thrive
HEALTH SYSTEMS

If we could scientifically pinpoint your problem, reveal it to you in a way you can understand and provide a health care solution that makes sense to you at an affordable price, would you commit to working with us to solve your current problem?

(Circle One)
Yes No

On a scale of 1 to 10, ten being the highest, rate your commitment to getting rid of this problem:
1 2 3 4 5 6 7 8 9 10

Concerns that could interfere with your commitment (time, transportation, other)
Please Specify:

_____

_____

_____

Name: _____ Date: _____

(Last) (First) (Middle Initial)

Address: _____ City: _____, CO Zip: _____

Home #: (_____)_____ Work #: (_____)_____ Cell #: (_____)_____

* Number in priority (1,2,3) the location you prefer us to contact you about your health care: _____ Home _____Work _____Cell

E-mail: _____

Age: _____ Birth Date: ____/____/_____ Sex: _____ Marital Status: M S W D P No. of Children:_____

Emergency Contact: _____ Ph #: (_____)_____ Relationship: _____

Family Doctor:_____Ph# (_____)_____

Who referred you into our office? _____ *OR* How did you hear about our office? _____

Type of Insurance Coverage (Circle One): Private Medicare Med-Pay/Auto Lien Worker's Comp None

Was this caused by an: Auto Accident? _____ Work Related? _____ Date of Accident: _____/_____/_____

Employer/Company Name: _____ Occupation: _____

Work Address: _____ City: _____, CO Zip:_____

Spouse Name: _____ Spouses Employer: _____ Occupation: _____

***If Private or Auto Insurance please give the front desk your card and we'll make a copy ***

Please list your complaint in order of severity and rate on a scale of 0 (no pain) to 10 (excruciating)

1. _____ 0 1 2 3 4 5 6 7 8 9 10
2. _____ 0 1 2 3 4 5 6 7 8 9 10
3. _____ 0 1 2 3 4 5 6 7 8 9 10

Quality of the pain: Sharp Dull Pins& Needles Stabbing Burning Numbness

Radiation: R or L/ Leg or Arm What makes the pain better or worse? _____

Medications: _____

Frequency: Constant Comes & Goes (last flare up) _____

First time the pain happened (date): _____

How is your pain affecting your life?_____

What activities are not enjoyed because of your pain? _____

Fractures_____ Surgeries_____

Have Have you seen a Chiropractor before? Y / N Name: _____

Last Adjustment: _____ X-rayed? Y / N Were you happy with the results? Y / N

Other doctors seen for this condition: MD / DO / Other _____

Are you active / do you exercise Y/N Time per session _____ Type of exercise _____

Does stress contribute to the pain? Y / N

What level of stress are you currently experiencing1 to 10 (1 is the lowest): _____

Please indicate the location and type of pain that you are currently experiencing in the diagram below.

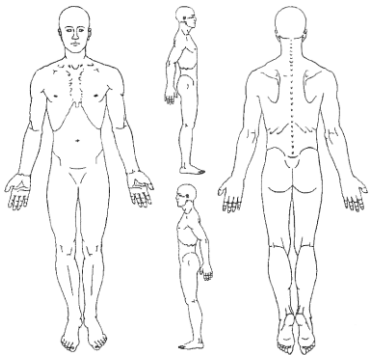
Pins & Needles 0 0 0

Numbness = = =

Stabbing / / / /

Aching a a a a

Burning X X X X



Recent changes in your ability to: Work / Sleep / See / Hear / Taste / Smell / Feel hot or cold sensations / Sit upright / Stand / Walk / Run /Pick up objects /Swing arms freely / Wiggle fingers

Patient Consent for use of Protected Health Information (PHI) For Treatment, Payment, & Healthcare Operations (TPO)

I consent to the use and/or disclosure of my (PHI) by Thrive Health Systems for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills, or conducting health care operations. I understand that diagnosis or treatment of me by Thrive Health Systems may be conditioned upon my consent as evidenced by my signature on this document.

I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future, to pay directly to, and exclusively in the name of Thrive Health Systems.

I understand I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Thrive Health Systems is not required to agree to the restrictions that I request; however, if Thrive Health Systems agrees to a restriction that I request, the restriction is binding to Thrive Health Systems. I have the right to revoke this consent in writing at any time, except to the extent that Thrive Health Systems has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or health care clearinghouse. This PHI relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Thrive Health Systems' Notice of Patient Privacy Practices prior to signing this document. The Thrive Health Systems Notice of Patient Privacy Practices has been provided to me. I have read and understand this notice, and have raised any questions regarding the use of my PHI to Thrive Health Systems HIPAA Compliance Officer. The Notice of Patient Privacy Practices describes the payment of my bills, or in the performance of health care operations of Thrive Health Systems. The Notice of Patient Privacy Practices also describes my rights and Thrive Health Systems', obligations with respect to my PHI. Thrive Health Systems reserves the right to amend the Notice of Patient Privacy Practices. I may obtain a revised Notice by calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment.

Consent to treat

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, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not. I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures. **I understand that results are not guaranteed.** I understand and am informed that , as in the practice of medicine and like all other health modalities, results are not guaranteed, and there is no promise of cure. I further understand and am informed that , as in the practice of medicine, in the practice of chiropractic 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 on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests. I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited to, self –administered, over-the-counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and to secure other opinions if I have concerns as to the nature of my symptoms and treatment options. I also understand that there is no guarantee that insurance will pay for care, and if insurance does not, I (the patient) is responsible for services rendered.

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 I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions(s) for which I seek treatment.

PATIENT SIGNATURE: Patient Guardian/Parent/Representative

_____DATE _____

Email/Text message Privacy Policy

Your email address and text message number will never be used or sold to any other company besides Thrive. It will be used for two and only two reasons: 1) We will email or text you appointment reminders, and 2) We will email you essential, well-research educational materials, as well as free and discounted offers for massage, chiropractic, health and hygiene products, and nutrition. You can unsubscribe from these services as any time.

_____ _____

Signature of Patient or Personal Representative Date

Pregnancy Release

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

Date of last menstrual period: _____ Signature of Patient: _____ Date: _____