Back In Action Chiropractic LLC
Jason GIllies, D.C.
824 E. Fillmore St, Colorado Springs, Co 80907 (719) 634-2579

ABOUT YOU:

Patient's Name:_____What you prefer to be called: _____

Date of Birth:__/__/__ Age:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Home Address:_____
Street City State Zip

How Did You Hear of Us: _____

Name of General/Family Physician:_____

Employer**:** _____Occupation: _____

How Did You Intend To Pay For Our Services: Insurance, Self Pay, PI/Workers Comp, Auto Accident

Responsible Party: Person responsible for payment of charges / parent or legal guardian of minor.
Leave Blank if Responsible Party is yourself.

Name:_____ Date of Birth:__/__/__

Address:_____

Phone: _____

In Case of Emergency Who Should We Contact:

_____
Name Address

Phone#_____ Relation: _____

Assignment of Benefits / Authorization for Evaluation and Treatment:

I hereby authorize payment to be made directly to Back In Action Chiropractic L.L.C. for Chiropractic/Medical services rendered by insurance coverage. I shall be personally responsible for any unpaid balance. A time of service discount is available to most patients. In cases of potential insurance coverage, I understand that if my insurance company does not pay outstanding charges within 60 days of the billing, I will be financially responsible for those charges. Balances over 60 days may be subject to interest of 1.5% per month, collection charges and collection court/attorney fees. I authorize Back In Action Chiropractic L.L.C. to release any information concerning my examination or treatment for payment purposes. I further authorize Jason Gillies D.C. of Back In Action Chiropractic L.L.C. to perform any medically necessary evaluation or treatment. I understand that every effort will be made to explain my diagnosis, treatment and risk factors, however, if there are any questions or concerns, I will bring this to the immediate attention of Dr. Gillies.

_____ _____

Date Signature of Patient (or parent if minor)

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Health Questionnaire

Patient Information:

Name:_____

Last First Middle Initial

Sex: □ Male □ Female Age:_____ Date of Birth:_____

Have you Gained of Lost More Than 10 LBS in the Last 6 Months: Gained Lost Neither

Are you Pregnant: YES or No Date of Last Cycle: _____ Started Menopause: YES or NO

Overall, How Would You Rate Your Health: Excellent Average Poor Other:_____

Past Health History

HOSPITALIZATION, OPERATIONS / WORK, AUTO, OR PERSONAL ACCIDENTS OR INJURIES

Please be Specific, Include Dates, Areas Involved, and Treatments Received

1. _____
2. _____
3. _____
4. _____
5. _____

SERIOUS ILLNESSES

List Current and Past Illnesses Not Mentioned Above, Including Cancer, Diabetes etc, and Include Dates

1. _____
2. _____
3. _____
4. _____
5. _____

ALLERGIES: **MEDICATIONS / SUPPLEMENTS**

_____
_____ | _____
_____ | _____
_____ | _____

Work and Social History

Smoke: Yes or No If yes how much: _____
Alcohol: Yes or No If yes how much: _____
Recreational Drug Use: Yes or No If yes Type and how much: _____
Married Yes or No Children: Yes or No Ages: _____
Activities affected by your symptoms: (sleep, relationships, recreational activities, work activites, and etc)
_____
_____

-Systems Review-

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List the health problems you now have, or have had, with each area. If no problem exists, write N/A in the space provided.

1. Head:_____
2. Ear/Eye/Nose/Throat:_____
3. Lungs/Respiratory:_____
4. Heart/Circulation/Stroke:_____
5. Stomach/Intestine/Colon:_____
6. Kidney/Bladder/Urinary:_____
7. Liver/Gallbladder/Pancreas/Spleen:_____
8. Skin/Hair/Nails:_____
9. Hematological/Bleeding/Anemia:_____
10. Nervous System:_____
11. Hormonal:_____
12. Lymph Glands:_____
13. Allergies:_____
14. Other:_____

Family Health History

Please list any diseases or conditions your immediate family has or has had in the past.
Example: (Heart Disease, Mother)

_____
_____
_____
_____

Patient Signature:_____Date:_____

Doctors Signature:_____Date:_____

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

I hereby request and consent to the performance of chiropractic adjustments and any other chiropractic procedures, including examination tests, diagnostic x-ray(s) and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future render treatment to me while employed by, working for or associated with, or serving as back-up for the doctor of chiropractic named below.

