Colburn Chiropractic

Phone: (860) 870-4100

351 Merline Road, Suite 103
Vernon, CT 06066

Marla Colburn, DC

NEW PATIENT REGISTRATION

Amy Person, DC

Please print clearly to help avoid billing errors

Patient Last Name _____ First _____ MI ____

Mailing Address _____ Apt or Unit# _____

City _____ State _____ Zip _____

Home Telephone (____) _____ Cell Number (____) _____ Work # (____) _____

Date of Birth ____/____/____ Age _____ SSN _____-____-_____ E-Mail _____

Marital Status: Single Married Divorced Domestic Partner Other Sex: Male Female

Employment Status: Employed Full Time Employed Part Time Full Time Student Unemployed Retired

GUARANTOR NAME (Person to Bill if Other Than Patient)_____

Mailing Address _____ Apt or Unit# _____

City _____ State _____ Zip _____

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to Marla Colburn, DC and I understand I am financially responsible for any and all non-covered services provided by Marla Colburn, DC.*

Signature: _____ Date: _____

**********Below for Office Use Only **********

DIAGS: (1) _____ (2) _____ (3) _____ (4) _____

INITIAL VISIT PROCEDURES

DOS: _____ Amt Paid This Visit: $ _____ Date of Current Illness: (Anthem & Medi Only) _____

New Exam:	9920 _____	9894 _____ *Manip.*	97110 _____ *Thera Ex.*	97112 _____ *Neuro Re-Ed*	97140 _____ *Trigger Point*
	98943 _____ *Extra-Spinal*	97010 _____ *H/C Packs*	97014 _____ *E-Stim/Un*	97012 _____ *Mech.Track*	97035 _____ *Ultrasound*

☐ **Check Box to Block Pt. Statements**

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PERSONAL INFORMATION

Today's Date:	Social Security Number:	Referred by:

First Name:	Initial:	Last Name:	Nick Name:	Gender: Male Female
Address:	City:	State:	Zip:	

Home Telephone:	Work Telephone:	Cell Phone:

Date of Birth:	Age:	Marital Status:	Number of Children:

Family Physician:	Telephone:	Address:

Occupation:	Employer:	Telephone:

Is this visit related to an accident?	**No**	**Work**	**Car**	**Personal Injury**

Primary Insurance Co:	ID:	Group#:
Address:		

Secondary Insurance Co:	ID:	Group #:
Address:		

Emergency Contact:	Relationship:	Telephone:	Cell Phone:

If patient is under 18 years old – please complete below			
Parent's Name:	Home Telephone:	Work Telephone:	Cell Phone:
Parent's Name:	Home Telephone:	Work Telephone:	Cell Phone:

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Name: _____ Date: _____ File: _____

CASE HISTORY

COMPLAINT AREA 1

There is room on this page to list 2 different areas of complaint. If you have more than 2 areas of compliant, please ask for more forms. Thank you.

What is your current condition or problem?		Onset of problem?	Sudden Gradual
What caused the problem?		Date Started:	
What makes the problem feel worse?			
What makes the problem feel better?			
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:		
Where is the primary site of the problem?			
Where does the problem refer to?	(For example: neck pain that **refers to the right arm.**)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed? Morning / Afternoon / Night	
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

COMPLAINT AREA 2

What is your current condition or problem?		Onset of problem?	Sudden Gradual
What caused the problem?		Date Started:	
What makes the problem feel worse?			
What makes the problem feel better?			
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:		
Where is the primary site of the problem?			
Where does the problem refer to?	(For example: neck pain that **refers to the right arm.**)		
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed? Morning / Afternoon / Night	
Other associated symptoms?			
What is the status of the condition?	Improving / Same / Worsening	Explain:	

