SMITH CHIROPRACTIC

DR. AMMON JACOBSON D.C.
1825 MAIN ST – UNIT C
COLORADO SPRINGS, CO 80911
(719) 390-5404

Directions:

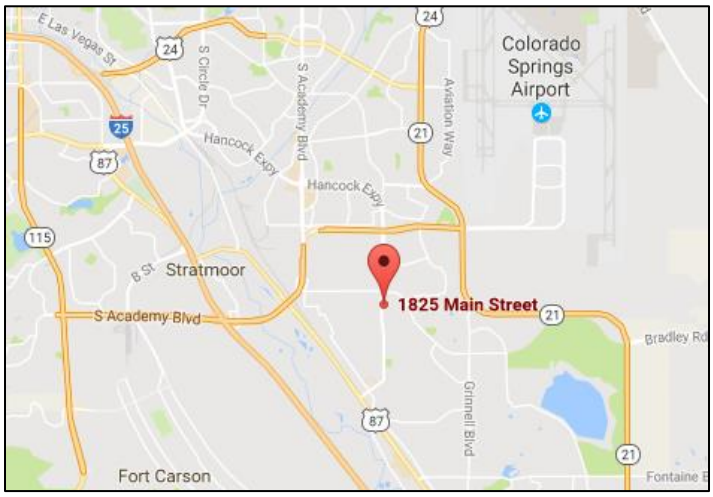
From the North:

Head south on I-25. Take exit 135. At the light turn left. Go .7 miles to the Bradley Rd exit. At the bottom of the off ramp there is a traffic circle. Go ¾ of the way around the circle and go east on Bradley (it is as if you are turning left onto Bradley without a traffic circle). Travel east to Hancock Rd sign and turn right. This road turns into Main St. We are on the left about 3 blocks down in a stucco building.

From South:

Head north on I-25. Take exit 135- South Academy. Turn right at the bottom of the ramp. Go .7 miles to the Bradley Rd exit. At the bottom of the off ramp there is a traffic circle. Go ¾ of the way around the circle and go east on Bradley (it is as if you are turning left onto Bradley without a traffic circle). Travel east to Hancock Rd sign and turn right. This road turns into Main St. We are on the left about 3 blocks down in a stucco building.

Please call us at 719-390-5404 if you have any trouble finding our office.



Please bring your paperwork completed and arrive 10 minutes early or your appointment may have to be rescheduled.

Your appointment is scheduled on _____ at _____.

We look forward to seeing you then!

Smith Chiropractic
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1825 Main St – Unit C
Colo. Springs, CO 80911
719-390-5404
www.SmithChiroCOS.com
info@smithchirocos.com

CONFIDENTIAL HEALTH HISTORY

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

ABOUT YOU

Today's Date: _____/_____/_____ File #:_____

Patient Name: _____
LAST FIRST MI

What you prefer to be called: _____ ☐Male ☐ Female

Birthdate: _____/_____/_____ Age: _____ SS#_____

Mailing Address:_____

_____
CITY STATE ZIP

Home Phone #: _____

Work Phone #: _____ Ext: _____

Cell Phone #:_____

E-Mail Address: _____

How did you hear about us? _____

Employer: _____ How Long? _____

Employer's Address: _____

_____
CITY STATE ZIP

Occupation:_____

Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How Many? _____

INSURANCE INFO

***Please allow our staff to photocopy your insurance card(s)**

Insurance Company Name:_____

Address:_____

_____
CITY STATE ZIP

Phone #:_____ Insured's SS#:_____

Group # (Plan, Local, or Policy #):_____

Insured's Name: _____

Relation:_____ Date of Birth: _____/_____/_____

Insured's Employer:_____

IN EVENT OF EMERGENCY

Who should we contact?_____

Relation:_____

Home Phone #:_____

Work Phone #:_____

Who is your Medical Doctor?_____

Phone #:_____

REASON FOR VISIT

The symptom(s) that have prompted me to seek care today include:_____

And are the result of: ☐ An accident or injury: ☐ Work ☐ Auto ☐ Other_____

☐ A worsening long-term problem ☐ An interest in: ☐ Wellness ☐ Other_____

Onset (When did you first notice your current symptoms?)**:**_____

Quality of symptoms (How does it feel?):

