New Patient Intake

Date:_____ How did you hear about us?_____

Name:_____

Date of Birth:_____ Age:_____ Gender ❑ M ❑ F

Address:_____ City:_____ State:_____

Zip:_____ Personal Phone:_____ Email:_____

Occupation:_____ Employer:_____

Work Phone:_____ Spouse Name:_____

Spouse Occupation:_____ # Children:_____

Payment Information

Our initial evaluation fee is $99. We do NOT accept insurance or Medicare for this initial evaluation fee. It includes your consultation, chiropractic examination, and first treatment. Dr. Ruppel will discuss your treatment options and fees after reviewing your initial examination and health history.

Health Insurance Company (if applicable, please present cards):_____

Do you have MEDICARE? ❑ No ❑ Yes Medicare Supplemental Company:_____

If you have insurance, do you want us to bill them? ❑ No ❑ Yes

Payment Policies Agreement

I understand and agree that I am responsible for any uncovered charges for any services that the insurance doesn't pay for any reason. I understand and agree that if I ask that insurance be billed, that the office will generally use the State of Colorado workers comp fee schedule; and I hereby assign my insurance company/Medicare or their intermediaries to pay Dr. Ruppel health care benefits directly at his business address as determined under Colorado law C.R.S 10-16-106.7 (assignment of health insurance benefits), to bill insurance for each medical service performed, and assign Dr. Ruppel to release any administrative or medical information necessary to process insurance claims. I understand there is a $35 charge for returned checks.

Privacy Disclosure (Updated: 1/1/2017): This office conforms to the current HIPAA guidelines and policies for health information. A privacy policy is posted in the reception area at all times and you may request a printed copy if desired. I hereby authorize that my medical records may be forwarded to my other healthcare providers in the best interest of my healthcare or insurance payors in order to process claims information. I understand that Dr. Ruppel provides regular care in an open, multiple-patient treatment area format and that if I have specifically confidential information to share, I will request and be provided private room consultation. I understand that omission of information on this health history, my compliance with care, and providing Dr. Ruppel with accurate health condition updates will directly affect the ability of providers at Thirty3 Chiropractic to come to proper diagnoses and provide safe and standard care and I agree to hold harmless Dr. Ruppel for any act of information omission on my part.

I hereby understand and agree to the privacy and payment policies and that the fee schedules are reasonable. I consent to chiropractic diagnostic and treatment procedures to be performed by Dr. Joel A. Ruppel, D.C.

Patient Signature (or guardian)_____ Date _____

Version: 9.14.2018

Name_____ **Date**_____

What is the reason for your visit today? Please write down anything you want the doctor to know:_____

When did your symptoms start?_____ Have you had these symptoms before? □**Yes** □**No**

What caused your symptoms? _____

Is this an injury from Work or is this a Worker's Compensation claim? □**Yes** □**No**

How often are you feeling your symptoms? (circle one): Constantly Frequently Occasionally Rarely

Describe your symptoms (circle all applicable):

dull sharp throbbing burning deep aching tingling stabbing cramping numbness radiating stiffness

How are your symptoms progressing? Getting Worse Not changing Getting Better

TODAY How severe are the symptoms on a scale of 1-10? (circle) 1 2 3 4 5 6 7 8 9 10

AVERAGE IN THE PAST WEEK - how severe have the symptoms been? 1 2 3 4 5 6 7 8 9 10

How much are your work or daily activities affected? Extremely Quite-a-Bit Moderately Little-bit None

Who else have you seen for these symptoms? Chiropractor MD-Physician Physical Therapist Masseuse Other:_____

Do you consider your condition to be severe? Yes Yes, at times No

What makes it worse?_____ **What makes it better?**_____

What concerns you the most about this problem (circle one or more)? Affecting Relationships Affecting Work Could be serious Isn't going away Affecting Leisure Activities It's Getting Worse Affecting Sleep

Other (please explain):_____

In general, how would you rate your current overall health? Excellent Very-good Good Fair Poor

When was your most recent Chiropractic Visit?

