

  
**BOYKIN**  
CHIROPRACTIC OFFICE, PC

PHONE #: 719-578-8820  
2575 MONTEBELLO WEST SUITE 102  
COLORADO SPRINGS, COLORADO 80918

## Patient Biography

Patient Name:		Today's Date:	
Social Security Number:		<i>(Only Required for VA*)</i>	
Date of Birth:		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status:			
Spouses Name <i>(if applicable)</i> :			
# of Children:			
Height:		Weight:	
Home Street Address:			
City:		State:	Zip:
Mobile Phone #:		Home Phone #:	
Email Address:			
Occupation:		Employer:	
Employer's Address:			

**STUDENT SECTION:** *Only Applies for Current Students (Young kids, write grade in "Other Information" box)*

What Type of Student Are You:  High School  College  Graduate School / Doctoral Program

Name of School:	State School Resides in:
City School Resides In:	Other Information:

### EMERGENCY CONTACT INFORMATION:

Name:	Phone Number:	Relation to You:
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**HOW DID YOU HEAR ABOUT US:** \_\_\_\_\_

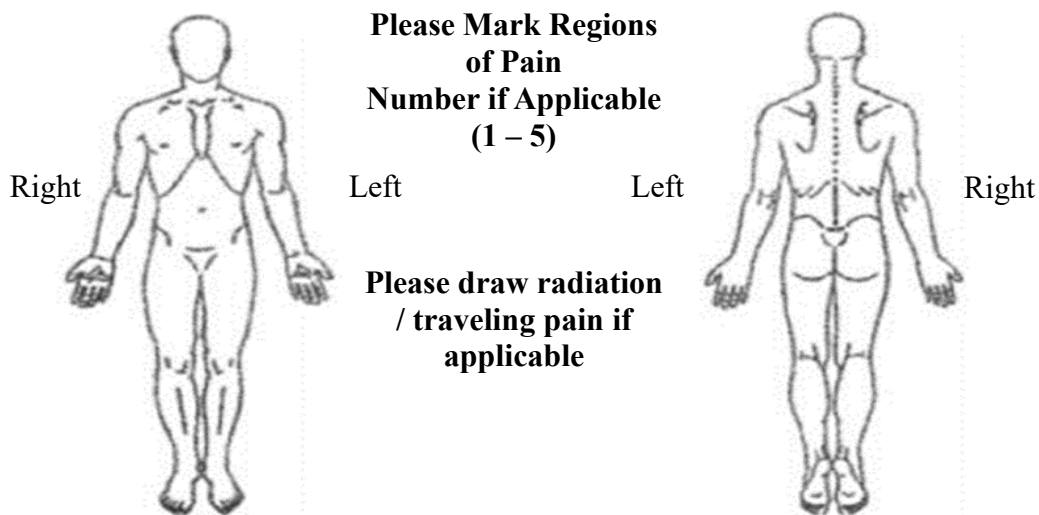
We request your permission to feature your chiropractic success story, including your image and testimonial, on our social media platforms for promotional purposes. We will never use images or testimonials without your consent. Would you consent to the use of your image and testimonial as described?  Yes  No

# Current Complaints & History

Have you received Chiropractic Care Before:  Yes  No Doctor's Name / Clinic Name: \_\_\_\_\_  
 Did you receive benefit from your previous chiropractic care?  Yes  No  
 Do you have any recent X-Rays (within the last 2 years):  No  Yes  Yes, and I have access to them

## Current Complaint(s) History:

Complaint	How Severe is it (0 to 10): 10 is Worst	How Does it Feel?	Has the Complaint Changed?	Start Date
<i>Example: Neck</i>	1 2 3 4 5 6 7 8 9 10	<i>Dull / Achy</i>	<i>Check 1 box</i>	<i>Last week</i>
	1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The Same	
	1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The Same	
	1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The Same	
	1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The Same	
	1 2 3 4 5 6 7 8 9 10		<input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> The Same	



## Complaint Information:

Are your complaints due to an injury?  Yes  No  On the Job  Auto Accident  Personal Injury  
 Are your complaints felt:  Constant  Intermittent  Occasional  Random  On & Off

Please Write a Brief Description of the Injury if Applicable:

What Time of Day Are You Most Affected:  Morning  Noon  Evening  Night

Are these Complaints (#) | Constant:  | Intermittent:  | Random:

Does the Pain Radiate (Travel to Any Other Regions):  No  Yes – please explain:

Have you ever had any of these complaints before?  No  Yes – please explain:

Any additional information you want us to know about your complaints:

## Your Medical History:

<b>Previous Surgeries (Joint Replacements, Spinal Surgeries, etc.):</b>
<b>Any Other Hospitalizations:</b>
<b>Current Medications:</b>
<b>Current Vitamins / Dietary Supplements:</b>

**Other Diagnosed Conditions: *Mark All That Apply***

- |  |   |                                    |  |
|--|---|------------------------------------|--|
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Stroke/TIA    |
| <input type="checkbox"/> Heart Disease           | <input type="checkbox"/> Cancer         | <input type="checkbox"/> Anemia    | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Obesity                 |   | <input type="checkbox"/> Epilepsy  | <input type="checkbox"/> HIV / AIDs    |
| <br><input type="checkbox"/> <b>Other:</b> _____ |   |                                    |  |

