FRONT RANGE
FAMILY HEALTH & CHIROPRACTIC

Dr. Kellen P. Schweitzer, DC
Dr. Branden R. Ramos, DC
1732 Topaz Drive Loveland, Co 80537 (970) 667-4062
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Auto Accident

Welcome! Please allow our staff to photocopy your driver's license and all available insurance cards.

PLEASE PRINT

Date _____

Full Name_____ **Home Phone**_____ **Cell Phone**_____

Preferred Name/Nickname_____ **Fax Number**_____

Address _____ **City** _____ **State** _____ **ZIP** _____

Age _____ **Birth Date** _____ **Gender:** M F **Marital Status:** S M W D Sep **# of Children**_____

Email _____ **SS#**_____ **Driver's License #**_____

Sign up for text appointment reminders ☐

Your Employer _____ **Your Occupation** _____ **Years on Job** _____

Employer Address _____ City _____ State ____ ZIP _____

Work Phone _____ Do ***you*** have health insurance at work? Yes No

Insurance Company _____ Plan/Group #_____ Cert #_____

Spouse_____Occupation_____Employer_____

How did you hear about our office? _____

Referring Doctor _____ Friend _____

Name & Phone Number of Emergency Contact _____

Family Medical Doctor_____OB/GYN_____Dentist_____

Reason for your visit today? (Please list areas of pain) _____

Is your condition due to an accident? Yes No Date of your Accident: _____

Please complete the following information only if your complaint was a result of an accident.

Accident Information

Did this injury occur as a result of a Car Accident, Fall or other Personal Injury? Yes _____No _____

Did this injury occur at work (Workers' Compensation)? Yes _____No _____

Please circle any and all insurance coverage that may be applicable in this case:

π Health Insurance π Medicare π Worker's Compensation π Auto Accident π Other

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if any): _____

Financial Policy: Our recommendations are based on a desire to see you get well and stay well. Chiropractic care is covered under many insurance plans. Regardless of your coverage, we will suggest the chiropractic care that we think you need. We ask that you read and understand our policy as it applies to your particular situation.

Insurance: Your health and accident insurance policies are an agreement between you and your insurance company. When possible, our office will call to verify benefits as a courtesy to you; however, the benefits quoted to us by your insurance company are not a guarantee of payment. Any co-pays or known deductible amounts will be collected at the time of service. Our office will complete any necessary insurance forms and file them with your insurance company at no additional charge. It is to be understood and agreed that any services rendered are charged to you directly and you are personally responsible for payment of any non-covered services, deductibles or co-pays.

Authorization and Release: I authorize payment of insurance benefits directly to the chiropractor or chiropractic office.

I authorize the doctor and the staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any consequences thereof.

I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage.

I authorize assignment of my insurance rights and benefits directly to the provider for services rendered.

I understand the above and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to immediately inform this office of any changes in my medical or account status.

I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I agree that a photostatic copy of this agreement shall serve as the original.

I have read and understand the payment policy of Front Range Family Health & Chiropractic. I agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I understand that my insurance is an arrangement between myself and my insurance company, NOT between Front Range Family Health & Chiropractic and my insurance company. I request that Front Range Family Health & Chiropractic prepare the customary forms at no charge so that I may obtain insurance benefits. I also understand that if my insurance does not respond within 60 days, or if I suspend or terminate my schedule of care as prescribed by the doctor at Front Range Family Health & Chiropractic that fees will be due and payable immediately.
I agree that a photostatic copy of this agreement shall serve as the original.

AUTO INSURANCE INFORMATION

Insurance Company Name_____ Agent's Name_____

Claim's Mailing Address_____

City State Zip

Agent's Phone(_____)_____

Insured's Name_____ Policy #_____ Claim#_____

Insured's SS#_____ Insured's date of birth_____

Insured's relationship_____ Insured's employer_____

(Please Initial)_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered (if offered at this office).

Patient's Signature _____ Date _____

Spouse's or Guardian's Signature _____ Date _____

Pain Drawing:

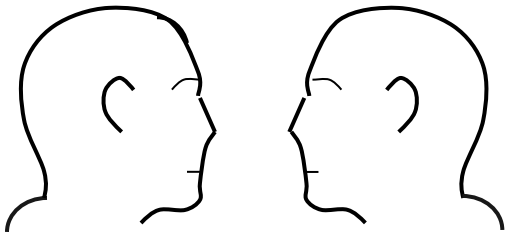
TELL US WHERE YOU HURT.