I understand that, as with any health care procedure, there are certain complications, which may arise during a chiropractic adjustment. Those complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, Horners' syndrome, diaphragmatic paralysis, cervical myelopathy and costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure(s) which the doctor feels at the time, based upon the facts then known, and are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of chiropractic adjustments and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

Name(s) and Address(es) of Office or Clinic Print Name(s) of Doctor(s) Treating this Patient

Back In Action Chiropractic LLC **_____Jason Gillies DC_____**
824 E. Fillmore St **_____**
Colorado Springs, CO 80907 _____

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

_____
Printed name of Patient

_____ _____
Signature of Patient Date

_____ _____
Signature of Patients' Representative Date
(if minor or physically incapacitated)

_____ _____
Witness to Patients' Signature Date

_____ _____
Translated By Date

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form.

PRIVACY POLICY

Your privacy is important to us. At Back In Action Chiropractic, we want you to better understand how we collect, use, communicate, disclose, share and protect information about you. By interacting with Back In Action Chiropractic, you consent to use of information that is collected or submitted as described in this privacy policy. The following outlines our privacy policy:

- Before or at the time of collecting personal information, we will identify the purposes for which information is being collected.
- We will collect and use personal information solely with the objective of fulfilling those purposes specified by us, unless we obtain the consent of the individual concerned or as required by law.
- We will only retain personal information as long as necessary for the fulfillment of those purposes.
- We will collect personal information by lawful and fair means and, where appropriate, with the knowledge or consent of the individual concerned.
- Personal data should be relevant to the purposes for which it is to be used, and, to the extent necessary for those purposes, should be accurate, complete, and up-to-date.
- We will protect personal information by reasonable security safeguards against loss or theft, as well as unauthorized access, disclosure, copying, use or modification.
- We will make readily available to customers information about our policies and practices relating to the management of personal information.

We are committed to conducting our business in accordance with these principles in order to ensure that the confidentiality of personal information is protected and maintained.

The Practice:

1) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to you PHI.

2) May be required by Colorado law to maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.

3) Is required to abide be the terms of the Privacy Notice.

4) Reserves the right to change the terms of the Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.

5) Will distribute any revised Privacy Notice to you prior to implementation.

6) Will not retaliate against you for filing a complaint.

This Notice is in effect as of 01/01/2011.

I, _____, have received a copy of *BACK IN ACTION CHIROPRACTIC, LLC's* Notice of Privacy Practices.

_____ _____
Signature of Patient of Guardian Date

_____
Patient's acknowledgement of this Notice could not be obtained because:

_____ Patient refused to sign
_____ Communication barrier prohibited obtaining acknowledgement
_____Emergency Circumstances

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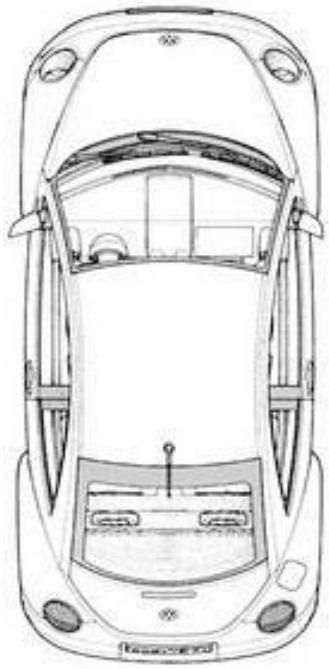
Motor Vehicle Collision Form

Nam: _____ **DOB:** _____ **Today's Date:** _____

Report of Accident:

Date of Accident: _____ Time of Accident: _____ ❑ A.M. ❑ P.M. City of Accident: _____
Street of Accident that your car was on: _____ Cross Street (intersection): _____
Road conditions at the time of incident: ❑ Wet ❑ Dry ❑ Icy ❑Other _____
Were there any witnesses? ❑ Yes ❑ No Were you wearing your seat belt? ❑ Yes ❑ No
Did the police come to the scene of the accident? ❑ Yes ❑ No Was an accident report filed? ❑ Yes ❑ No
If a traffic violation was issued, to whom was it issued? _____
Please explain the details of the accident to the best of your knowledge: _____