**Habits & Exercise:**

Habits	Exercise
<input type="checkbox"/> Smoking – Packs/Day: <input type="checkbox"/> Previous Smoker	<input type="checkbox"/> None
<input type="checkbox"/> Drinking Alcohol – Drinks / Day / Week:	<input type="checkbox"/> Moderate (2+ Times per week)
<input type="checkbox"/> Coffee (Caffeine Drinks) – Cups/mg per day:	<input type="checkbox"/> Daily
<input type="checkbox"/> Recreational Drugs:	<input type="checkbox"/> Would like to Start / Planning on Starting

How Many Glasses of Water do you Drink per Day (8 oz. Glasses):  1-2     3-4     5-6     7-8     8+

Are you participating in a specific diet? Vegetarian / Vegan / Carnivore / Keto / Paleo / Other: \_\_\_\_\_

**Family History:**

Family Member	Diabetes	Heart Disease	Kidney Disease	Cancer	Back Problems	Other: <i>write in</i>
<b>Mother</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Father</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Brother</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>Sister</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Any additional information you would like us to know before starting care:

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# Notice of Privacy Practices

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

## **OUR PLEDGE REGARDING MEDICAL INFORMATION**

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This Notice applies to all records of your care generated and maintained by this medical spa.

We are required by law to: 1) make sure that medical information that identifies you is kept private; 2) make available to you this Notice of our legal and privacy practices with respect to medical information about you; and 3) follow the terms of the Notice that is currently in effect.

## **HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

We may disclose medical information, about you to doctors, nurses, or other personnel involved in taking care of you. We may also disclose medical information to people outside the medical group, such as family members, specialists or others who are involved in providing services that are part of your care.

We may use or disclose medical information about you for operations. These may include use of information to evaluate the performance of our staff, effectiveness of programs, and ways to improve care and services we offer. These uses and disclosures are necessary to ensure that all of our patients receive quality care.

We may use and disclose medical information to contact you as a reminder that you have an appointment for treatment or care.

- We may use or disclose medical information to tell you about or recommend possible treatment options or alternatives, and about health-related benefits, services, events and activities that may be of interest to you.

We may disclose medical information about you to other healthcare providers in the event you need emergency care.

We may disclose medical information about you as required by federal, state, or local law.

- We may use or disclose medical information to a public health organization or federal organization when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

We may disclose medical information about you in special situations such as for workers' compensation programs, as required by military command authorities or the Department of Veterans Affairs, in response to a court or administrative order, or for public health activities. Other uses and disclosures of medical information not covered by this Notice or the laws that apply to us will be made only with your written authorization. You may later revoke this permission in writing at any time.

## **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU**

You have the right to review and receive a copy of medical information that may be used to make decisions about your care. Usually this includes medical and billing records. You must submit a

written request to review and copy your medical information. We may charge a fee for the costs of supplying a copy of the records.

- You have the right to ask us to amend medical information that you feel is incorrect or incomplete. Your request for an amendment must be submitted in writing and must provide a reason that supports your request.

We may deny your request for amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if the information: 1) was not created by us; 2) is not part of the medical information kept by or for us; 3) is not part of the information which you are permitted to inspect and copy; or 4) is accurate and complete

- You have the right to request an "accounting of disclosures." This is a list of disclosures we have made of medical information about you, with some exceptions. The exceptions are governed by federal health privacy law, and include: 1) routine disclosures for treatment, payment and operations conducted pursuant to your signed consent form; and 2) disclosures to-you. You must submit a written request. The request must state a time period that may not be longer than six years and may not include dates before April 14, 2003, when current federal health privacy laws became effective.

- You have the right to request restrictions or limitations on the use or disclosure of medical information about you, You must submit a written request for restriction that specifies: 1)-what information you want to limit; 2) whether you want to limit our use, disclosure, or both; and 3) to whom you want the limits to apply. We reserve the right to refuse your restriction if it is in conflict with providing you quality healthcare or in an emergency situation.

- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location, such as only at work or by mail. You must submit a written request for confidential communications restrictions, specifying how or where you wish to be contacted. We will accommodate reasonable requests.

- You have the right to possess a copy of this Privacy Notice upon request. You may receive a paper copy of this notice, or you can also obtain a copy of this Notice at our offices.

You have the right to file a complaint if you believe your rights to privacy have been violated. All complaints must be submitted in writing. All complaints will be investigated. No personal issue will be raised for filing a complaint.

### CHANGES TO THIS NOTICE

We reserve the right to change this Notice at any time. We will post a copy of the current notice at our clinical site.

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## ACKNOWLEDGMENT OF RECEIPT OF HIPPA PRIVACY NOTICE

I, \_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. I understand that I have certain to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.

Obtain payment from third-party payers. .

Conduct normal health care operations such as quality assessments and accreditation.

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Patient

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Signature

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Date

## For Office Use Only

**We attempted to obtain written Acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:**

- Individual refused to sign**
- Communication barriers prohibited obtaining the Acknowledgement**
- An emergency situation prevented us from obtaining Acknowledgement**
- Other (please specify):**

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**Staff Signature**

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**Date**

# Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent or Guardian: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_