City Center Chiropractic

CONFIDENTIAL HEALTH INFORMATION (*For Ages 8 and Above*)

____
Today's Date (MM/DD/YYY)

Have you consulted a chiropractor before?
☐ No ☐ Yes **When?** ____________ ____________________
If so, Whom?

____
Whom may we thank for referring you?

Gender
☐ Male ☐ Female

____
Your Last Name

____
Your Social Security Number

____
Your First Name

____
Your Middle Name (or initial)

____
Birth Date (MM/DD/YYY)

Marital Status
☐ Single ☐ Married ☐ Divorced
☐ Widowed ☐ Separated

____
____
Address

____
City

____
State/Province

____
Zip/Postal Code

____
Home Phone

____
Spouse's Name

____
Email Address

____
Cell Phone

____
Child's Name/Age

____
Emergency Contact

____
Phone

____
Child's Name/Age

____
Your Occupation

____
Child's Name/Age

____
Your Employer

____
____
Address

May we contact you at work?
☐ Yes ☐ No

____
City

____
State/Province

____
Zip/Postal Code

____
Work Phone

____
Insurance Carrier

____
Policy Number

____
Primary Care Provider

____
Insured's Last Name

Who carries this policy?
☐ Self ☐ Spouse ☐ Parent

____
First Name

____
Middle Name (or initial)

____
____
Address

____
City

____
State/Province

____
Zip/Postal Code

City Center Chiropractic

PERMISSION TO COMMUNICATE PROTECTED HEALTH INFORMATION

Patient Name ____

Date of Birth ____

I authorize information regarding the scheduling of appointments to be communicated via all the following modalities that I provided to the office, and that my/my child's name may be used in the communication:

- Telephone voicemail (on phone number(s) I have provided to the office)
- Via e-mail (if an e-mail address has been provided)

_____________________________________ __________________

Patient or Parent/Guardian Signature Date

I decline all the above forms of communications. I prefer that NO INFORMATION at all be communicated by e-mail or voicemail. (I understand that I am responsible for knowing the dates and times of all scheduled appointments, as this office is unable to send reminders of any scheduled appointments. Any missed appointments will be the responsibility of the person/parent/guardian and will be subjected to the office policy.)

_____________________________________ __________________

Patient or Parent/Guardian Signature Date

SYMPTOM QUESTIONNAIRE (*For Ages 8 and Above*)

Name: ______________________________ **Date:** ______________

1) **Date Problem Began:** ______________

2) **How did your current problem(s) begin:** ______________________________

____

____

3) **Can you perform your daily activities?** ☐Yes ☐No (Describe)

____

____

4) **Have you had spine x-rays, MRI or CT Scan?** ☐Yes ☐No

Date(s) taken: __________ **What areas were taken?** ______________________

Please complete the following questions for each problem that you are having

Problem #1 ______________________________

Problem 1 (How you feel today): **Please Circle your current level of symptoms**

No pain or discomfort **0 1 2 3 4 5 6 7 8 9 10** Severe pain or discomfort

Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Problem #2 ______________________________

Problem 2 (How you feel today): **Please Circle your current level of symptoms**

No pain or discomfort **0 1 2 3 4 5 6 7 8 9 10** Severe pain or discomfort

Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Problem #3 ______________________________

Problem 3 (How you feel today): **Please Circle your current level of symptoms**

No pain or discomfort **0 1 2 3 4 5 6 7 8 9 10** Severe pain or discomfort

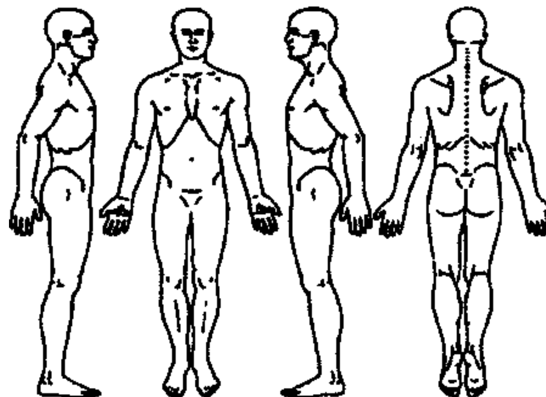
Since this problem began, are the symptoms: ☐ Increasing ☐ Decreasing ☐ Unchanged

How often are your symptoms present?