Please read carefully:

Mark the areas on your body where you feel your pain. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels. Use the appropriate letter(s) listed below. Place the letters and the corresponding pain in the proper place on the body below.

SUBJECTIVE PAIN ASSESSMENT

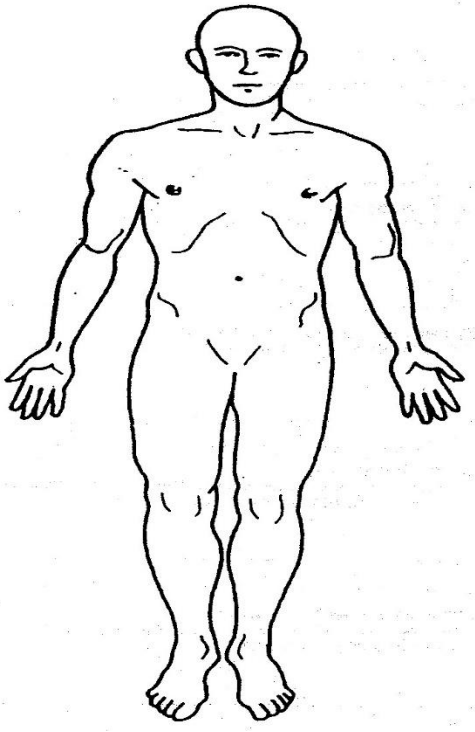
Right **Left**



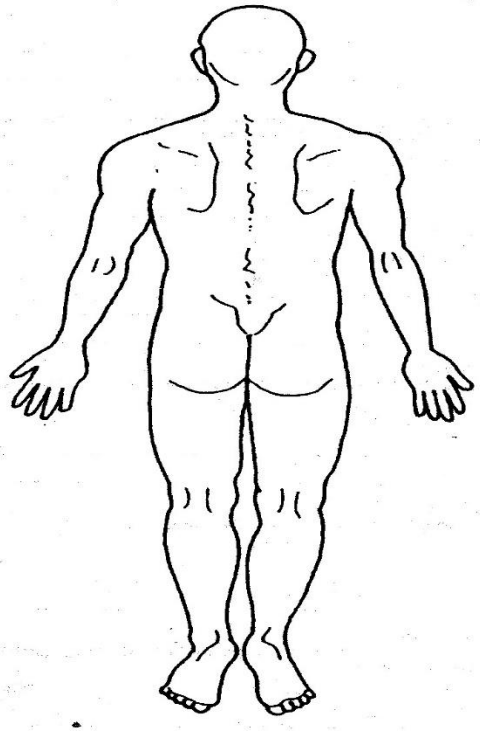
RATE YOUR PAIN

A=Aching
B=Burning
SH=Sharp
ST=Stabbing
SP=Spasm
N=Numbness
P=Pins and Needles
T=Throbbing

Front



Back



AUTO RELATED ACCIDENT

Please circle or answer all questions.
Date of Accident_____
Were you the: Driver Front Passenger Rear Passenger
Number of people in accident vehicle_____
Did the police come to the accident site: Yes No
Was a police report filed? Yes No
Were you wearing your seat belt? Yes No
Was this vehicle equipped with airbags? Yes No
If yes, did it/they inflate? Yes No
In relation to the base of your skull, where was the headrest?
Above Below At base of skull
During impact, were you facing? Right Left Forward
Were you ____aware or ____surprised by the impact?
Did any part of your body strike anything in the vehicle? Yes No
If yes, please describe_____
What did your vehicle impact? Another vehicle
Other (please describe) _____
Did the impact to your vehicle come from the
Front Rear Right Side Left Side Other
Make & model of the vehicle you were occupying:
_____
Name of the location/street on which you were traveling:
_____
In which direction were you headed? North South East West
What was the approximate speed of your vehicle? _____
If another vehicle made impact with your vehicle . . .
Make & model of that other vehicle_____
Direction other vehicle was headed?
North South East West
Speed of the other vehicle_____

