1940 East 18th Ave. Suite B Denver, CO 80206

Welcome to Moving Body Chiropractic!

We're glad you're here. Whether you're looking to work on a specific problem or just feel great, this form is the start to your wellness journey! Please take the time to fill out all applicable information and include details. If you have any questions, please don't hesitate to ask.

Patient Name: _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Sex: Male / Female / Other _____

Home Phone # _____ Cell # _____ Carrier _____

Email _____

Relationship Status: Single / Married / Divorced / Widowed / Civil Union

Emergency Contact Name_____

Relationship _____ Phone # _____

If Patient is under 18: Parent/Guardian Name & Phone: _____

How did you hear about us? _____

Primary Complaint: _____

Any Other Concerns: _____

When did this begin? _____ **Has it gotten better/worse since then?** _____

Has this occurred before? Yes / No If Yes, please explain: _____

Describe the Quality of your Symptoms (circle all that apply)

Deep/Dull Sharp/Stabbing Electrical/Shooting Achy/Burning

Please Indicate the Severity of your Current Discomfort

0 - 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

(no pain) (emergency room pain)

Emily Gerson, D. C.

MOVING BODY CHIROPRACTIC

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How often are your symptoms present? ❑0-25% ❑26-50% ❑51-75% ❑76-100%

What makes your symptoms Better? _____

What makes your symptoms Worse? _____

Does your discomfort travel down your arms/legs? Y / N

Have you experienced lack of sleep due to the pain? Y / N

Have you experienced unexpected weight loss? Y / N

Does this problem interfere with your life or work? Y / N

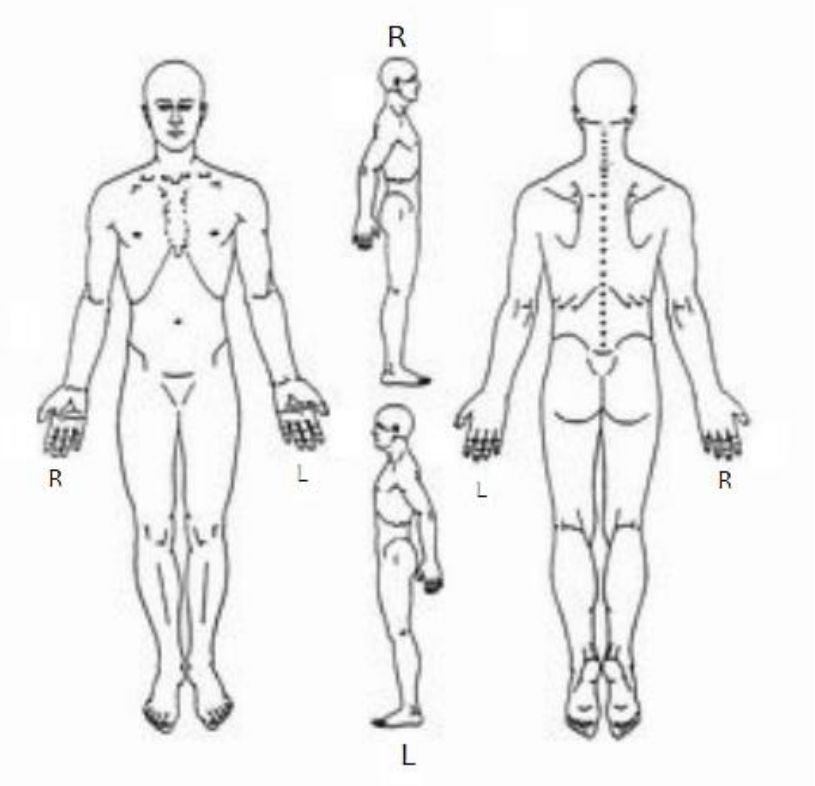
What activities would you like to be able to do pain-free? _____

Have you received any other treatment or had any imaging done for this condition? Y/ N

If yes, please explain: _____

Have you received chiropractic care before? If yes, where? _____

To help you feel better faster, we treat the whole body every visit.
In addition to your primary complaint, please indicate any other areas of pain or discomfort



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Are you taking any vitamins or supplements? _____

How many glasses of water do you drink in a day? _____

How many glasses of alcohol do you consume in a week? _____

How many servings of fruits & vegetables do you eat per day? _____

How often do you exercise and what kind? _____

Are you currently pregnant? Y / N

What medications are you currently taking? _____

_____

Has any member of family (parents, grandparents, siblings) been diagnosed or treated for Cancer, Heart Disease, Diabetes, Arthritic Conditions or Neurological Conditions? Y / N

