Tel & Text: (970) 587-7029
32 S. Rutherford Avenue
Johnstown, CO 80534
E-mail: connectedchiro@gmail.com
www.connectedchiropractic.com

CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant? Yes ☐ No ☐**
Height:	**Weight:**
Occupation:	
Employer's name & location:	
Marital status: M S W D	**Significant Other's name:**
Significant Other's Occupation:	
Name of person responsible for account:	

Who may we thank for referring you? ____

Addressing What Brought You Into This Office:

*If you have no symptoms or complaints and are here for Optimal Health & Wellness Services, please skip to the **"General Health History"**.*

Check any of the symptoms or conditions below that you experience.

___Headaches
___Neck Pain
___Mid-Back Pain
___Low-Back Pain
___Sciatic Pain
___Leg or Hip Pain
___Jaw Pain/TMJ
___Low Energy/Fatigued
___Carpal Tunnel
___Problem Sleeping
___Ringing in Ears
___Loss of Balance
___High or Low Blood Pressure
___Weight Trouble
___Scoliosis
___Other____
___Asthma
___Vertigo
___ Cancer
___ Allergies
___ Dizziness
___Depression
___Seizures/Convulsions
___Digestive Problems/Heartburn
___Pain Between Shoulder Blades
___Shortness of Breath
___Tension Across Top of Shoulders
___ Numbness in Arms/Legs
___ Menstrual Pain
___Shoulder/Arm Pain

Which one of the above symptoms is worst?________________________ How long have you had it?_______________

When it is at its worst, how does it feel?____

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain/symptom present
1.					
2.					
3.					
4.					

ONSET

Did your symptoms start suddenly or progressively? ____

What were you doing when your symptoms started?____

Since the problem started is it: About the same? ☐ Getting better? ☐ Getting worse? ☐

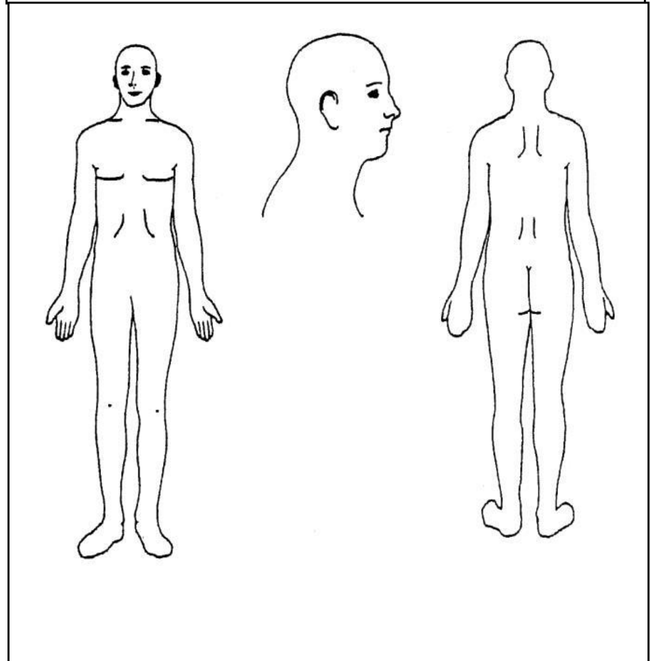
Provocation/Palliation
What makes it worse? ____

____

What makes it better? ____

____

Please mark on the diagram below where your problems are located;
P = Sharp pain **A** = Ache
T = Tightness **N** = Numbness
W = Weakness



Quality
How would you describe your symptoms? Dull? Sharp? Ache? Etc.
____

____

Region/Radiation
Where do you feel the symptoms? Does it radiate? ____________________

____

____

What have you done for this condition? Was it of benefit? _______________

____

____

I do (do not) have a family history of this or similar symptoms (Please explain):
____

____

Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain)	☐
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	☐
Medical Doctor	☐
Dentist	☐
Other (please describe)	☐

Doctor's details:

Name:	Location:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?

Name:	Location:
When did you see them?	
What did they say was wrong?	
What did they do?	Did it help?

Have you made, or felt the need, to make any changes in your life due to this pain, illness, condition, etc?
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?
____

____

Is this condition interfering with any of the following:

Work ☐	Sleep ☐	Daily routine ☐	Sports/exercise ☐	Other ☐ (please explain):

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, sports or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes ☐ No ☐
2. Type:	When?	Hospitalized? Yes ☐ No ☐
3. Type:	When?	Hospitalized? Yes ☐ No ☐

Do you wear orthotics or heel lifts? Yes ☐ No ☐

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription) Continue listing on the back if needed.