Year:_____ Reason:_____

When was your most recent spinal x-ray taken?

_____

Have you had any MRIs or CT scans taken of your problem areas? □**No** □**Yes** _____

When were your most recent blood or urine tests?

_____/____/_____

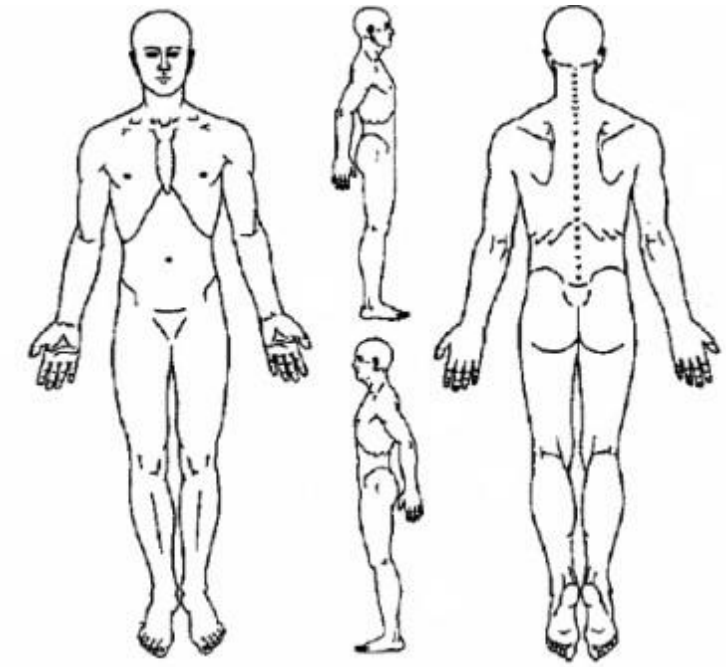
Name of Your Primary Medical Physician:

_____

Do you see other types of Providers REGULARLY?

(**Circle):** acupuncturist, personal trainer, naturopath, physical therapist, massage therapist, other:

Mark your problem areas on the drawing below



DOCTOR'S NOTES:

Tech:

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Lifestyle

Tobacco Use: ☐ Non-smoker ☐ Less than 1 pack/day ☐ 1-2 packs/day ☐ More than 2 packs/day ☐ Former smoker

Alcohol Use: ☐ No alcohol use ☐ Light/moderate drinker ☐ Heavy drinker ☐ Binge drinker ☐ Former alcoholic

Activity Level: ☐ Light physical activity ☐ Moderate physical activity ☐ Vigorous physical activity ☐ Sedentary lifestyle

Medical History

Hospitalizations: _____

Surgeries: _____

Prior Accidents/Injuries: _____

Ongoing Illness: _____

Allergies: _____

Current Medications: _____

Family History: _____

Social History: _____

Sexual History: _____

Previous Tests: _____

Medical Procedures: _____

Dietary Habits: _____

Nutritional Supplements: _____

Prior Chiropractic Care: _____

Last known: Height_____ **Weight**_____ **Blood Pressure** _____/_____ ❑ **Don't know**

***THESE ARE IMPORTANT RED-FLAG INDICATORS FOR THE DOCTOR. DO *NOT* SKIP ANY PORTION OF THE NEXT 2 PAGES!!!**

Review of Symptoms

General:

□ Lethargy/Weakness
□ Recurring Fever
□ Recent weight gain or loss
□ Dizziness
□ Fever
□ Chills
Other: _____

Heent:

□ Headaches or migraines
□ Eye or vision problems
□ Eyeglasses or contact lenses
□ Nose bleeds
□ Eye Surgery
□ Cataracts
□ Glaucoma
□ Sore throat
□ Hoarseness
□ Swollen glands
□ Nose congestion or sinus trouble
□ Ear or hearing problems
□ Dental problems
□ Gum problems
□ TMJ problems
□ Postnasal drip
Other: _____

Skin/Hair:

