WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: _____ Last Name: _____

Nickname: _____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Preferred: _____ (circle: Home Cell Work)

Other: Home _____ Cell: _____

Work: _____ Date of Birth: _____

Do we have your permission to send appointment reminders, health newsletters, and occasional promotions to your email address? Yes _____ No _____
We will not sell or give your email to any other agency.

Email Address: _____

Emergency Contact:

Name: _____ Telephone: _____

Relationship: _____

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)
Friend or Family (name) _____ Internet Search Facebook Radio
Physician (name) _____ Our Website Signholder Newspaper
Walk-in Insurance Company _____ Health Fair _____
Other _____

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and is responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _____ **Date**: _____

Gregory A Justice, DC, PC
9075 Forsstrom Dr.
Lone Tree, CO 80124
(303) 470-1995

PATIENT INFORMATION

Date: _____

Full Name: _____ Name You Prefer: _____

Address: _____ City/State/Zip: _____

Best Phone#: _____ Cell Home Work S.S.#: ___-___-___ (for insurance only)

E-mail address: _____ Best way to contact you? Phone E-mail

Birth Date: ___/___/___ Age: _____ Sex: _____ Marital Status: S M W D Sep

Spouse's Name: _____ Children (ages): _____

Your Employer: _____ Your Occupation: _____

INSURANCE—Please allow our staff to photocopy your current health insurance card(s)

Name of Insurance: _____ ID#: _____ Group#: _____

Name of Insured: _____ Insured's DOB: _____

Insured's Address: _____ City/State/Zip: _____

Insured's Employer: _____ Patient Relationship to Insured: _____

**Please notify the front desk if you have other insurance that you think may apply.*

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accidents (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): _____

List all current over-the-counter and prescription medications used (include reason used): _____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.): _____

Have you been under a physician's care in the past year? ☐ no ☐ yes (reason) _____

When was your last physical examination? _____ Dr: _____

Have you ever been under chiropractic care? ☐ no ☐ yes (describe) _____

If female, is there a possibility that you are pregnant? ☐ no ☐ yes

Do you smoke/use tobacco? ☐ no ☐ yes Exercise habits? ☐ never ☐ occasional ☐ frequent

HAVE YOU HAD ANY OF THE FOLLOWING:

NOW:

- ☐ Pain worse at night
- ☐ Constant pain
- ☐ Unexplained weight loss
- ☐ Recent bacterial infection (30 days)
- ☐ Loss of bowel or bladder control
- ☐ Recent surgery (30 days)

EVER:

- ☐ History of cancer
- ☐ History of IV drug use
- ☐ History of blood transfusion

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CONFIDENTIAL CASE HISTORY FILE

Check any of the following symptoms you have noticed: (☐ = Now, ○ = Previously)

☐○ Headaches
☐○ Dizziness or light-headed
☐○ Jaw pain, clicking, or locking
☐○ Pain or difficulty swallowing
☐○ Neck pain or stiffness
☐○ Shoulder pain
☐○ Mid back pain
☐○ Chest pain or cough
☐○ Pain/trouble breathing
☐○ Arm/hand numbness/tingling
☐○ Arm/hand fatigue/weakness
☐○ Low back pain
☐○ Leg/foot numbness/tingling
☐○ Leg/foot fatigue/weakness
☐○ Leg pain with walking
☐○ Nausea or vomiting
☐○ Diarrhea or constipation
☐○ Blood in urine or stool
☐○ Difficulty or pain w/ urination
☐○ Difficulty with sexual function
☐○ Abnormal menstrual periods
☐○ Abdominal pain
☐○ Sensitive to light or sound
☐○ Visual or hearing disturbance
☐○ Memory loss/problems
☐○ Irritability or depression
☐○ Fatigue or loss of energy
☐○ Fainting or convulsions
☐○ Trouble with balance or coordination
☐○ Sleep disturbances/problems
☐○ Rashes (face, body, limbs)
☐○ Joint pain or swelling
☐○ Pain with exertion (climbing stairs, etc.)

What is your primary complaint / problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ☐ Constant ☐ Intermittent Is your condition getting worse? _____

What words best describe your present condition? (ex. ache, stabbing, burning) _____

Circle the number that matches your level of pain at its worst (0 = No Pain, 10 = Most Severe)

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1. _____
2. _____
3. _____

Have you had: ☐ Xray ☐ MRI or CAT Scan ☐ EMG ☐ Bone Scan ☐ Blood Work

Who is your family medical doctor? _____

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work_____ sleep_____ normal daily routine _____

Have you had symptoms like this before? ☐ no ☐ yes (describe) _____

Is your condition related to an accident? ☐ NO ☐ YES

Date of accident: _____ Type: ☐ Auto ☐ Work ☐ Other _____

Referred by: _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- I give this office the right to use my name for any in-office publications.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)