☐ Numbness ☐ Tingling ☐ Stiffness
☐ Dull ☐ Aching ☐ Cramps
☐ Nagging ☐ Sharp ☐ Burning
☐ Shooting ☐ Throbbing ☐ Stabbing
☐ Other_____

How does you current condition interfere with :

Work:_____

Recreation:_____

Home:_____

Relationships:_____

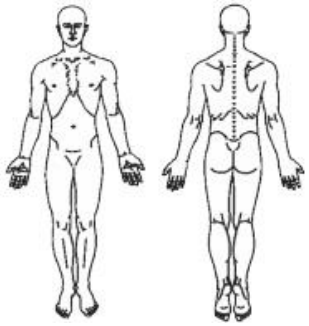
Sleep:_____

Other:_____

Intensity (How extreme are your current symptoms?)**:**

0 o-o-o-o-o-o-o-o-o-o **10**
Absent Uncomfortable Agonizing

Location (Where does it hurt?)
Circle the area(s)
"0" for current conditions
"X" for past conditions



Duration and Timing (When did it start and how often do you feel it?):

☐ Constant ☐ Comes and goes. How often? _____

Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot, or travel?)**:**

_____

Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, activities, etc)**:**

Worsens problem(s):_____

Lessens problem(s):_____

Prior interventions (What have you done to relieve the symptoms?)

☐Prescription medication ☐Surgery ☐Ice
☐Over-the-counter drugs ☐Acupuncture ☐Heat
☐Homeopathic remedies ☐Chiropractic ☐Other__
☐Physical therapy ☐Massage _____

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Please print clearly.

13. Review of Systems

Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Osteoporosis	○	○	Arthritis	○	○	Scoliosis	○	○	Neck pain	○	○	Back problems	○	○	Hip disorders
○	○	Knee injuries	○	○	Foot/ankle pain	○	○	Shoulder problems	○	○	Elbow/wrist pain	○	○	TMJ issues	○	○	Poor posture

NONE ○ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anxiety	○	○	Depression	○	○	Headache	○	○	Dizziness	○	○	Pins and needles	○	○	Numbness

NONE ○ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	High blood pressure	○	○	Low blood pressure	○	○	High cholesterol	○	○	Poor circulation	○	○	Angina	○	○	Excessive bruising

NONE ○ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Emphysema	○	○	Hay fever	○	○	Shortness of breath	○	○	Pneumonia

NONE ○ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/bulimia	○	○	Ulcer	○	○	Food sensitivities	○	○	Heartburn	○	○	Constipation	○	○	Diarrhea

NONE ○ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred vision	○	○	Ringing in ears	○	○	Hearing loss	○	○	Chronic ear infection	○	○	Loss of smell	○	○	Loss of taste

NONE ○ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○	○	Hair loss	○	○	Rash

NONE ○ Initials ____

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid issues	○	○	Immune disorders	○	○	Hypoglycemia	○	○	Frequent infection	○	○	Swollen glands	○	○	Low energy

NONE ○ Initials ____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney stones	○	○	Infertility	○	○	Bedwetting	○	○	Prostate issues	○	○	Erectile dysfunction	○	○	PMS symptoms

NONE ○ Initials ____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low libido	○	○	Poor appetite	○	○	Fatigue	○	○	Sudden weight gain/loss (circle one)	○	○	Weakness

NONE ○ Initials ____

Doctor's Initials

Smith Chiropractic LLC

Patient name

Patient Number
(office use only)

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio			
○	○	Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

○ ○ Medications (prescription and over-the-counter): _____

Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

Family History

Some health issues are hereditary. Tell Dr. Smith about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