☐ Constant (76-100%) ☐ Frequent (51-75%) ☐ Occasional (26-50%) ☐ Intermittent (25% or less)

Doctors' Initials ________

Patient Name_______________________



On the diagrams, mark where you currently have pain or other symptoms. Include symptoms of pain, numbness, tingling, etc…

Please check all of the following that apply to you:

☐ **None Apply**

Yes	No	Condition	Yes	No	Condition
☐	☐	Numbness/Tingling	☐	☐	Osteoporosis
☐	☐	Past trauma (i.e. bone fracture)	☐	☐	Prostate Problems
☐	☐	HIV/AIDS	☐	☐	Frequent Urination
☐	☐	Diabetes	☐	☐	Pregnancy, # of births ____________
☐	☐	Corticosteroid Use (steroid inhaler)	☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Birth Control Pills	☐	☐	Epilepsy/Seizures
☐	☐	High Cholesterol	☐	☐	Visual Disturbances
☐	☐	High Blood Pressure	☐	☐	History of Low/Mid Back Pain
☐	☐	Dizziness/Fainting	☐	☐	History of Neck Pain
☐	☐	Stroke (date) ____________	☐	☐	Arthritis
☐	☐	Heart Attack (date) ____________	☐	☐	History of Alcohol Use: #______day/wk
☐	☐	Aortic Aneurysm	☐	☐	History of Tobacco Use: #______day/wk
☐	☐	Cancer/Tumor	☐	☐	Medications: ____________
☐	☐	Surgeries: ____________			____________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐Cardiovascular Problems / Stroke

Current Work Activities (circle one): Sit more than stand — Stand more than sit — Sit/stand equally — Walking

Previous Auto Injuries: None — Yes, describe ______________________________

Previous Work Injuries: None — Yes, describe ______________________________

Allergies: ______________________________

Exercise Habits (circle one): None — Regular Program — Semi-regular program (describe)____________

I certify that, to the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern. I agree to notify the doctor immediately whenever I have changes in my health condition or health plan coverage in the future.

______________________________ ____________

Patient or Parent/Guardian Signature Date

Doctor's Notes: ______________________________

Doctors' Initials _______

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ I have no pain at the moment.
① The pain is very mild at the moment.
② The pain comes and goes and is moderate.
③ The pain is fairly severe at the moment.
④ The pain is very severe at the moment.
⑤ The pain is the worst imaginable at the moment.

Personal Care

⓪ I can look after myself normally without causing extra pain.
① I can look after myself normally but it causes extra pain.
② It is painful to look after myself and I am slow and careful.
③ I need some help but I manage most of my personal care.
④ I need help every day in most aspects of self care.
⑤ I do not get dressed, I wash with difficulty and stay in bed.

Sleeping

⓪ I have no trouble sleeping.
① My sleep is slightly disturbed (less than 1 hour sleepless).
② My sleep is mildly disturbed (1-2 hours sleepless).
③ My sleep is moderately disturbed (2-3 hours sleepless).
④ My sleep is greatly disturbed (3-5 hours sleepless).
⑤ My sleep is completely disturbed (5-7 hours sleepless).

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
④ I can only lift very light weights.
⑤ I cannot lift or carry anything at all.

Reading

⓪ I can read as much as I want with no neck pain.
① I can read as much as I want with slight neck pain.
② I can read as much as I want with moderate neck pain.
③ I cannot read as much as I want because of moderate neck pain.
④ I can hardly read at all because of severe neck pain.
⑤ I cannot read at all because of neck pain.

Driving

⓪ I can drive my car without any neck pain.
① I can drive my car as long as I want with slight neck pain.
② I can drive my car as long as I want with moderate neck pain.
③ I cannot drive my car as long as I want because of moderate neck pain.
④ I can hardly drive at all because of severe neck pain.
⑤ I cannot drive my car at all because of neck pain.

Concentration

⓪ I can concentrate fully when I want with no difficulty.
① I can concentrate fully when I want with slight difficulty.
② I have a fair degree of difficulty concentrating when I want.
③ I have a lot of difficulty concentrating when I want.
④ I have a great deal of difficulty concentrating when I want.
⑤ I cannot concentrate at all.

Recreation

⓪ I am able to engage in all my recreation activities without neck pain.
① I am able to engage in all my usual recreation activities with some neck pain.
② I am able to engage in most but not all my usual recreation activities because of neck pain.
③ I am only able to engage in a few of my usual recreation activities because of neck pain.
④ I can hardly do any recreation activities because of neck pain.
⑤ I cannot do any recreation activities at all.

Work

⓪ I can do as much work as I want.
① I can only do my usual work but no more.
② I can only do most of my usual work but no more.
③ I cannot do my usual work.
④ I can hardly do any work at all.
⑤ I cannot do any work at all.