If yes, please specify: _____

Please Circle all that apply to your personal health history from the list below:

Cardiovascular	**Gastrointestinal**	**Neurological**	**General**
Heart Trouble Chest Pain Heart Murmur Palpitations Varicose Veins Calf Pain with Walking	Nausea Diarrhea Constipation Abdominal pain Flatulence Change in appetite	Light headed/dizzy Convulsions/Seizures Numbness/Tingling Tremors Head Injury Memory Loss Fainting Poor Balance	Weight Change Loss of appetite Fatigue Insomnia Fever Anemia Frequent Headaches Allergies
Eyes	**Respiratory**	**Ear/Nose/Throat**	**Mental/Emotional**
Eye disease Glasses or contacts Blurred or Double Vision Vision Loss	Shortness of Breath Chronic Cough Asthma	Hearing loss Ringing in the ears Sinus problems Nose bleeds TMJ/Pain in Jaw	Depression Anxiety
Musculoskeletal	**Endocrine**	**Skin**	**Gynecological**
Joint pain Joint swelling Muscle weakness Back Pain Neck Pain Fracture/Dislocation	Excessive Thirst Heat or cold intolerance	Rash Itching Dry Skin Easily bruise	Last Menstrual period: _____ Menopause onset? _____

Additionally, please list any diagnoses, surgeries or illnesses here: _____

_____

Patient Signature _____ **Date _____**

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Informed Consent Form for Chiropractic

Patient Name (printed) _____

Every type of healthcare is associated with some risk of potential problems. State law requires that you sign an informed consent prior to receiving care.

Chiropractic focuses on the nervous system and spinal cord. During chiropractic treatment, the doctor will use his/her hands or a mechanical device in order to align your spine to correct interference to the nervous system and improve the body's ability to control and coordinate many functions. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint.

Spinal adjustments have been used routinely in the management of patients with a variety of symptoms and/or disorders, including those without symptoms who want to improve overall health. Any procedure provided at Moving Body Chiropractic is intended to aid in wellness.

You consent to the performance of spinal examination in which the doctor uses their hands to feel the muscles and joints of the spine or other body parts (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for spinal or other body parts, and performs any further orthopedic or neurological tests. X-rays or other imaging may be ordered by the chiropractor.

I understand and am informed that the risk of complications due to chiropractic treatment have been described as rare, but, as with any medical treatment, complications are possible. Complications could include, but are not limited to, muscular strain, ligamentous sprain, dislocations of joint, injury to the arteries of the neck, headaches, or a worsening of the condition. Soreness is the most common reported after effect following an adjustment. The doctor will make every reasonable effort during the examination to screen for contraindications to care.

I understand that I can discuss the risks and benefits of any procedure with my practitioner before signing this form. I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to her, is in my best interest.

My signature indicates that I have read, or have had read to me, the above consent. I have had the opportunity to ask questions about its content, and by signing below I agree to chiropractic and related treatments prescribed by Dr. Emily Gerson at Moving Body Chiropractic. 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. I hereby give consent for myself, or my dependent, to be examined and/or treated by the practitioner at Moving Body Chiropractic.

_____ _____

Patient Signature Date
(Signature of Parent or Guardian (if under 18 years old)

_____ _____

Doctor signature Date

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Patient Name (printed) _____

HIPAA

I hereby acknowledge that upon request, I will receive a copy of HIPAA privacy forms.

Initial _____

Privacy Practices Acknowledgment

I understand that my personal health information will not be shared with any agencies or individuals without my written consent. For more details, a Notice of Privacy Practices is available, ask your healthcare provider.

Initial _____

Financial Policies

Payment is required at time of service. Although Moving Body Chiropractic will give you all the information you need to obtain reimbursement from your insurance company if you have chiropractic benefits, the ultimate financial responsibility remains with you, the patient. By signing this, you are consenting to receive chiropractic care and agreeing to pay for services rendered.

Initial _____

Cancellation and No Show policies

Moving Body Chiropractic strives to keep all appointments on time. Out of respect to the chiropractor, and other patients, we ask that you please arrive a few minutes prior to your scheduled appointment. Relax and enjoy the calming vibes of the center! If you are unable to keep an appointment, please call 24 hours in advance to cancel or re-schedule. We understand that delays sometimes occur, but please be courteous and contact the office if running late. Accommodations will try to be made, but if the doctor is unable to provide appropriate patient assessment and treatment due to time constraints, the appointment will have to be re-scheduled. **A $45.00 no show or late cancellation will be applied.**

Initial _____

Your signature below states that you agree to and understand office policies and procedures.

Patient Signature _____ **Date** _____

Emily Gerson, D. C.