 \_\_\_\_\_

22. List all of the over-the-counter medications you are currently taking:  
 \_\_\_\_\_

23. List all surgical procedures you have had:  
 \_\_\_\_\_

24. What activities do you do at work?  
 Sit:  Most of the day  Half the day  A little of the day  
 Stand:  Most of the day  Half the day  A little of the day  
 Computer work:  Most of the day  Half the day  A little of the day  
 On the phone:  Most of the day  Half of the day  A little of the day

25. What activities do you do outside of work?  
 \_\_\_\_\_

26. Have you ever been hospitalized?  No  Yes  
 If yes, why \_\_\_\_\_

27. Have you had significant past trauma?  No  Yes

28. Anything else pertinent to your visit today? \_\_\_\_\_

29. Family Health Profile:  
 At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:  
 Children \_\_\_\_\_  
 Spouse \_\_\_\_\_  
 Mother \_\_\_\_\_  
 Father \_\_\_\_\_  
 Brothers \_\_\_\_\_  
 Sisters \_\_\_\_\_  
 Others \_\_\_\_\_

The Statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation.

Practice Member Signature \_\_\_\_\_ Date: \_\_\_\_\_

# KING CHIROPRACTIC HEALTH CENTERS

## Consent for Purposes of Treatment, Payment & Healthcare Operations (3/03)

In this document, “I” and “my” refer to the patient, and “Chiropractor” refers to Dr. M, Brian King, DC, and Dr. Kevin G. King, DC.

I consent to the use or disclosure of my protected health information by Chiropractor 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 Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor 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. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor 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 have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to have that 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 Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at 735 U.S. Hwy 24, Ste C, Leadville, CO 80461, 28350 CR317, Ste 3, Buena Vista, CO, and 709 Palmer, Salida, CO. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor 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 Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Date of Signing

\_\_\_\_\_  
Description of Personal Representative's Authority



## KING CHIROPRACTIC HEALTH CENTERS

### Notice of Privacy Practices (3/03)

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

- (1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.
- (2) We are required to abide by the terms of this Notice currently in effect.
- (3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

**Treatment:** We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

**Payment:** We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

**Operations:** Your health records may be used in our business planning and development operations, including improvements in our methods of operation, and general administrative functions. We may also use the information in our overall compliance planning, healthcare review activities, and arranging for legal and auditing functions.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization**. Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

**Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

**Communication Barriers and Emergencies:** We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain **rights regarding your health record information**, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction.

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to you health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) You have a limited right to receive an accounting of all disclosures we make to other persons or entities of your health information except for disclosures required for treatment, payment and healthcare operations, disclosures that require an Authorization, disclosure incidental to another permissible use or disclosure, and otherwise as allowed by law. We will not charge you for the first accounting in any twelve-month period; however, we will charge you a reasonable fee for each subsequent request for an accounting within the same twelve-month period.

(6) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, <http://www.hhs.gov/ocr/hipaa>.

All questions concerning this Notice or requests made pursuant to it should be addressed to

PRIVACY OFFICER,  
PO Box 813, Salida, CO 81201  
Or  
735 U.S. Hwy 24, Ste C, Leadville, CO 80461