WELCOME

Date: _____

Patient Information

Name: _____
Last First MI

Email address: _____

Mailing Address: _____ City _____ State _____ Zip _____

Phone # (H)_____ (W) _____ (Cell) _____

Can we call you at work? ❑ Yes ❑ No

Date of Birth: _____ Sex: ❑ Male ❑ Female **SS#:** _____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Ethnicity ❑ Hispanic ❑ Latino ❑ Non-Hispanic / Non-Latino

Occupation: _____ Employer: _____

Employer Address: _____ Phone: _____

How did you hear about our practice? _____

Emergency contact: Name: _____ Relation: _____ Phone #: _____

Phone #: (H) _____ (W) _____

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other _____

Has it been reported? ❑ Yes ❑ No If yes, to whom? _____

Insurance Information

Policy Holder Name: _____ D.O.B. :_____

Relationship to patient (if other than self): _____ Phone # _____

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: _____

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: _____

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with _____ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PHYSICIAN/MEDICAL PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) _____ **DATE** _____

Form 2

Name:_____ DOB:_____

Colorado Mandatory Disclosure and Informed Consent

Advanced Healthcare
2531 S. Shields Street, Suite 2H, Fort Collins, CO 80526
Robert Smigelski, D.C., DiplAc.

This disclosure statement is in compliance with the State of Colorado, Department of Regulatory Agencies, Colorado Statute Title 12 Article 29.5. All rules and regulations set forth by the Department of Health are strictly adhered to, including proper cleaning, sterilization, and sanitation of equipment and office. The practice of acupuncture is regulated by the Director of Registrations, Colorado Department of Regulatory Agencies. If you have any comments, questions, or complaints, contact the Acupuncturists Registrations Office, 1560 Broadway, Suite 1350, Denver, Colorado 80202, (303) 894-2440. The patient is entitled to receive information about the methods of therapy, the techniques used, and the duration of therapy, if known. The patient may seek a second opinion from another healthcare professional or may terminate therapy at any time. In a professional relationship, sexual intimacy is never appropriate and should be reported to the Director of the Division of Registration in the Department of Regulatory Agencies.

Clinic Fee Schedule

Initial Exam/Treatment: $149.00 Subsequent Treatment:$50.00

24 hour notice is required for change of appointment or cancellation. If you are unable to give 24 hour notice, we will do our best to fill your space but if we are unable to do so you will be charged a $50.00 fee for that appointment.

Practitioner Education, Certification, and Experience

Robert Smigelski, D.C., DiplAc.: Doctor of Chiropractic degree from Palmer College of Chiropractic, Masters of Acupuncture degree from Institute of Taoist Education and Acupuncture, Diplomat of Acupuncture from NCCAOM 2015.

Informed Consent I hereby request and consent to the performance of acupuncture procedures by my acupuncturist (s). I have been informed that acupuncture is a safe method of treatment but that it may have side effects including discomfort, pain, dizziness, bruising, or numbness at site of procedure. Unusual and rare risks of acupuncture include nerve damage, organ puncture including lung puncture, infection, and spontaneous miscarriage. Other side effects and risks may occur. If I suspect that I am pregnant, I will immediately inform the acupuncturist. I have discussed the nature and purpose of my treatment with the acupuncturist(s) named above. I understand that there are no guarantees regarding cure of improvement of my condition. I understand that there may be limitations to the care provided and that in my best interest I may be referred to another acupuncture practitioner or other healthcare provider who may be more qualified to treat me outside of these facilities. I do not expect the acupuncturist(s) to anticipate and explain all possible risks and complications, and I permit the acupuncturist(s) to determine and/or alter the course of treatment which the acupuncturist(s) judges to be in my best interests based upon the facts then known. I understand that I have the choice to accept or reject treatment at any time. If you are receiving treatments from another provider for the same condition, consult your practitioner before implementing changes recommended. I have read or have had read to me the above consent. I have also had the opportunity to ask questions about its content, and by signing below, I agree to all terms and conditions stipulated by this document. I intend this form to cover the entire course of treatment for my condition(s) and for any future condition(s) for which I seek treatment.