Headaches

⓪ I have no headaches at all.
① I have slight headaches which come infrequently.
② I have moderate headaches which come infrequently.
③ I have moderate headaches which come frequently.
④ I have severe headaches which come frequently.
⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck Index Score

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name ______________________ **Date** __________

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

⓪ The pain comes and goes and is very mild.
① The pain is mild and does not vary much.
② The pain comes and goes and is moderate.
③ The pain is moderate and does not vary much.
④ The pain comes and goes and is very severe.
⑤ The pain is very severe and does not vary much.

Sleeping

⓪ I get no pain in bed.
① I get pain in bed but it does not prevent me from sleeping well.
② Because of pain my normal sleep is reduced by less than 25%.
③ Because of pain my normal sleep is reduced by less than 50%.
④ Because of pain my normal sleep is reduced by less than 75%.
⑤ Pain prevents me from sleeping at all.

Sitting

⓪ I can sit in any chair as long as I like.
① I can only sit in my favorite chair as long as I like.
② Pain prevents me from sitting more than 1 hour.
③ Pain prevents me from sitting more than 1/2 hour.
④ Pain prevents me from sitting more than 10 minutes.
⑤ I avoid sitting because it increases pain immediately.

Standing

⓪ I can stand as long as I want without pain.
① I have some pain while standing but it does not increase with time.
② I cannot stand for longer than 1 hour without increasing pain.
③ I cannot stand for longer than 1/2 hour without increasing pain.
④ I cannot stand for longer than 10 minutes without increasing pain.
⑤ I avoid standing because it increases pain immediately.

Walking

⓪ I have no pain while walking.
① I have some pain while walking but it doesn’t increase with distance.
② I cannot walk more than 1 mile without increasing pain.
③ I cannot walk more than 1/2 mile without increasing pain.
④ I cannot walk more than 1/4 mile without increasing pain.
⑤ I cannot walk at all without increasing pain.

Personal Care

⓪ I do not have to change my way of washing or dressing in order to avoid pain.
① I do not normally change my way of washing or dressing even though it causes some pain.
② Washing and dressing increases the pain but I manage not to change my way of doing it.
③ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
④ Because of the pain I am unable to do some washing and dressing without help.
⑤ Because of the pain I am unable to do any washing and dressing without help.

Lifting

⓪ I can lift heavy weights without extra pain.
① I can lift heavy weights but it causes extra pain.
② Pain prevents me from lifting heavy weights off the floor.
③ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
④ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
⑤ I can only lift very light weights.

Traveling

⓪ I get no pain while traveling.
① I get some pain while traveling but none of my usual forms of travel make it worse.
② I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
③ I get extra pain while traveling which causes me to seek alternate forms of travel.
④ Pain restricts all forms of travel except that done while lying down.
⑤ Pain restricts all forms of travel.

Social Life

⓪ My social life is normal and gives me no extra pain.
① My social life is normal but increases the degree of pain.
② Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
③ Pain has restricted my social life and I do not go out very often.
④ Pain has restricted my social life to my home.
⑤ I have hardly any social life because of the pain.

Changing degree of pain

⓪ My pain is rapidly getting better.
① My pain fluctuates but overall is definitely getting better.
② My pain seems to be getting better but improvement is slow.
③ My pain is neither getting better or worse.
④ My pain is gradually worsening.
⑤ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back Index Score [ ]

Patient Name_________________________ Date___________

INFORMED CONSENT

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, please ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I may use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures (***please initial each of the below procedures***):

___ spinal manipulative therapy
___ range of motion testing
___ muscle strength testing
___ ultrasound
___ acupuncture
___ moxibustion
___ palpation
___ orthopedic testing
___ postural analysis
___ hot/cold therapy
___ mechanical traction
___ vital signs
___ basic neurological testing
___ electrical stimulation
___ cupping

The material risks inherent in chiropractic adjustment

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. 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. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care. However, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.

The probability of those risks occurring

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during your history intake and during examination. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants, and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment, making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.
PLEASE CHECK THE APPROPRIATE BLOCK BELOW AND SIGN.

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with *Dr. Michele M. Orchard, D.C.* and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Date: _______________ Date: _______________

_______________________________ _______________________________
Patient Name Doctor Name

_______________________________ _______________________________
Signature Signature

____
Parent/Guardian Signature (if a minor)

Patient Name__________________________ Date____________

OFFICE POLICY

OUR PURPOSE IS TO EDUCATE AND ADJUST AS MANY FAMILIES AS POSSIBLE TOWARD OPTIMAL HEALTH THROUGH CHIROPRACTIC CARE.

To help you receive the greatest benefit from your care, all patients are accepted on the following policies. Please read carefully and sign when completed.

