THE SOURCE
CHIROPRACTIC

Name: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (Home) _____ (Cell) _____ Cell Provider: _____

Email Address: _____ Date of Birth: _____ /_____ /_____

Height: _____ Weight: _____ Age: _____ Gender Pronoun: _____

For the purposes of creating a safe space in our office, in what other ways do you self-identify that you'd like to specifically and explicitly let us know? _____

Occupation: _____ Employer's Name: _____

Active Military/Veteran: ☐ YES ☐ NO – Which branch/years: _____

Single / Married / Widowed /Life Partnered – Name: _____

Pregnant? ☐ YES ☐ NO Number of Children: _____ Names & Ages: _____

_____

Who may we thank for referring you in? -- _____

Emergency Contact: _____ Relationship: _____ Phone: _____

PLEASE LIST YOUR HEALTH CONCERNS

Health Concerns: List Main Concern First	**Rate Severity 1= Mild 10= Unbearable**	**When did this episode start?**	**Did you have this condition before? When?**	**Did the problem begin with an injury?**	**Constant? Intermittent?**

Since these complaints/concerns started, are they:
☐ ABOUT THE SAME ☐ GETTING BETTER ☐ GETTING WORSE

What makes it worse? _____

What makes it better? _____

What are these concerns keeping you from doing? _____

_____

Have you seen any other doctors/ health providers for this condition?

☐ Chiropractor ☐ Medical Doctor ☐ Other

If so, WHO & WHEN: _____

List SURGERIES (if any) and dates: _____

_____

List all MEDICATIONS you are currently taking: _____

When was your last Auto Accident? _____

Have you ever been knocked unconscious? ☐ YES ☐ NO

Fractured any bones? ☐ YES ☐ NO – If YES, please describe: _____

Any other bodily trauma: _____

CHECK ANY & ALL OF THESE PROBLEMS YOU'VE HAD IN THE LAST 2 YEARS

☐ DIZZINESS	☐ ASTHMA	☐ KIDNEY PROBLEMS	☐ CHRONIC FATIGUE
☐ HEADACHES	☐ ULCERS	☐ BLADDER PROBLEMS	☐ LUPUS
☐ VERTIGO	☐ CHEST PAINS	☐ IRRITABLE BLADDER	☐ FYBROMYALGIA
☐ EAR INFECTIONS	☐ ARM NUMBNESS	☐ SCIATICA	☐ ADD / ADHD
☐ ALLERGIES	☐ ARM PAIN	☐ LEG NUMBNESS	☐ GERD
☐ TMJ	☐ HAND NUMBNESS	☐ FEET NUMBNESS	☐ ANXIETY
☐ NECK PAIN	☐ SHOULDER PAIN	☐ LOW BACK PAIN	☐ NERVOUSNESS
☐ MIGRAINES	☐ HEART DISORDERS	☐ HIP PAIN	☐ EPILEPSY
☐ STIFFNESS IN NECK	☐ MID BACK PAIN	☐ LEG PAINS	☐ DISC PROBLEMS
☐ CHRONIC SINUS	☐ STOMACH DISORDERS	☐ KNEE PAIN	☐ INFERTILITY
☐ THROAT ISSUES	☐ NAUSEA or REFLUX	☐ LIVER DISEASE	☐ OTHER
☐ THYROID ISSUES	☐ HIGH BLOOD PRESSURE	☐ MENSTRUAL ISSUES	

CIRCLE ANY CONDITIONS YOU HAVE CURRENTLY OR IN THE PAST:

STROKE - CANCER - HEART DISEASE - SPINAL SURGERY - SEIZURES - SPINAL FRACTURE - SCOLIOSIS – DIABETES

Are you interested in tracking your emotional well-being while in care at The Source Chiropractic? ☐ YES ☐ NO

What are your expectations with care at The Source Chiropractic? _____

_____

_____ _____ _____

PRINT NAME **SIGNATURE** **DATE**

THE SOURCE CHIROPRACTIC

EMOTIONAL HEALTH AND WELLBEING

Below are some statements about feelings and thoughts. Please check the number that best describes your experiences of each over the last 2 weeks.