Indicate where the initial impact struck your vehicle by marking an "X" on the diagram below:



The following questions pertain to you, the patient, and the vehicle you were in:
Number of people in accident vehicle: _____
Were you the: ❑ Driver ❑Front Passenger ❑Rear Passenger
Were you ❑ aware of the approaching collision ***or*** ❑surprised by impact?
Were you rendered unconscious? ❑ Yes ❑ No If yes, for how long? _____
In relation to the base of your skull, where was the headrest?
❑ Above ❑ Below ❑ At base of skull
Was this vehicle equipped with airbags? ❑ Yes ❑ No
If yes, did it/they inflate? ❑ Yes ❑ No
What did your vehicle impact? ❑ Another Vehicle ❑Other _____

Vehicle Information & Velocity pertaining to the vehicle you were in:
Vehicle Year: _____ Make: _____ Model: _____
What direction was your vehicle traveling? ❑North ❑South ❑East ❑West
Was your car ❑ Moving ***or*** ❑Stopped
If your car was moving:
How fast were you traveling? Approximately _____ MPH
Just before impact, the vehicle you were in was:
❑Slowing down ❑Speeding Up ❑Constant Speed
Did the impact to your vehicle come from the:
❑ Front ❑Rear ❑ Right Side ❑ Left Side ❑ Other: _____

The following questions pertain to the other vehicle involved in the accident:
Other Vehicle Year: _____ Make: _____ Model: _____
What direction was the other vehicle traveling? ❑North ❑South ❑East ❑West
Was the other car ❑ Moving ***or*** ❑Stopped
If the other car was moving:
How fast was it traveling? Approximately _____ MPH
Just before impact, the other car was:
❑Slowing down ❑Speeding Up ❑Constant Speed

Were there bleeding cuts caused by the accident? ❑ Yes ❑ No Where: _____
Where there any bruises caused by the accident? ❑ Yes ❑ No Where: _____
If any part of your body struck anything during the collision please describe what and where: _____
What were the cost of damages to the vehicle you were in? $_____
Which (if any) of the following car parts broke during the accident:
❑Windshield ❑ Steering Wheel ❑ Front Seat ❑ Back Seat ❑Side Window (R/L) ❑ _____
Other Was the trunk of your body pointed straight forward at the time of impact? ❑ Yes ❑ No
If No, which direction was it pointed, and by how much? _____

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Was your head pointed straight forward at the time of impact? ❑ Yes ❑ No
If No, which direction was it turned, and by how much? _____

If you have been involved in previous auto accidents, please list the year of each incident:

_____

Please list any additional information not covered above that we should know about:

_____

_____

_____

Insurance Information:

Name of Insurance Company: _____ Telephone #: _____
Address: _____ City: _____ State: _____ Zip: _____
Insured's Name: _____ Insured's SS #: _____ DOB: _____
Insured's Employer: _____ Policy #: _____ Claim #: _____
Name of Claim Representative: _____ Telephone #: _____

Attorney Information:

Name of Attorney/Law Office: _____ Telephone #: _____
Address of Attorney: _____ City: _____ State: _____ Zip: _____

Medical Care:

Have you gone to a Hospital or seen any other Doctor? ❑ Yes ❑No
When did you go? ❑ Just after accident ❑ Next Day Other: _____
Mode of Transportation: ❑ Ambulance ❑ Privately transported Name of Hospital and/or Attending Doctor: _____
Was he/she a: ❑ D.C. ❑ M.D. ❑ D.O. ❑ D.D.S. ❑ P.A.

Were X-Rays taken? ❑ Yes ❑ No
If yes, what was X-Rayed: _____
Was medication prescribed? ❑ Yes ❑No
Describe any treatment you received: _____

Work:

To evaluate the effect that continuing work will have on your recovery please complete the following:

Have you been able to work since the injury? ❑ Yes ❑ No

Are your work activities restricted as a result of your injuries sustained? ❑ Yes ❑ No

How many hours are in your normal work day? _____

What can you do for work with minimum physical effort and for how long? _____ ❑ N/A

Prior to the injury were you capable of working on an equal basis with others your age? ❑ Yes ❑ No ❑ N/A

While in recovery, is there any light duty work you could request? ❑ Yes ❑ No ❑ N/A