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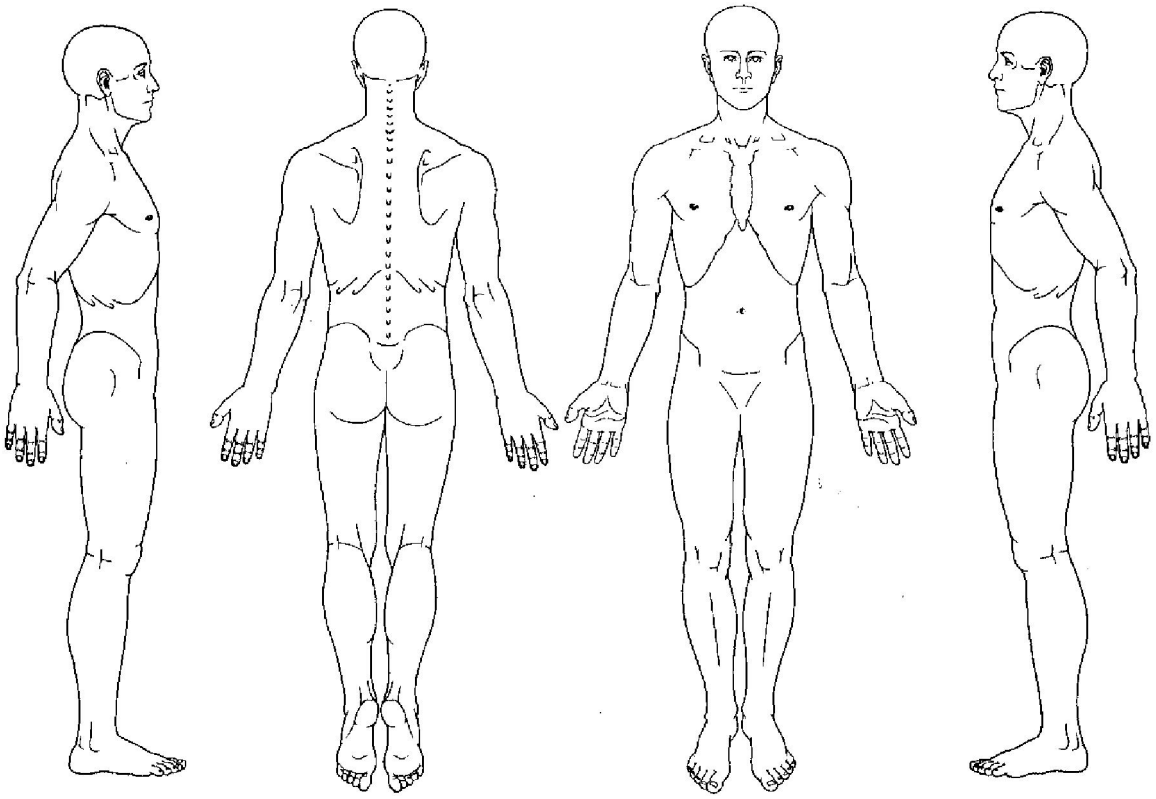
SYMPTOM DRAWING

Mark the area on your body where you feel the following sensations

Aches: AAAA Cramping: CCCC Pins & Needles: PNPN Stabbing: / / / / /
Burning: XXXX Numbness: +++++ Sensitive: SSSSS Other: OOOOO



Rate the severity of your symptom(s) from 0 to 10 by marking "X" at the appropriate point on the line.

(Example: 0_____X_____10)
No Symptoms 5 Worst possible, Unbearable

( ) Rate your head symptom(s) 0_____10
( ) Rate your neck symptom(s) 0_____10
( ) Rate your mid back symptom(s) 0_____10
( ) Rate your low back symptom(s) 0_____10
( ) Rate your arm symptom(s) 0_____10
( ) Rate your leg symptom(s) 0_____10

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PAST HISTORY & SYSTEM REVIEW

PAST AND/OR CURRENT CONDITIONS

Circle **(P) Past** or **(C) Current** for any diseases, conditions or symptoms. Please explain in space provided at the end.

Childhood		
Chicken Pox	P	C
Measles	P	C
Mumps	P	C
Rubella	P	C
Other	P	C
Constitutional		
Addiction(alcohol, smoke, etc)	P	C
Habits (alcohol, smoke, other)	P	C
Easting disorder	P	C
General fatigue/ weakness	P	C
Fevers/ chills	P	C
Eyes		
Glaucoma	P	C
Vision problems	P	C
Ears		
Ear infections/ earaches	P	C
Hearing loss	P	C
Ringing	P	C
Nose	P	C
Sinus		
Sinusitis/ infection	P	C
Pain	P	C
Mouth		
Jaw click or mal-position	P	C
Grinding	P	C
Throat	P	C
Cardiovascular		
Heart disease	P	C
Arteriosclerosis	P	C
Murmur	P	C
Varicose veins	P	C
Arm and/or leg swelling	P	C
Chest pain/ pressure	P	C
Cold hands and/or feet	P	C
High or low blood pressure	P	C
High cholesterol	P	C
Leg pains or cramps	P	C
Palpitations	P	C

Respiratory		
Lung disease	P	C
Asthma	P	C
Emphysema	P	C
Pneumonia	P	C
Chronic cough	P	C
Difficulty breathing/ tightness	P	C
Gastrointestinal		
Esophagus disease		
Stomach disease	P	C
Gall bladder disease	P	C
Liver disease	P	C
Intestinal disease	P	C
Hernia	P	C
Peptic ulcer	P	C
Bowel movement changes	P	C
Heartburn/ constriction	P	C
Indigestion/ nausea	P	C
Jaundice	P	C
Stools bloody/ dark	P	C
Regurgitation/ vomiting	P	C
	P	C
Genitourinary		
Bladder disease		
Kidney disease	P	C
Stones	P	C
Urinary tract infections	P	C
	P	C
Male Reproductive		
Prostate disease		
Testicular disease	P	C
Sexually transmitted disease	P	C
	P	C
Female Reproductive		
Ovary disease		
Uterus disease	P	C
Sexually transmitted disease	P	C
Menstrual symptoms	P	C
Menstrual cycle # days	P	C
Pregnancies	_____	
Deliveries	_____	
Birth control	_____	
	P	C
Musculoskeletal		
Arthritis		
Braces/ Supports/ Orthotics	P	C
Joint pain/ swelling/tightness	P	C
Neck pain	P	C
Back pain	P	C
	P	C

