BACK TO BASICS HEALTH CENTER

PHONE 303-922-7946 FAX 303-922-7950

Please answer the following questions by **printing clearly**.
Your answers help us provide better service and will be kept completely confidential.

CLIENT INFORMATION

Name:_____ Birthdate:_____
Address: _____ City:_____ State:_____ Zip:_____
Phone Home:_____ Work:_____ Cell:_____
Age:_____ Height:_____ Weight:_____ Gender:_____ Marital Status:_____
Occupation:_____
Emergency Contact:_____ Phone:_____
E-mail Address:_____

MASSAGE INFORMATION

Have you ever received Chiropractic, Acupuncture, Massage therapy before? Yes ❑ No ❑
What physical or therapeutic goals would you like to achieve.

_____ .

Referred by:_____

MEDICAL INFORMATION

Are you currently under a physician's care? Yes ❑ No ❑
If yes, please explain:_____
Physician's Name:_____ Phone:_____
Have you used any alcohol or drugs in the past 24 hours? Yes ❑ No ❑
Please indicate which of the following apply to your family history.

❑ Allergies	❑ Circulation Problems	❑ Heart Attack/Stroke	❑ Pace Maker
❑ Arthritis	❑ Clench/Grind teeth	❑ Heart Condition	❑ Pregnant
❑ Artificial Joints	❑ Depression	❑ Hepatitis	❑ Severe Bruises
❑ Asthma/Cold	❑ Diabetes	❑ HIV/AIDS	❑ Sexually Trans. Disease
❑ Back Pain	❑ Digestive Problems	❑ Inflammation of Joints	❑ Strain/Sprain
❑ Bleeding Disorder	❑ Disk Problems	❑ Insomnia	❑ Stress/Anxiety
❑ Blood Clots	❑ Drug Dependency	❑ Kidney Problems	❑ Surgeries
❑ Blood Pressure	❑ Epilepsy/Seizures	❑ Liver Disease	❑ Thyroid Problems
❑ Broken Bone(s)	❑ Fibromyalgia	❑ Mental Illness	❑ Ulcers
❑ Bursitis	❑ Gallbladder Disease	❑ Neck Pain	❑ Varicose Veins
❑ Cancer	❑ Headaches	❑ Osteoporosis	❑ Wear Contacts

Do you have any of the following today?

❑ Cold/Flu	❑ Inflammation	❑ Open Cut/Bruise/Burn	❑ Severe Pain
❑ Headache	❑ Irritated Skin Rash	❑ Poison Ivy	❑ Sunburn

Notice of Privacy Policy

Back to Basics Health Center
7500 W. Mississippi Ave., #B120 - Lakewood, CO 80226 (303) 922-7946

THIS NOTICE DESCRIBES SOME MEDICAL INFORMATION ABOUT YOU WHICH MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THIS NOTICE WAS EFFECTIVE 4/14/2003 UNTIL FURTHER NOTICE.

Right to Notice
As a patient, you have the right to adequate notice of the uses and disclosures of your protected health information. Under the Health Insurance Portability Accessibility Act (HIPPA), we can use your protected health information for treatment, payment and healthcare operations.

Treatment-we may use and disclose health information to a physician or other healthcare provider providing treatment to you.

Payment-we may use and disclose your health information to obtain payment for services that we provide you.

Healthcare Operations-we may use and disclose health information in connection with our healthcare operations. Healthcare operations include quality assessment and any improvement activities, reviewing the competency or qualifications of healthcare professionals, evaluating provider performance, conducting training programs, accreditation, certification, licensing and credentialing activities.

Your Authorization
Most uses and disclosures that do not fall under treatment, payment, or healthcare operations will require written authorization. Upon signing, you may revoke your authorization (in writing) through our practice at any time.

Emergency Situations
In the event of your incapacity or an emergency situation, we will disclose health information to a family member or another person responsible for your care, using our professional judgment. We will only disclose health information that is directly relevant to the person's involvement in your healthcare.

Marketing
We will not use your health information in marketing communication without your written consent.

Required by law
We may also use or disclose health information when we are required by law.

Abuse or Neglect
We may disclose health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence, or the victim of

other crimes. We may disclose your health information to the extent necessary to avert a serious threat to you or other people's health and safety.

National Security
We may disclose the health information of our Armed Forces to military authorities under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence, and other national security activities. We may disclose health information of inmates or patients to the appropriate authorities under certain circumstances.

Appointment Reminders
We may use or disclose health information to provide you with appointment reminders via phone, e-mail, or letter.

Your Rights as a Patient
You have the right to restrict the disclosures of your protected health information (in writing). The request for restriction may be denied if the information is required for treatment, payment, or healthcare operations.

- You have the right to receive confidential communications regarding your protected health information.
- You have the right to inspect and copy your protected health information.
- You have the right to amend your protected health information.
- You have the right to a paper copy of this notice of privacy practices.

Legal Requirements
Back to Basics independent practitioners are required by law to maintain the privacy of your protected health information. We are required to abide by the terms of this notice as it is currently stated, and we reserve the right to change this notice. The policies in any new notice will not be in effect until they are posted to this site, or available within the office.

Complaints
If you have complaints regarding the way your protected health information was handled, you may submit a complaint in writing to our office. You will not be retaliated against in any manner for a complaint.

Sharing Information
If and when we believe it is necessary to share your protected information in any situation that is not included in the above paragraphs, we will first seek special written permission from you.