Please indicate your daily job duties and any activities in which you are occasionally asked to perform:

❑ Standing ❑ Sitting
❑ Walking ❑ Lifting
❑ Driving ❑ Twisting
❑ Crawling ❑ Bending
❑ Operating equipment ❑ Working with arms above head
❑ Typing ❑ Stooping
❑ Other: _____

Complaint(s)/Pain Location(s):

❑ Dizziness
❑ Memory Loss
❑ Blurred vision
❑ Ringing/Buzzing in ear
❑ Left ❑ Right ❑ Bi-lat
❑ Difficulty sleeping
❑ Fatigue
❑ Irritability
❑ Stomach Upset
❑ Nausea
❑ Migraine(s)
❑ Headache(s)

❑ Neck
❑ pain ❑ stiffness
❑ Jaw problems
❑ Arm pain
❑ Left ❑ Right ❑ Bi-lat
❑ Shoulder pain
❑ Left ❑ Right ❑ Bi-lat
❑ Numb Hands/Fingers
❑ Left ❑ Right ❑ Bi-lat
❑ Chest pain
❑ Shortness of breath
❑ Tension

❑ Upper back
❑ pain ❑ stiffness
❑ Mid back
❑ pain ❑ stiffness
❑ Lower pain
❑ pain ❑ stiffness
❑ Leg pain
❑ Left ❑ Right ❑ Bi-lat
❑ Numb Feet/Toes
❑ Left ❑ Right ❑ Bi-lat
❑ Other: _____

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	Comfortable	Uncomfortable	Painful
Lying on back	❑	❑	❑
Lying on side	❑	❑	❑
Lying on stomach	❑	❑	❑
Lovemaking	❑	❑	❑
Sports	❑	❑	❑
Working	❑	❑	❑
Sitting	❑	❑	❑
Standing	❑	❑	❑
Stretching	❑	❑	❑
Walking	❑	❑	❑
Running	❑	❑	❑
Bending	❑	❑	❑
Lifting	❑	❑	❑
Kneeling	❑	❑	❑
Pulling	❑	❑	❑
Reaching	❑	❑	❑
Standing from a seated position	❑	❑	❑
Other:_____	❑	❑	❑

What have you tried to help alleviate your condition?

_____

_____

_____

_____

_____

Does your condition interfere with your....

❑ Sleep
❑ Work
❑ Daily Routine
❑ Recreational activities
❑ Other:_____

Additional information / Any recent falls and/or injuries / Prior condition related medical history:

_____

_____

_____

_____

_____

_____

Please circle any of the following you suffer from now, which you did not suffer from prior to the accident.

Headaches	Dizziness	Difficulty Concentrating
Long Term Memory Loss	Short Term Memory Loss	Amnesia
Loss of Consciousness at Scene	Black Outs	Forgetting ATM or other Numbers
Reding Problems	Writing Problems	Typing Problems
Apathy	Irritability	Sleep Disturbances
Personality Changes	Emotional Difficulties	Relationship Difficulties
Blurred Vision	Photophobia, Sensitive to light	Vision Changes
Intolerance to Alcohol	Intolerance to Heat	Intolerance to Cold
Impaired Comprehension	Impaired Learning	Attention Impairment
Loss of Libido	Missing Periods of Time	Speech Difficulties
Concussion in Collision	Nausea	Vomiting
Extreme Thirst since Collision	Fatigue	Menstrual Irregularities
Tinnitus (Ringing in Ears)	Noise Intolerance	Loss of Coordination
Bumping into Objects in View	Loss of Balance	Fluid In Ears
Hearing Loss	Vertigo (Spinning Sensation)	Increased Symptoms in Crowds
Anxiety	Depression	Change in Personality
Flashbacks to Accident Scene	Intrusive Thoughts of Accident	Nightmares Since Collision
Unusual Behavior Since Collision	Social Withdrawal	Panic Attacks
Thoughts of Death / Suicide	Weight Loss/ Gai lbs	Loss of Taste / Smell
Blackouts with Neck Movement	Dizziness with Neck Movement	“Clunk” Sound with moving neck
Jaw Pain	Clicking in Jaw	Pain with Chewing
Fear of Driving	Relationship Difficulty	Other:

Patient Signature:_____ **Today's Date:** _____