STATEMENTS	NONE OF THE TIME	RARELY	SOME OF THE TIME	OFTEN	ALL THE TIME
I've been feeling optimistic about the future.	☐1	☐2	☐3	☐4	☐5
I've been feeling useful.	☐1	☐2	☐3	☐4	☐5
I've been feeling relaxed.	☐1	☐2	☐3	☐4	☐5
I've been feeling interested in other people	☐1	☐2	☐3	☐4	☐5
I've had energy to spare.	☐1	☐2	☐3	☐4	☐5
I've been dealing with problems well.	☐1	☐2	☐3	☐4	☐5
I've been thinking clearly.	☐1	☐2	☐3	☐4	☐5
I've been feeling good about myself.	☐1	☐2	☐3	☐4	☐5
I've been feeling close to other people.	☐1	☐2	☐3	☐4	☐5
I've been feeling confident.	☐1	☐2	☐3	☐4	☐5
I've been able to make up my own mind about things.	☐1	☐2	☐3	☐4	☐5
I've been feeling loved.	☐1	☐2	☐3	☐4	☐5
I've been interested in new things.	☐1	☐2	☐3	☐4	☐5
I've been feeling cheerful.	☐1	☐2	☐3	☐4	☐5

Please read each item and circle the number which comes closest to how you have been feeling in the past 2 weeks. Don't take too long over your replies, your immediate reaction to each item will probably be more accurate than a long thought

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Informed Consent for Chiropractic Care

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

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that 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 vertebra in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to 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 a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during the course of care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects; i.e. muscle spasms, stiffness, rib fracture, headache, dizziness and stroke.

All questions regarding the doctor's objective to my care in this office has 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.

Pregnancy Release

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle:_____

Sign **Date**

The Source Chiropractic
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(303) 993- 5769
Sourcechirodenver@gmail.com

THE SOURCE
CHIROPRACTIC

The Source Chiropractic No Call, No Show Cancellation Policy.

Here at The Source Chiropractic, we understand that life can throw us unexpected emergencies. These unanticipated things are not always within our control. Due to appointments being in high demand, we ask that you do your best to notify us in advance about any changes to your appointment. It is our commitment to you as a Source member that you have an exceptional experience here at our office. Out of respect for our chiropractors and other Source members, we appreciate at least 24 hours advanced notice from our practice members when they are unable to keep their scheduled appointment. This is valuable time that can be dedicated to someone who may have an immediate need for care.

I understand:

• If I have not shown up within 15 minutes past my scheduled appointment and have not notified the office, it will be considered a No Call, No Show Cancellation. In this case, I will be charged 50% of my appointment cost.

• My care plan payments do not cover payment for missed appointments; therefore, I am responsible for these additional charges when applicable.

• Optional reminder texts, emails, and/or calls can be made 24 hours prior to my appointment, as a courtesy, and that I am expected to be in attendance of my appointment.

I authorize The Source Chiropractic to use the credit card I have on file for these additional charges when applicable. To reschedule your appointment, please call (303) 993- 5769. If you are unable to reach us, please leave a detailed message on our voicemail system available 24 hours a day, 7 days a week. You may also cancel via email: info@sourcechirodenver.com. Thank you for your understanding. We are available to answer any questions you may have. We look forward to caring for you here at The Source Chiropractic!

I have read and agree to the terms of The Source Chiropractic's No Call, No Show Cancellation policy.

Practice Member Name (Please Print): _____

Practice Member Signature: _____ Date: _____

Office Signature: _____

NAME: EVAL COST:
DOB:
DATE:

INITIAL EXAM

Romberg	A-P or L-M	**MOTOR**	Lt. Rt.	**SUBLUXATION**	————
Gillet's	Lt___ Rt___	Delt: C5	/	Occ	T9
L-ROM	Flex: /90	Bicep: C6	/	C1	T10
---	Ext: /30	Tricep: C7	/	C2	T11
---	LF: /30(R)	W. Flx:	/	C3	T12
---	LF: /30(L)	W. Ext:	/	C4	L1
---	Rot: /30(R)	Inteross: T1	/	C5	L2
---	Rot: /30(L)	Psoas: L1-L2	/	C6	L3
C-ROM		Quad: L2-L4	/	C7	L4
---	Flex: /60	TFL: L5/S1	/	T1	L5
---	Ext: /50	QL:	/	T2	S-Base
---	LF: /40(R)	**SENSORY**		T3	S-Apex
---	LF: /40(L)	**ORTHO**		T4	AS
---	Rot: /80(R)	SLR		T5	PI
---	Rot: /80(L)	Prone SLR		T6	Ribs
DvE	+ R or L	Valsalva		T7	Ext (1)
DvF	+ R or L	MCC/Kemps		T8	Ext (2)

Additional Exam Notes: _____

Health Hx: _____ Posture:

Fx Exam: _____ Gait:

Thermography: _____ Squat:

X-Ray: _____ X-Ray Findings:

SOURCE SCORE: ____ Specific Listings:

X-Ray Referral: NorCal – Other _____
2v Cervical _____ 2v Thoracic_____ 2v Lumbar _____ Special Films: _____