I have received, read and understand this notice of privacy policy and understand I may receive a copy of it upon request.

Signature of Patient or Parent/Guardian _____

Date _____

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Name:_____ Date:_____

Please list all medications you are currently taking:

Medication	Dosage	Reason/Condition

Please list all supplements (vitamins, minerals, herbs) you are taking:

Please list the amount and frequency you consume:

Substance	Amount	Frequency
Alcohol		
Tobacco		
Coffee		
Recreational Drugs-Type		

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Please answer the following questions as completely and as detailed as possible. Even minor symptoms help to form an accurate medical diagnosis. All information is kept private and confidential. Information contained here and in your file cannot be released or shared with anyone without your prior written consent.

Name:_____ Date:_____

What is your chief complaint, illness or injury?

_____

_____

When did it begin?

_____

_____

What caused it?

_____

_____

What makes it better?

_____

_____

What makes it worse?

_____

_____

What other treatments or healing modalities have you tried?

_____

_____

Please list all secondary complaints:

_____

_____

Please list what you hope to gain from acupuncture, chiropractic, or massage therapy or herbs:

_____

_____

Please list any surgeries or hospitalizations, including ailment and date:

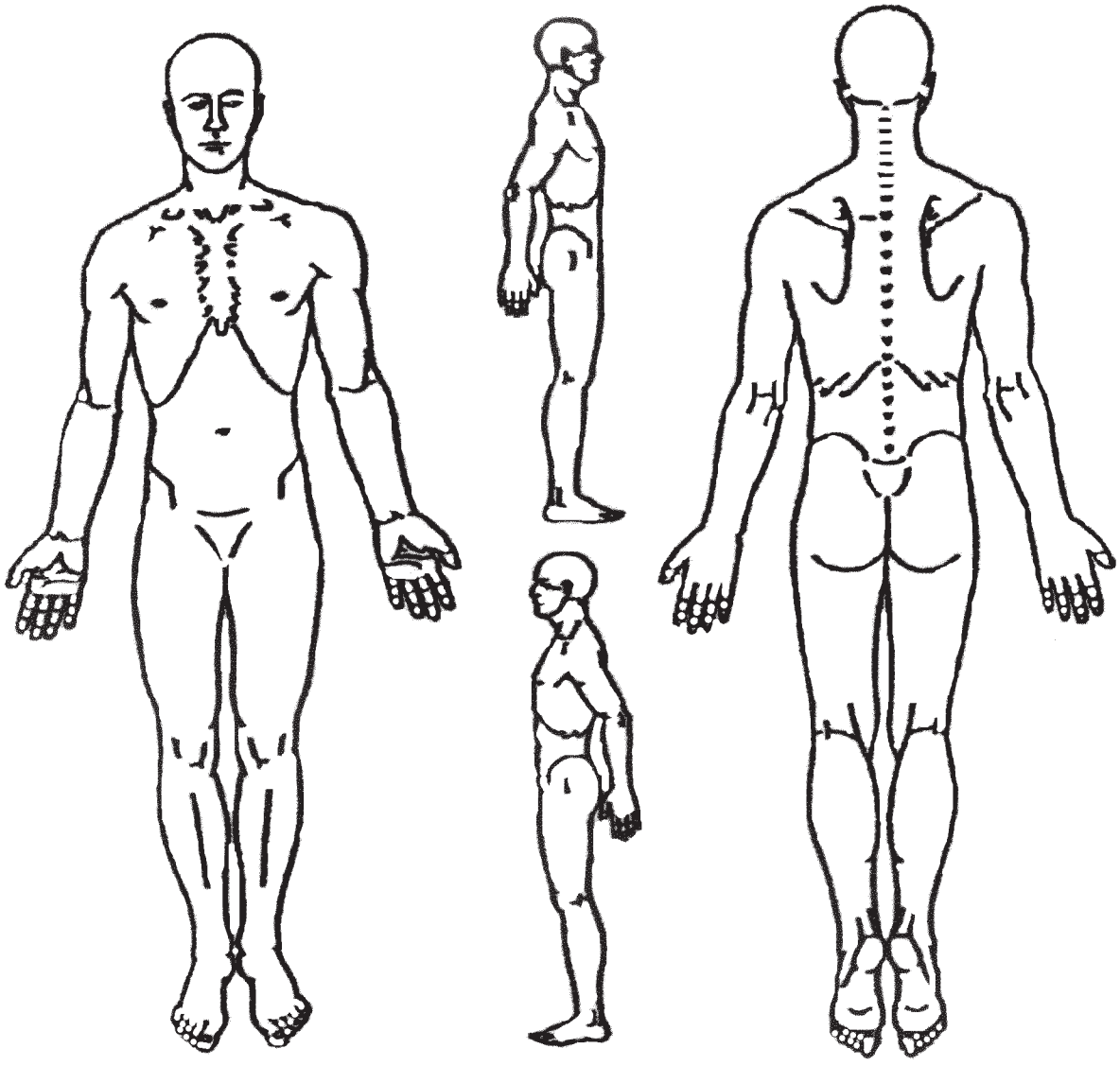
_____

_____

SYMPTOM SURVEY FORM

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY
A=Ache
B=Burning
N=Numbness
O=Other
P=Pins and Needles/Tingling
S=Stabbing/Shooting
W=Weakness



Please indicate the level of pain you are experiencing

No Pain **Severe Pain**

0 1 2 3 4 5 6 7 8 9 10

Patients Signature _____ **Date**_____