Patient's Signature: _____ Date: _____

Guardian's Signature (if applicable): _____ Date: _____

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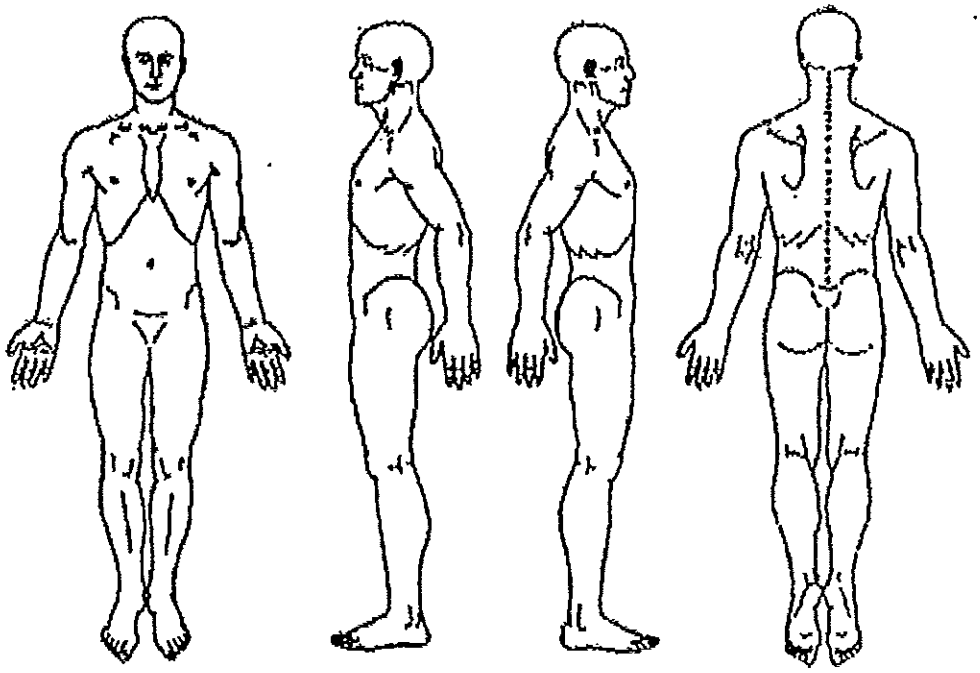
PAIN DRAWING

Name: _____ Date: _____

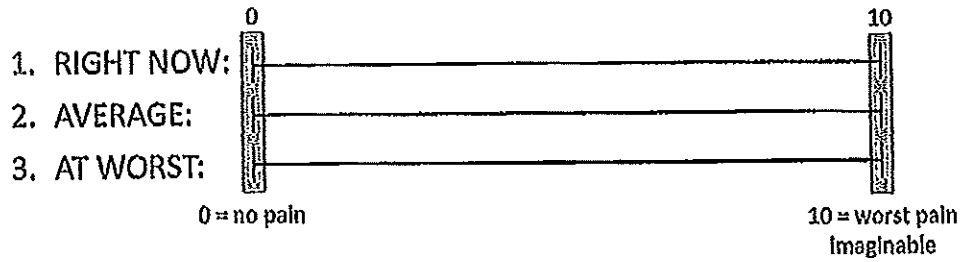
Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
** = sharp/stab
OO = numb/tingle
⟶ = shooting
/// = stiff/tight



Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Additional Comments:

_____

_____

_____

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Chiropractic @ Whole Health Center
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SCHEDULE OF FEES

Spinal Manipulation - CMT 1-2 Areas (98940)	$50.00
Spinal Manipulation - CMT 3-4 Areas (98941)	$60.00
Spinal Manipulation - CMT 5 Areas (98942)	$70.00
Extremity Manipulation (98943)	$40.00
Extremity Manipulation (Rib) (98943-52)	$30.00
Initial Rehabilitation (97530)	$45.00
Follow-Up Rehabilitation (97110-52)	$40.00
Manual Therapy / TPT (97140-59)	$35.00
NMR - Neuromuscular Re-education (97112-59)	$30.00
Established Patient Re-Evaluation 10mins. (99212)	$55.00
Established Patient Re-Evaluation 15mins. (99213)	$85.00
New Patient Initial Evaluation 10mins. (99201)	$55.00
New Patient Initial Evaluation 20mins. (99202)	$80.00
New Patient Initial Evaluation 30mins. (99203)	$120.00

NOTE: At various times throughout the year we may be offering special or introductory services at a reduced fee. These services generally include, but are not limited to, a consultation and brief examination to determine if there is a need for chiropractic care. **You will be made aware of any fees for services *before* those services are rendered.** Last revision 6/25/2012.

Signature: _____ Date: _____

WHICH TYPE OF CARE YOU ARE SEEKING (Check all that apply):

_____ RELIEF CARE:
Relief of pain/symptoms. Underlying structural problems may or may not be corrected. Upon stress or strain the problem may return or be worse.

_____ CORRECTIVE/REHABILITATIVE CARE:
Relief of pain/symptoms. Underlying structural problems addressed, thereby minimizing the probability of recurrences.

_____ OPTIMUM HEALTH AND WELLNESS CARE:
Correction of underlying structural problems. Chiropractic wellness and maintenance programs for optimal health and well being.

Informed Consent for Chiropractic Care

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____
have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date