AFTER INJURY

Did accident render you unconscious? Yes No
If yes, for how long? _____
Please describe how you felt immediately after the accident: _____
_____
Have you gone to a hospital or seen any other doctor? Yes No
When did you go? Just after accident ____
the next day ____ 2 days plus____
How did you get there? Ambulance____ or
Private transportation ____
Name of hospital and/or attending doctor: _____
_____
Describe any treatment you received_____
_____
Were X-rays taken? Yes No
Was medication prescribed? Yes No
Have you been able to work since this injury? Yes No
Are your work activities restricted as a result of this injury? Yes No

AFTER INJURY Continued

Indicate the symptoms that are a result of this accident:

Place an "X" next to all that apply:

___ Neck Pain
___ Neck Stiffness
___ Upper Back Pain
___ Mid Back Pain
___ Lower Back Pain
___ Back Stiffness
___ Headache(s)
___ Tension
___ Difficulty Sleeping
___ Arm/Shoulder Pain
___ Leg/Hip Pain
___ Numb Hands/Fingers
___ Numb Feet/Toes
___ Chest Pain
___ Shortness of Breath
___ Fatigue
___ Irritability
___ Dizziness
___ Memory Loss
___ Nausea
___ Upset Stomach
___ Blurred Vision
___ Buzzing Ear(s)
___ Ringing Ear(s)
___ Other

Is your condition getting worse (Circle One)?
Yes No Constant Comes & goes

RECOVERY

To evaluate the effect that continuing work will have on your recovery, please complete the following:
How many hours are in your normal work day? _____
Please indicate your daily job duties and any activities which you are occasionally asked to perform.

__Standing __Driving __Operating equipment
__Sitting __Twisting __Work w/arms above head
__Walking __Crawling __Typing
__Lifting __Bending __Stooping

Other_____
_____

What positions can you work in with minimum physical effort and for how long? _____
_____
Prior to the injury, were you capable of working on an equal basis with others your age? Yes No N/A
Do you work with others who can help you with any heavy lifting? Yes No N/A
While in recovery, is there any light duty work you could request? Yes No N/A

1. Have you ever had any previous chiropractic experience?
   Manual Adjustments _____ Instrument Adjustments _____ None _____
   Acupuncture _____ Rehabilitation Therapy _____ Other: _____
2. In your words, please describe the auto accident if not all details were covered above:

   _____
   _____
3. What is your major symptom(s)?

   _____
4. What does this prevent you from doing or enjoying?

   _____
5. What are your primary goals you hope to achieve with chiropractic care?

   _____
6. If this is a reoccurrence, when was the first time you noticed the problem?

   _____
   • How did it originally occur? _____
7. Has it become worse recently? Yes ___ No ___ Same ___ Better ___ Gradually Worse ___
   If yes, when and how? _____
8. How frequent is the condition? Constant ____ Daily ____ Intermittent ____ Night Only ____
   How long does it last? All Day ____ A Few Hours ____ Minutes ____
9. Are there any other conditions or symptoms that may be related to your major symptom?
   Yes ____ No ____ If Yes, please describe _____
10. Describe the pain: Sharp ___ Dull ___ Numbness ___ Tingling ___ Aching ___Throbbing ___
    Tight/Stiff ___ Burning ___Stabbing ___ Other: _____
11. Is there anything that you can do to relieve the problem? Yes ____ No ____
    If yes, please describe: _____
    If no, please let us know what you have tried that didn't work: _____
    _____
12. What makes the problem worse? Bending _____ Lifting _____ Lying _____ Sitting _____
    Standing _____ Twisting _____Other: _____
13. WOMEN ONLY: Are you pregnant or is there any possibility that you may be pregnant?
    Yes _____ No _____ Uncertain _____

PAIN SCALE: Please circle the number that best describes your overall pain:

0	1	2	3	4	5	6	7	8	9	10	10+
NONE		LITTLE			MEDIUM			SEVERE			EXCRUCIATING

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Past Medical History:

1. Have you been hospitalized or had any surgeries? Yes _____ No _____
   If yes, when did it take place, for what condition, and what was the result? _____
   _____