Are there any other hereditary health issues that you know about? _____

Social History

Tell Dr. Smith about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily	○ Weekly	How much?		Prayer or meditation?	○ Yes	○ No
Coffee use	○ Daily	○ Weekly	How much?		Job pressure/stress?	○ Yes	○ No
Tobacco use	○ Daily	○ Weekly	How much?		Financial peace?	○ Yes	○ No
Exercising	○ Daily	○ Weekly	How much?		Vaccinated?	○ Yes	○ No
Pain relievers	○ Daily	○ Weekly	How much?		Mercury fillings?	○ Yes	○ No
Soft drinks	○ Daily	○ Weekly	How much?		Recreational drugs?	○ Yes	○ No
Water intake	○ Daily	○ Weekly	How much?				

Hobbies: _____

Doctor's Initials

Smith Chiropractic LLC

Activities of Daily Living

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

What is the major stressor in your life? _____ **How much sleep do you average per night?** _____ **Hours**

What is the type and approximate age of your mattress and pillow? _____ **What is your preferred sleeping position?** _____

Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

What would be the most significant thing that you could do to improve your health? _____

In addition to the main reason for your visit today, what additional health goals do you have? _____

Patient Name _____

Patient Number (office use only) _____

Notes

INFORMED CONSENT FOR CHIROPRACTIC CARE

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me (or the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below, other licensed doctors of chiropractic, or other staff members who now or in the future work at the office listed below or any other associated office. _____ (initials)

I understand and am informed that, as in the practice of medicine, the chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. There are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and 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 him, is in my best interest. It is my responsibility to make known any conditions that might not come to the attention of the doctor. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic and I understand that results are not guaranteed. _____ __ (initials)

Chiropractic is a science, philosophy and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) relative to range of motion, muscular and neurological aspects, as the relationship may affect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease, pain or infirmity. I understand that the chiropractor will use his hands or mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". _____ (initials)

Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases. If during the course of care, we encounter non-chiropractic or unusual finding, we will advise you of those findings and recommend that you seek the services of another health care provider. _____ (initials)

I understand that my consent need only be obtained one time for my present condition and any future condition (s) for which I may seek treatment. I also understand that I can revoke this consent at any time in writing for all future procedures. I also understand that any video or photographic material I may appear in, may be used for documentation and for any way this office sees fit to further research and awareness. If I decline to sign this consent this office has the right to refuse to render care. _____ (initials)

I have read, or have had read to me, this Informed Consent for Chiropractic Care. I have had the opportunity to ask questions about its content, and have had my questions explained to my satisfaction in a way that I can understand. By voluntarily signing below I agree to the above named procedures regarding my care in this office and am authorizing them to proceed with any treatment they may deem necessary in my case. _____ (initials)

PREGNANCY RELEASE: This is to certify that to the best of my knowledge, I am not pregnant and the above doctor (and associates) has my permission to perform and x-ray evaluation if deemed necessary. I have been advised that x-ray can be hazardous to an unborn child.

Date of last Menstrual Cycle: _____ Initials: _____

_____	_____	_____	_____
Name (printed)	DOB	Signature	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here.

_____

Signature

_____

Date

FOR OFFICE USE ONLY

We have made every effort to obtain acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details):*

_____

_____

_____

_____ _____

Employee Signature *Date*

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This notice will take effect on February 1, 2017 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH IINFORMATION

We will keep your health information confidential, using it only for the following purposes:

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical record staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process). We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim or other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Copies, if requested, may be $14.00 for the first ten pages, $0.25 for pages 11-40, and $0.33 for each page thereafter. If you want the copies mailed to you, postage may also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on February 1, 2017. Information prior to that date would not have to be released. (*Example: if you request information on March 1, 2018, the disclosure period would start on February 1, 2017 up to March 1, 2018. Disclosures prior to February 1, 2017 do not have to be made available).*

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing, request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Smith Chiropractic
Dr. Ammon Jacobson D.C.

Telephone: 719-390-5404

Fax: 719-390-8313

Address: 1825 Main St, Unit C
Colorado Springs, CO 80911