Integument (skin)		
Skin disease/ rashes/ sores	P	C
Eczema	P	C
Dryness	P	C
Neurological		
Neurological disease	P	C
Convulsions/ seizures	P	C
Dizziness/ fainting	P	C
Severe headaches	P	C
Migraines	P	C
Sleep problems	P	C
Psychological		
Mental illness	P	C
Depression	P	C
Mood swings	P	C
Nervousness	P	C
Breasts		
Breast disease	P	C
Pain or discomfort	P	C
Self-exam	P	C
Endocrine		
Endocrine gland disease	P	C
Thyroid disease	P	C
Diabetes	P	C
Osteoporosis	P	C
Thirst- excess/ reduced	P	C
Weight change	P	C
Blood		
Anemia	P	C
Immunity		
Allergies	P	C
Cancer	P	C
Cold sores	P	C
Lyme's disease	P	C
Any Other Condition	P	C

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DESCRIPTION OF PAST AND/OR CURRENT CONDITIONS

CONDITION	AGE	CONDITION(S) BRIEFLY DESCRIBE

IMMUNIZATION HISTORY

Describe immunizations received over the past year: _____

_____

HEALTH SCREENING HISTORY

Indicate the last time you were examined or screened for the following (Leave blank if never, ? mark if date in Unknown)

Exam	Date	Exam	Date	Exam	Date
History & Physical		Blood Pressure		Bone Density	
Breast		Cholesterol		Other	
Pelvic & Pap Smear		Mammogram			
Rectal		Prostate			

Results: _____

_____

MEDICINES & SUPPLEMENTS

List all current medicines, nutrients, herbs, botanicals, etc. consumed:

_____

_____

_____

_____

_____

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HEALTH CARE PROVIDERS

List health care providers currently seen for your current problem(s) and any condition.

Name/ Address/Phone	Last Visit	Diagnosis	Treatment
1.			
2.			
3.			
4.			

FAMILY HISTORY

Please list the occurrence of any disease or condition WITHIN YOUR FAMILY such as:
Addictions and Habits (Drugs, alcohol, smoking), Allergies, Anemia, Arthritis, Asthma, Cancer, Dental Disease, Diabetes, Emotional Condition, Epilepsy, Gallbladder Disease, Heart Disease, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Mental Illness, Osteoporosis, Ulcer, Stroke, Thyroid Disease, Tuberculosis, Any Other Conditions

Relative	Alive/ Deceased	Age	Describe Condition(s), Illnesses, Etc.
Mother			
Father			

PAST SURGERIES

_____

_____

_____

_____

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CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

_____ _____

Printed Name Date

_____

Signature

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care is a system of health care delivery. As with many health care disciplines, we cannot promise a cure for any symptom, disease or condition as a result of treatment. We will promise to give you our best to achieve good health and well-being the natural way.

The doctor will primarily provide chiropractic adjustments or manipulation during the course of treatment. This is done with the use of his/her hands and/or a mechanical device upon your body in order to move your joints in certain directions. This procedure may cause a "pop" or "click" to be heard from the area treated and should not be a cause for alarm. There are some material risks involved in these procedures and include:

1. Pain: Treatment may result in temporary increased soreness in the area treated.
2. Rib fractures: These are rare and may occur in patients with osteoporosis or weakened bones. Evidence of osteoporosis or weakened bones may be noted on x-ray. If detected, treatment is modified to assure a gentle and effective adjustment is provided. Gentle treatment is applied to all patients. Specialized care is provided to young, frail, and elderly individuals.
3. Disc injury: Chiropractic treatment is appropriate for many types of spinal related conditions, including disc conditions. Occasionally, treatment may aggravate a problem if the disc is in a severely weakened state. This occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at one per 100 million spinal manipulations.
4. Stroke: The incidence of stroke in the general population is 2 per 1000 people. Manipulation of the neck has been implicated as a cause for stoke in the past. Upon review of the literature and data, the incidence is one per 5 million manipulations. Usually, the type of manipulation is violent, not specific, to the area requiring treatment and delivered by a non-chiropractic provider. In comparison, the risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen, motrin, etc) is 4 per 100,000 patients. The risk of serious complications or death from spinal surgery of the back is 11.25 per 1000 patients. The risk of chiropractic treatment is far less than the risk of medical and surgical treatment. Even though the risk of injury is very low, we include procedures and tests that may help us reduce the potential for stroke or other complications.
5. _____

_____

_____

I (We)_____ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on_____, by COLBURN CHIROPRACTIC, LLC and/or other licensed doctors of chiropractic or other health care providers who may be employed by or engaged in practice of their respective discipline in the office of COLBURN CHIROPRACTIC, LLC.

I have had an opportunity to discuss with the doctor, or other clinical personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result may not necessarily indicate error in judgment; that no guarantee as to results has been made to nor relied upon me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but ate not limited to, fractures, disc injuries, strokes, dislocations and sprains, and which may be related to physical aberrations unknown to or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the named procedures.

_____ / _____ _____ / _____

Witness Name | Witness Signature | Patient's Name | Patient's Signature

_____ _____ / _____

Date | Parent/ Guardian Name | Parent/ Guardian Signature