2. Have you had any trauma or been involved in any accidents (*Car, Work, Falls, etc…)?* Yes ___ No ___
   If yes, when, what type of trauma/accident, were you injured and what type of care did you receive? _____
   _____

3. Have you had any broken bones, dislocation or sprains? Yes _____ No _____
   If yes, please describe the area of injury, when and how it happened: _____
   _____

4. Have you been diagnosed with any childhood illness(es) *(Measles, Chickenpox, Mumps, Scarlet Fever, Rheumatic Fever, Diabetes, Cancer, Birth Defects, etc…)* ? Yes _____ No _____
   If yes, which illness(es)? _____
   _____

5. Do you have any Congenital Conditions? Yes ___ No ___ If yes, please describe: _____
   _____

6. Have you been diagnosed with any illness(es) as an adult *(Shingles, Diabetes, Cancer, High Blood Pressure, etc)* ? Yes _____ No _____
   If yes, which illness(es)? _____

7. Have you been treated for any health condition by a physician in the last year? Yes_____ No _____
   If yes, please describe: _____

8. Do you have any allergies to any medications? Yes _____ No _____
   If yes, please describe: _____

9. Do you have allergies of any kind? Yes _____ No _____
   If yes, please describe: _____

10. Have you ever had x-rays, MRI, or CAT Scan of your body? Yes _____ No _____
    If yes, when and for what reason? _____

11. WOMEN ONLY: Please include information, if any, about childbirth (include date): _____
    _____

Habits and Social History:

1. Do you use: Caffeine: Cups per day ____ Tobacco/Packs per day ____
   Alcohol: Drinks per month ____ Recreational Drugs (yes/no) ____ (If yes what kind)_____

2. Please describe your work:
   Type: __Professional __Physical Labor __Driver __Clerical __Factory __Homemaker
   Physical Demands: __Heavy __Moderate __Mild __Sedentary
   Stress Level: __High __Medium __Low

3. Exercise: None ___ Moderate ___ Vigorous___ Daily ___ Type? _____

4. Your Diet is: ____Balanced ____Fair ____Poor ____Excessive ____Restricted

5. Do you have: Family Pressures ____ Financial Pressures ____ Other Mental Stresses ____

6. In what position do you usually sleep, and how well?
   _____

7. Are you wearing (please circle) Heel Lifts, Sole Lifts, Inner Soles, Arch Supports?

8. Medications:

   If not taking any please check here: _____

   Please list all medications (prescription, non-prescription & vitamins/herbs) you are taking or take on an occasional basis:
   _____
   _____
   _____

Review of Systems:

Have you had or do you now have any of the following symptoms/conditions? Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions **previously**.

N = Now **P** = Previously

Headaches_____ Frequency _____
Neck Pain _____
Stiff Neck _____
Muscle Spasms _____
Back Pain _____
Tension _____
Shoulder/Arm Pain _____
Leg Pain _____
Joint Pain/Swelling _____
Rheumatoid Arthritis _____
Osteoarthritis _____
Numbness in Fingers _____
Numbness in Toes _____
Weakness in Extremities _____
Dizziness _____
Loss of Balance _____
Fainting _____
Ears Ringing _____
Loss of Smell _____
Loss of Taste _____
Light Bothering Eyes _____
Chest Pain/Tightness _____
Heart Disease _____
High Blood Pressure _____
Low Blood Pressure _____
High Cholesterol _____
Pacemaker _____
Circulation Problems _____
Cold Hands _____
Cold Feet _____
Asthma _____

Difficulty Breathing _____
Frequent Colds _____
Sinus Problems _____
Fever _____
Indigestion _____
Unusual Bowel Pattern _____
Eating Disorder _____
Gallbladder Problems _____
Ulcers _____
Irritability _____
Nervousness _____
Sleeping Problems _____
Fatigue _____
Weight Loss _____
Weight Gain _____
Depression _____
Loss of Memory _____
Buzzing in Ears _____
Seizures/Epilepsy _____
Diabetes _____
Excessive Bleeding _____
Osteoporosis _____
Broken Bones/Fractures_____
Difficulty Urinating _____
Menstrual Difficulties _____
Drug Addiction _____
Alcoholism _____
HIV/Hep C Positive _____
Coughing up Blood _____
Cancer _____
Stroke _____

Family History:

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER Age [ ]	MOTHER Age [ ]	SPOUSE Age [ ]	BROTHER(S) Age [ ] Age [ ]	SISTERS Age [ ] Age [ ]	CHILDREN Age [ ] Age [ ]
Arthritis						
Asthma-Hay Fever						
Back Trouble						
Bursitis						
Cancer						
Constipation						
Diabetes						
Disc Problems						
Emphysema						
Epilepsy						
Headaches						
Heart Trouble						
High Blood Pressure						
Insomnia						
Kidney Troubles						
Liver Problems						
Lung Disease						
Migraine						
Nervousness						
Neuritis						
Neuralgia						
Pinched Nerve						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Other:						

If any of the above family members are deceased, please list their age at death and cause:

_____

I certify the information provided is accurate to the best of my knowledge:

Name of Patient _____

Signature of Patient/Legal Guardian _____

Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

- The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed to what the insurance companies require for payment.

The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Identification of Persons with Authorization of Access to Patient Health Information

Those individuals or parties that could have access to Patient Health Information at Front Range Family Health & Chiropractic include but may not be limited to:

The Staff of Front Range Family Health & Chiropractic. This includes:

_x_ Dr. Kellen P. Schweitzer, DC

_x_ All Chiropractic Assistants

Necessary health care providers or family members who may need to be consulted if related to the patient's condition. This includes:

_____ _____

_x_ Your Primary Care Physician

Name: _____

Medical Group/Office: _____

City: _____ State: _____ ZIP _____

_____ _____

Patient or Authorized Representative Signature Date

Informed Consent for Chiropractic Care

In coming to Dr. Schweitzer, you give the doctor permission and authority to care for you, the patient, in accordance with the chiropractic tests, diagnosis, and analysis. Dr. Schweitzer is licensed in chiropractic and is available to work with other types of providers in your health care regime. Dr. Schweitzer will use his hands or a mechanical instrument upon your body in such a way as to move your joints. This procedure is referred to as "Spinal Manipulation" or Spinal Adjustment" As the joints in your spine are moved, you may experience a "pop" as part of the process.

The chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities, or pathologies may render a patient susceptible to injury. Dr. Schweitzer will not give any treatment or health care if he is aware that such care may be contra-indicated. It is the responsibility of the patient to make it known should they be aware of any conditions they may have. There are certain complications that can occur as a result of a spinal manipulation. These complications include, but are not limited to: muscle strain, cervical myelopathy, disc and vertebral injury, fractures, strains and dislocations, Bernard-Horner's Syndrome (also known as oculosympathethetic palsy), costovertebral strains and separation. Rare complications include, but are not limited to stroke. The most common complication or complaint following spinal manipulation is an ache or stiffness at the site of adjustment.

Dr. Schweitzer is aware of these complications, and in order to minimize their occurrence he will take precautions. These precautions include, but are not limited to taking a detailed clinical history of you and examining you for any defect which would cause a complication. This examination may include the use of x-rays. The use of x-ray equipment may pose a risk if you are pregnant. If you are pregnant, you should tell Dr. Schweitzer when he takes your clinical history. I understand that if I am accepted as a patient by Dr. Schweitzer at Front Range Family Health & Chiropractic, I am authorizing him to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

DATE _____

_____
Printed Name

_____
Patient or Authorized Representative Signature

Photo/Announcement Release:

I, Patient Name (please print) _____, give Front Range Family Health & Chiropractic permission to use my name and picture in its patient newsletter and on any office bulletin or other notice boards for purposes of announcing births, birthdays, weddings, graduations or acknowledging my referrals.

Initial _____

Missed Appointment Policy

We want to thank you for choosing us as your chiropractic health provider. In order to provide you and our other patients with the best optimal spinal care, we request that you follow our guidelines regarding broken and/or cancelled appointments. Please remember that we have reserved appointment times especially for you. Therefore, we request at least 24 hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients that desire to get their treatment completed. When you cancel your appointment at the last minute, everyone loses – you, the doctor and other patients that would like to have utilized the appointment time.

Our office does reserve the right to charge for missed appointments without 24 hour notice. Thank you for your consideration of our policies and for the opportunity to be your chiropractic office of choice.

Initial _____