____
____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

____
____

If specific exercises or stretching help, would you consider adding them to your program?	Yes ☐ No ☐ Maybe ☐

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

☐ Alcoholism	☐ Allergy	☐ Anemia	☐ Arteriosclerosis	☐ Arthritis	☐ Asthma
☐ Back Pain	☐ Cancer	☐ Cold Sores	☐ Constipation	☐ Convulsions	☐ Depression
☐ Diabetes	☐ Diarrhea	☐ Eczema	☐ Emphysema	☐ Epilepsy	☐ Gall Bladder Problems
☐ Gout	☐ Headaches	☐ Heart Attack	☐ Heart Disease	☐ High Blood Pressure	☐ HIV (Aids)
☐ Irregular Periods	☐ Low Blood Sugar	☐ Blood Clots	☐ Measles	☐ Menstrual Cramps	☐ Migraines
☐ Miscarriage	☐Multiple Sclerosis	☐Mumps	☐ Neck Pain	☐ Anxiety	☐ Neuritis
☐ Pleurisy	☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Ringing in ears	☐Sinus Problems
☐ Stroke	☐ Thyroid Problems	☐Tuberculosis	☐ Ulcers	☐ Venereal Disease	☐ Whooping Cough

Other (please explain) ____
____

Stressors

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, sports etc.)
   a. ____________________
   b. ____________________
   c. ____________________

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. ____________________
   b. ____________________
   c. ____________________

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)
   a. ____________________
   b. ____________________
   c. ____________________

How do you rate your present levels of stress?

*At home? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*At work? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*At play? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

How do you rate your:

*Eating habits? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*Exercise habits? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*Sleep? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*General health? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*Mindset? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*Physical health? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

*Emotional/mental health? Is it

Excellent ☐	Good ☐	Fair ☐	Poor ☐	Getting better ☐	Getting worse ☐

Is there anything else which may help to better understand you which has not been discussed?
____

____

____

____

Why are you here at this point in time?

____

____

____

____

Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.
HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.
VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.
Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our only practice objective is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I,(Printed name)______________________________ (Signature)____undertake any care with the understanding of, and agreement with, the above explanation. _________________(Date).

Consent to evaluate and adjust a minor and/or child: I, ____ (Print name) being the parent or legal guardian of ____(Print name) give permission for my child to receive any care.

How we protect your Health Information:

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HEALTHCARE PURPOSES

By signing this Consent, I acknowledge and provide permission to Connected Chiropractic (Practice) as follows:

1. Connected Chiropractic's Privacy Notice has been provided to me prior to my signing this Consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out is health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.

2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. I understand that, and consent to, the following appointment reminders that will be used by the Practice:
a) telephoning my home and leaving a message on my answering machine or with the individual answering the phone; b) an e-mail sent to the e-mail address provided by me; c) a text message sent to the cell phone number provided by me.

4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.

5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.

6. I understand that this Consent is valid for seven (7) years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.

7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice reserves the right to not treat me.

I have read and understand the health information disclosure and protection in the foregoing notice,

______________________________ ______________________________
PRINTED Name SIGNATURE

____
DATE

______________________________ ______________________________
Signature of Legal Guardian Relationship to minor
(e.g. if a minor)

Informed Consent

REGARDING: Chiropractic Adjustments, Modalities, and Therapeutic Procedures:

I have been advised that chiropractic care, like all forms of health care, holds certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Connected Chiropractic have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

REGARDING: X-rays/Imaging Studies:

FEMALES ONLY → *please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.*

☐ The first day of my last menstrual cycle was on ____-____-____ Date

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

____ ____/____/____ ☐ *Witness Initials*

Patient or Authorized person's Signature Date

NO SHOW/MISSED APPOINTMENT POLICY

We, at Connected Chiropractic and Vitality Massage understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 4-hour notice).

You can cancel appointments by calling or texting the following number: **970-587-7029**.

Or you can e-mail **deskchiro@gmail.com**.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder text to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel or reschedule your appointment with at least a 4 hours' notice.
2. If less than a 4-hour cancellation is given this will be documented as a No-Show" appointment.
3. If you do not present to the office for your appointment, this will be documented as a ''No-Show'' appointment.
4. After the first "No-Show/Missed" appointment, you will receive a phone call or letter warning that you have broken our "No-Show" policy. Connected Chiropractic or Vitality Massage will assist you to reschedule this appointment if needed.
5. If you have 2 "No-Show/Missed" appointments within a one-year time period, you will receive a warning letter from our office and will be assessed the full fee for the missed appointment.

I have read and understand Connected Chiropractic's No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and notify Connected Chiropractic appropriately if I have difficulty keeping my scheduled appointments.

______________________________ ________________ ________________
Patient Name Date of Birth Date

______________________________ ________________
Patient Signature or Parent/Guardian if minor Relationship to Patient

______________________________ ________________
Staff Signature Date

Dr. Brad Cranwell
32 S. Rutherford Avenue
Johnstown, CO 80534
970-587-7029

Patient Care Agreement List

I agree to follow Dr. Brad's recommendation to achieve best results:

___I will begin to dramatically increase my daily water consumption.
(The goal is to drink at least ½ my body weight in ounces of water daily)

___I will begin to decrease my daily caffeine consumption.

___I will adjust all my fixed body positions for the better (work, desk, home, car, etc.)

___I will not consciously go to sleep on my stomach.

___I will be aware of my head posture for the next hour after an adjustment.

___I will use the Cervical or Lumbar therapeutic equipment if recommended.

___I will get a posture-pedic pillow.

___I will inform Dr. Brad of the positive or negative changes in my health. I will also let Dr. Brad know if there are any changes to my goals.

___I am responsible for any appointments cancelled within 4 hours or "no-shows". The office policy states that, if I "no-show" for an appointment and don't call to reschedule it OR if I call to reschedule an appointment with less than four (4) hours' notice, the full amount for the appointment will be charged to my card on file. This applies to all types of appointments with Connected Chiropractic and/or Vitality Massage Studio.

Patient Signature: ____ **Date:** _________