

Your Name: _____ Today's Date: _____

Address: _____ _____ Telephone #s: (hm) _____ (wk) _____ (cell) _____ Your email address: _____ Your Employer: _____ Employer's Address: _____ Your Occupation: _____ Your Spouse's Name: _____ Your Spouse's Date of Birth: _____ Your Spouse's Employer: _____ Your Spouse's Occupation: _____	Your Date of Birth: _____ Age: _____ Gender assigned at birth: M F Preferred gender identity now: _____ Your Personal Social Status: S M D W DP CU FT Employed _____ PT Employed _____ Retired _____ FT Student _____ PT Student _____ What is the cause of your symptoms?: Your employment? Y N A vehicle crash? Y N What state? _____ Home accident? Y N Illness? Y N Unknown? Y N How did you hear about our office? _____ _____
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Do you have any previous chiropractic experience? Y N

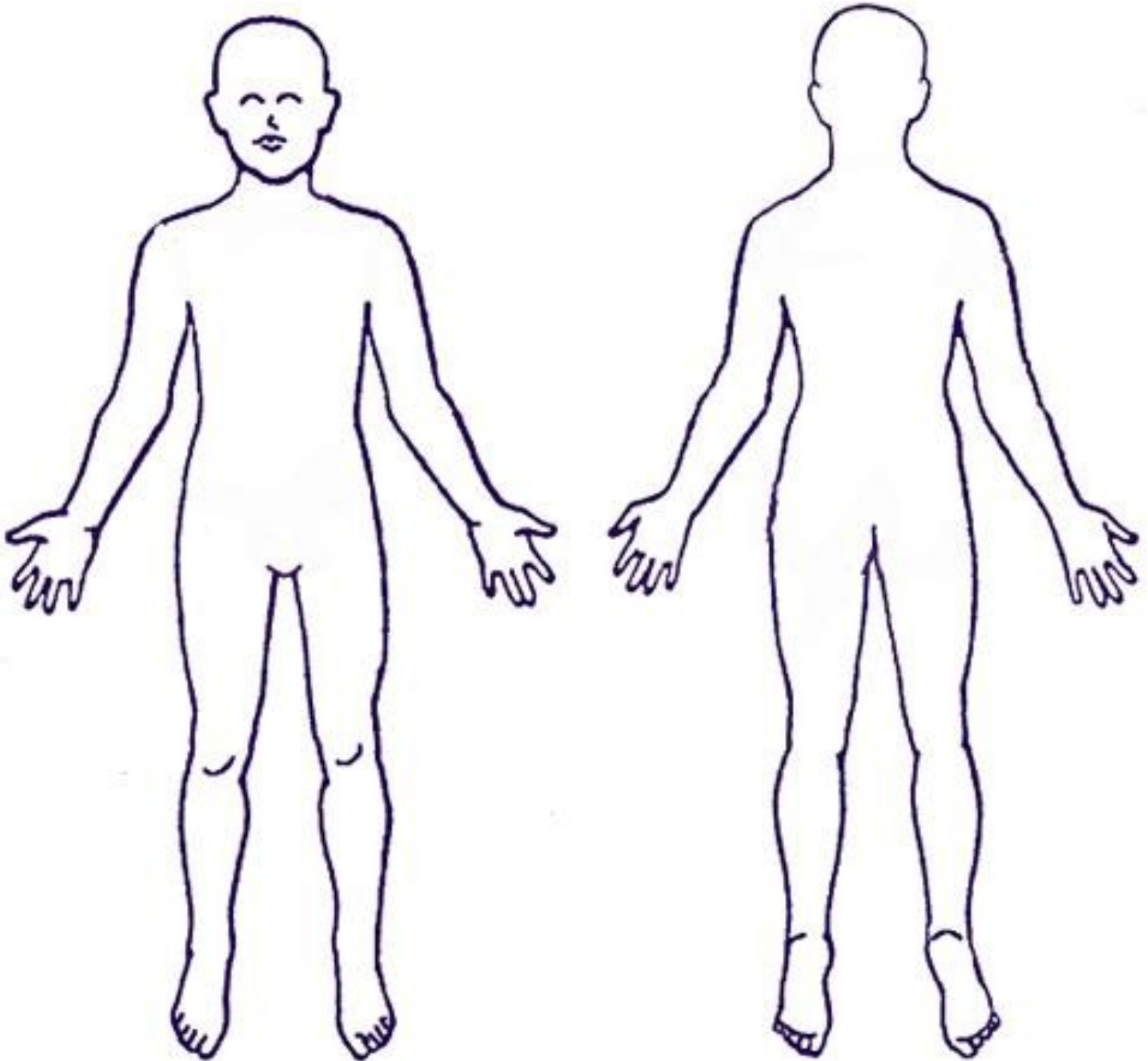
Do you see primary care physicians or medical specialists regularly? Y N If so, please list their names and specialties, and the approximate date of your last visit. _____

