

GOLD CHIROPRACTIC FAMILY WELLNESS CENTER

6851 S. Holly Circle, Centennial CO 80112
Dr. Gold D.C., C.C.S.T., F.I.A.M.A., C.C.E.P. - CO License 4592

PATIENT INFORMATION FORM

Last Name _____ First Name _____

E-Mail Address _____ [] Female [] Male

Street Address _____

City/State/Zip: _____

Cell Phone: _____ Work Phone: _____

Home Phone: _____ Date of Birth: ____/____/____ Age ____

Occupation: _____ Employer: _____

Marital Status: [] Single [] Married [] Widowed [] Divorced

Family Physician _____ Phone: _____

Can We Keep Your Physician Advised of Your Condition? [] Yes [] No

Emergency Contact _____ Phone: _____

I was Referred By: _____

LIST YOUR COMPLAINTS IN ORDER OF SEVERITY:

(1) _____ For How Long? _____

(2) _____ For How Long? _____

(3) _____ For How Long? _____

(4) _____ For How Long? _____

Check symptoms you have had in the past 6 months:

- | | | |
|---|--|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Fatigue (tired) | <input type="checkbox"/> Neck Stiffness | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Head feels heavy | <input type="checkbox"/> Shoulder Pain | <input type="checkbox"/> Lower Back Pain |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Pain into Arm(s) | <input type="checkbox"/> Pain moving into Leg |
| <input type="checkbox"/> Sleep Problems | <input type="checkbox"/> Elbow Pain | <input type="checkbox"/> Knee Pain |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Wrist Pain | <input type="checkbox"/> Chronic ankle strain |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Tingle in Fingers | <input type="checkbox"/> Numbness in Toes |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Upper Back Pain | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> T.M.J. pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Bruise Easily |
| | <input type="checkbox"/> Chest Pains | |

Other: _____

Is this injury related to an automobile accident? Yes No
Is this an on the job injury? Yes No

Describe accident if applicable: _____

Medical History:

Past chiropractic care? Yes No Year _____ Dr.'s Name _____

Have you seen another doctor for this condition? Yes No

If yes who? _____

How did this doctor treat your condition? _____

What medications are you taking?

_____ For _____
_____ For _____
_____ For _____
_____ For _____
_____ For _____

What vitamins or supplements are you taking?

None Multi-Vitamin More than 1 type of vitamin for my health
 Other _____

Have you had any of the following conditions?

Anemia Heart Disease Arthritis Epilepsy Mental Disorder
 Polio Liver Disease Diabetes Cancer Tuberculosis
 AIDS/HIV Kidney Disease Congenital birth defects

Other: _____

Have you been hospitalized? Yes No

If yes explain: _____

Have you ever broken any bones? Yes No

If yes explain: _____

Family History

	Back	Heart	Stroke	Cancer	Diabetes	High Blood Pressure
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sisters # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers # _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children # _____ Ages _____						

Other Information that You Feel is Relevant? _____

INSURANCE INFORMATION / ASSIGNMENT OF BENEFITS

I authorize and request assignment of my insurance benefits. Send payments directly to Dr. Gold/Gold Chiropractic. I authorize the release or any records you may need to process my claims.

Your Insurance Company: _____

Patient Signature: _____ Date: _____

CONSENT FOR TREATMENT

I hereby consent to the performance of chiropractic care, massage therapy and/or medical acupuncture on me, or the patient named for whom I'm legally responsible. This may include chiropractic adjustments, various therapies, acupuncture and X-rays by Dr. Shane Gold, assistants, other licensed chiropractors, and massage therapists whom now or in the future treat me while employed by, working for, or associated with Dr. Shane Gold. This includes those working at the clinic or office located at 7061 S. University Blvd. Suite 9, Littleton, Colorado, or any other clinic, whether signatories to this form or not.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, massage or acupuncture there are some risks to treatment, including, but not limited to, fractures, disc injuries, strokes, dislocations, bruising and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. 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. I understand that results are not guaranteed.

I understand that my X-rays may be placed in the public adjusting area on the view box. It is ok to have my name on the public sign in sheet and my first name and last initial on the "Thank you for referring" board (When you refer your friends/in).

I have read, or have had read to me, the above consent. 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.

Patient Signature: _____ Date _____

Guardian/Representative Signature: _____

PREGNANCY AFFIRMATION

I am certain I am not currently pregnant or trying to become pregnant. Should this change, I will notify Dr. Gold, therapist and/or staff.
Initials _____

Gold Chiropractic
6851 S. Holly Circle, Suite 110
Centennial, CO 80112
(303) 798-2000

Cancelled Massage Agreement

A minimum of 24 hours is required to cancel your massage therapy appointment without penalty. If 12 – 24 hours notice is given you are responsible for paying for half the normal cost of your appointment. If you forget your appointment or just can not make it in you are responsible for paying regular price for your scheduled session.

If something comes up at the last minute and you are unable to keep your appointment, since your paying for it anyway, make someone happy; send in a friend, co-worker or family member to take your place.

Patient Signature

Date

ACKNOWLEDGEMENT

Copy of (HIPPA) Privacy Notice is in top of magazine rack. You are encouraged to read it. I acknowledge that I have received, and/or had the opportunity to read the Practice's Privacy Notice that has an effective date of April 1, 2004.

Name of Individual (Printed)

Signature of Individual

Date Signed ____/____/____