The patient understands that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. The patient instructs the chiropractor to deliver the care that, in her professional judgement, can best help in the restoration of their health. Chiropractic is a separate and distinct healing art form from medicine and does not proclaim to cure any named disease or entity.

OFFICE HOURS

Our office is open as many hours as possible to accommodate our patients. These office hours are subject to change.

Monday
8:15am – 11:00am and 2:30pm – 4:45pm

Tuesday
CLOSED

Wednesday
8:15am – 11:00am and 2:30pm – 6:00pm

Thursday
2:30pm – 6:00pm

Friday
8:15am – 10:45am

SCHEDULING APPOINTMENTS

Dr. Orchard will design a specific course of treatment to allow for your optimal care. If Dr. Orchard accepts your individual case, you will be given your choice of appointment times. Due to the large volume of patients that this clinic sees, we kindly ask that you give a 24-hour notice if you cannot keep your scheduled appointment. If you are more than 15 minutes late for an appointment, you will be asked to re-schedule.

MISSED APPOINTMENTS

If your appointment is missed, you will be asked to make up the appointment that week or the following week so that you stay in line with your treatment plan. If two consecutive appointments are missed without notice or excuse, patient treatment may be terminated.

PATIENT PAYMENT POLICY

CHARGES ARE DUE UPON SERVICES RENDERED unless otherwise discussed and agreed upon with the doctor or office manager. All accounts over 60 days past due are subject to a $5.00 monthly rebilling fee.

It is the patient's responsibility to provide City Center Chiropractic with their current insurance information. Until the necessary information is provided and verified, the patient is responsible for all charges. Patient is responsible for all co-pays and deductibles related to health insurance, as well as any and all non-covered services

In the event that your account is referred for collection and/or is subject to other lawful measure employed by Dr. Orchard in collecting what you owe, you will be held accountable for all costs associated with such actions, inclusive of but not limited to collection agency fees, court costs and attorney fees. In any event, irrespective of whatever action may be taken and whether collection costs are documented or not, a penalty surcharge of not less than 50% of your total outstanding balance as of the date upon which your account goes into default, will be assessed.

REFERRALS

The success of our office and the health of your loved ones greatly depend on your referrals. If there is someone you know that you would like us to invite to our office, please let us know.

We at City Center Chiropractic appreciate your commitment to your health and welcome you to our clinic!

______________________________________ __________________

Patient or Parent/Guardian Signature Date

USUAL OFFICE FEES

(Effective January 1, 2016)

EXAMS	FEE
Brief Exam/New Patient	$ 82.00
Limited Exam/New Patient	$ 103.00
Intermediate Exam/New Patient	$ 135.00
Extended Exam/New Patient	$ 192.00
Minimal Service/Established Patient	$ 43.00
Brief Service/Established Patient	$ 62.00
Limited Service/Established Patient	$ 79.00
Intermediate Service/Established Patient	$ 114.00

TREATMENTS	
Manipulation (1 to 2 areas)	$ 45.00
Manipulation (3 to 4 areas)	$ 82.00
Manipulation (5 areas)	$ 108.00
Manipulation (Extremity)	$ 42.00

SUPPLIES	FEE
BioFreeze	$ 16 / $ 19.00
Cervical Pillow	$ 50.00

THERAPY	
IST	$ 36.00
EMS	$ 36.00
Ultrasound	$ 35.00
Manual Therapy	$ 44.00 / unit
Acupuncture	$ 80.00
Therapeutic Exercise	$ 55.00 / unit

TIME OF SERVICE DISCOUNT	
New Patient Exam	$ 45.00
Adjustment	$ 45.00
Kids adjustment 0-15yrs	$ 30.00
Kids new patient exam	$ 30.00

I hereby certify that I have been informed of the fees of City Center Chiropractic. Any treatment that my minor child or I received will have charges incurred. I understand that I am responsible for any deductible and/or co-payment. Pursuant to Colorado Criminal Code 18-13-119, it is illegal for City Center Chiropractic to waive my deductible or co-payment. At the end of my care if there are any unpaid visits, I will also be responsible for those visits. If I do not have insurance, I am responsible for the costs incurred unless other arrangements are made with City Center Chiropractic. I agree that I am fully responsible for all charges my minor child or I should incur.

PAYMENT IS DUE AS SERVICE IS RENDERED

_______________________________ ______________

Patient or Parent/Guardian Signature Date

Michele M. Orchard, D.C. **PHONE** 303 752 1982 **ADDRESS** 578 S. Chambers Road | Aurora CO 80017 **WEB** chirocitycenter.com