How many prescription and over the counter medicines are you currently taking? _____ Who is monitoring your use of these medicines? _____
Please list any condition that the doctor here should be aware of: _____

Is there any chance that you are pregnant at this time? Y N If so, how many weeks? _____
Name of your Midwife: _____
Doula: _____
OB: _____
EDD: _____
Where will you be delivering? _____

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Please use this figure to show us where your pain/symptoms are. Mark each area of pain or symptoms with an X. The doctor will discuss each one with you during your visit.



The Human Joint

455 South Hudson Street Suite 103 Denver, Colorado 80246
Phone: 720-524-7747
www.thehumanjoint.com

Your Name: _____ Today's Date: _____

Please mark a small **vertical line** at the location on the scales below that most closely describes your "Activities Of Daily Living" and your daily experience at this time.

Pain Frequency ● _____ ●
Never Constant (100% of the time)

Pain Intensity ● _____ ●
No Pain Worst Possible Pain

Personal Care ● _____ ●
No Restrictions Need 100% Assistance

Travel (Driving, riding, etc.) ● _____ ●
No Pain Unable to Travel
(even on long trips)

Work (Home & Office) ● _____ ●
Working Without Pain Unable to Work

Recreation ● _____ ●
Doing All Activities Unable to Play at all

Sleeping/Rest ● _____ ●
Perfect Sleep/Rest Unable to Sleep/Rest

Lifting ● _____ ●
No Pain With Any Weight Unable to Lift

Walking ● _____ ●
No Pain With Any Distance Unable to Walk

Standing ● _____ ●
No Pain After Several Hours Unable to Stand

Your Name: _____ Today's Date: _____

The Doctor-Patient Relationship

Informed Consent

Please discuss any questions that this agreement brings up with a doctor before signing.

Chiropractic health care seeks to restore health through natural means without the use of drugs or surgery. This gives the body maximum opportunity to utilize its innate healing powers and heal itself.

A Doctor of Chiropractic conducts analysis for the purpose of determining whether there is evidence of Vertebral Subluxation Complex (VSC). Chiropractic adjustments and ancillary procedures may be administered in an attempt to restore spinal integrity. Due to the complexities of the human body and nature, no doctor can promise you specific results. Every chiropractic patient should be mindful of his or her own symptoms and should seek other opinions if he or she has any concern as to the nature of his or her total condition. You are always responsible for the decisions which concern your health.

In coming to this office and signing this form, you have granted all of the Doctors of Chiropractic at The Human Joint, and any qualified visiting Doctor of Chiropractic, permission and authority to examine and treat you or your minor child. You authorize the performance of chiropractic adjustments and other chiropractic procedures, as well as various modes of adjunctive therapy. The chiropractic adjustment and other clinical procedures are usually beneficial and seldom cause any problem. However, in rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The Doctor of Chiropractic will not render a chiropractic adjustment or other procedures if they are aware that such care may be contra-indicated. The doctors will not be responsible for any pre-existing medically diagnosed condition or for any medical diagnosis of which they have not been made aware. We also want you to be comfortable. Therefore, if you would like to stop, for any reason, at any point during examination or treatment, please make this known to the doctor.

I have read, and I understand the above statement of Informed Consent.

Signed: _____

Date: _____

Financial Agreement

Please discuss any questions that this agreement brings up with a doctor before signing.

I agree that I am responsible for all expenses incurred at The Human Joint. If I have insurance, I understand that my insurance benefits exist as part of a contract between me and my insurance company, and that The Human Joint may provide insurance paperwork as a convenience to me.

With this signature, I hereby commit to pay for services at the time they are rendered.

I have read, and I understand the above Financial Agreement.

Signed: _____

Date: _____

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