□ Skin trouble or rashes
□ Flushing
□ Excessive acne
□ Eczema
□ Psoriasis
□ Skin cancer
□ Skin pigmentation issues
□ Change in hair or nails
□ Blood in stool
□ Easy bruising
□ Gum bleeding
Other: _____

Cardiovascular:

□ Chest pain or tightness
□ Heart attack

□ Shortness of breath
□ Palpitations
□ Swelling of feet or hands
□ High blood pressure
□ High cholesterol or triglycerides
□ Heart murmur
□ Blood clots
□ Pacemaker
□ Mitral valve prolapse
□ Congenial heart defects
□ Rheumatic fever
□ Leg pain upon walking
□ Varicose veins
□ Dizziness
□ Excessive bruising
□ Coronary heart disease
Other: _____

Respiratory:

□ Persistent cough
□ Spitting up blood
□ Asthma or wheezing
□ Shortness of breath
□ Exercise intolerance
□ Sleep apnea
□ Emphysema
□ Snoring issues
□ Tuberculosis
□ Pneumonia
□ Breathing
□ Hay Fever
Other: _____

Gastrointestinal:

□ Loss of appetite
□ Nausea or vomiting
□ Diarrhea
□ Constipation
□ Abdominal pain
□ Stomach ulcer
□ Bloating/cramping
□ Heartburn
□ Hemorrhoids
□ Hepatitis
□ Cirrhosis
□ Difficulty swallowing
□ Jaundice
□ Liver disease
□ Gallbladder problems
□ Pancreatitis
□ Change in bowel habits
□ Black or bloody stool
□ Colon cancer or colon polyps
□ Food sensitivities
□ Irritable bowel syndrome
□ Crohn's disease
□ Gastric reflux
□ Colitis
Other: _____

Neurological:

□ Frequent headaches
□ Migraines
□ Dizziness
□ Fainting
□ Memory loss
□ Poor balance
□ Numbness or tingling
□ Pins and needles
□ Epilepsy or seizures
□ Stroke
□ Tremors
□ Head injury
□ Anxiety and/or panic
□ Depression
□ Sleeping issues
□ Weak muscles
□ Loss of smell or taste
□ Temporary loss of vision
□ Difficulty concentrating
Other: _____

Musculoskeletal:

□ Arthritis
□ Joint pain or swelling
□ Neck pain
□ Back pain
□ Trauma
□ Osteoporosis
□ Scoliosis
□ Cramping
□ Fractures
□ Implants, plates, pins or screws
□ Hip disorders
□ Knee injuries
□ Foot/ankle pain
□ Shoulder problems
□ Elbow/wrist pain
□ Poor posture
□ Gout
Other: _____

Blood/Lymph:

□ Anemia
□ Bleeding
□ Bruising
□ Blood clots
□ Past transfusions
□ Leukemia
□ Lymphoma
□ HIV/AIDS
□ Sickle cell
Other: _____

Allergies:

□ Seasonal
□ Medication
□ Food
Other: _____

Psychiatric:

□ Alzheimer's disease
□ Insomnia
□ Difficult concentrating
□ Memory loss/confusion
□ Depression
□ Anxiety
□ Agitation/Irritability
□ Suicidal thoughts
□ Chemical dependency
Other: _____

Endocrine:

□ Diabetes
□ Thyroid problems
□ Sweating
□ Heat intolerant
□ Cold intolerant
□ Weight gain
□ Weight loss
□ Frequent urination
□ Excessive thirst
□ Change in appetite
□ Hair changes
□ Hyperthyroidism
□ Hormonal or glandular concerns
□ Hyperparathyroidism
□ Testosterone deficiency
□ Crushing's syndrome
□ Steroid treatments
Other: _____

Urinary:

□ Painful or frequent urination
□ Incontinence
□ Hesitancy
□ Urgency
□ Blood in urine
□ Kidney stones
□ Urinary infections
□ Genital/bladder/urinary complaints
Other: _____

Female:

□ Painful sex
□ Vaginal discharge
□ Breast pain or lumps
□ Hot flashes
□ Menstrual irregularity
□ Loss of libido
□ Menopause
□ Sexually transmitted disease
Other: _____

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