Signature of Patient or Person authorized to consent Relationship _____ Date _____

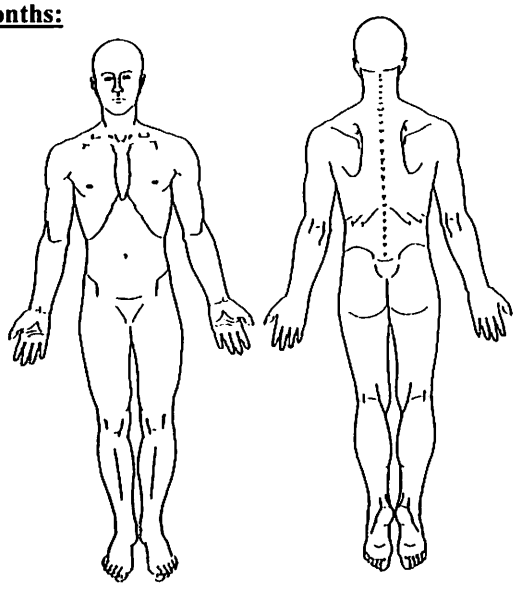
Advanced Healthcare

Health Questionnaire

Name: _____ Age____ Date of Birth: _____

Occupation: _____ # Hours/Week Currently Working:_____

Check off any of the following symptoms you have experienced in the past 6 months:



(Circle areas of symptoms/pain/discomfort)

- □Neck Pain
- □Headaches
- □Tension across top of shoulders
- □Numbness/Tingling in arms/hands
- □Carpal Tunnel
- □Pain between shoulder blades
- □Difficulty sleeping
- □Allergies
- □Low Back Pain
- □Numbness/Tingling in legs/feet
- □Pain in legs
- □Pain in feet
- □Fibromyalgia
- □Tired/Fatigued
- □Digestive problems

Other _____

Which of the above is the worst/most concerning symptom?

_____

How long have you had it? _____

How frequently do you experience it:

□Constant (100%-75%) □Frequent (75%-50%)
□Intermittent (50%-25%) □Occasional (25%-1%)
Times per Week _____ Times per Month _____

What does it feel like? (Circle all that apply)

Sharp, Dull, Achy, Burning, Numb/Tingling, Shooting, Tightness, Throbbing
Other: _____

Discomfort increases with: (Circle all that apply)

Movement, Applied pressure, Prolonged sitting, Coughing/Sneezing
Other: _____

What have you tried that has helped this problem? (Circle all that apply)

Ice, Heat, Rest, Over the counter meds, Stretching, Chiropractic, PT
Other: _____

▶Medication helped:	Little	Some	Much
▶Exercise helped:	Little	Some	Much
▶Physical Therapy helped:	Little	Some	Much
▶Nutrition helped:	Little	Some	Much
▶Chiropractic helped:	Little	Some	Much
▶Stretching helped:	Little	Some	Much

Does this cause you to be?

- □Moody
- □Irritable
- □Interrupt sleep
- □Restricted in your daily activities

Does this affect your work?

- □Decision making
- □Poor attitude
- □Decreased productivity
- □Exhausted at the end of the day
- □Unable to work long hours

Does this affect your life?

- □Lose patience with spouse/children
- □Restricted household duties
- □Hinders ability to exercise/sports
- □Interferes with hobbies/activities

What activities would you like to do if this was not a problem?

_____

_____

I consent to receiving a health screening. I realize that I am not receiving a diagnosis, treatment or prognosis for any condition that I may be experiencing. I acknowledge that I am receiving a demonstration only and agree to hold harmless the therapist and/or clinic from any damage resulting from this demonstration.

Signature: _____ **Date:** ____/____/____

Review of Systems

Name_____ **Date**_____

Y	N	**Neurological**
___	___	Migraines
___	___	Headaches
___	___	Slurring of speech
___	___	Ringing in Ear
		Ear/Nose/Throat
___	___	Altered taste/smell
___	___	Night Blindness
___	___	Sore Throat
___	___	Gingivitis
___	___	Nose bleeds
		Cardiovascular
___	___	Chest pain
___	___	Palpitations-racing heart beat
___	___	Swelling in hands/feet
___	___	Anemia
		Respiratory
___	___	Recurrent Respiratory Infections
___	___	Asthma
___	___	Chest Congestion
___	___	Wheezing
___	___	Frequent Sneezing
		GI
___	___	Stomach Pains or Cramping
___	___	Constipation
___	___	Reflux or Heartburn
___	___	Bloating
___	___	Gas
___	___	Nausea or Vomiting
		Musculoskeletal
___	___	Joint Pain
___	___	Arthritis
___	___	Chronic pain
___	___	Muscle Aches

Y	N	**Skin**
___	___	Eczema
___	___	Dermatitis
___	___	Excessive Sweating
___	___	Rashes
___	___	Brittle Nails
___	___	Hair Loss
___	___	Easy Bruising
___	___	Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
___	___	Uterine fibroids
___	___	Ovarian cysts
___	___	Cancer (breast, ovarian, prostate, uterine)
___	___	Prostate problems
		Emotional/Mental
___	___	Depression
___	___	Anxiety
___	___	Mood Swings
___	___	Irritability
___	___	Memory Loss
___	___	Confusion
		Energy
___	___	Fatigue
___	___	Hyperactivity
___	___	Restlessness
___	___	Insomnia
___	___	Decreased Libido
___	___	Stress
		Weight
___	___	Decreased Appetite
___	___	Weight Gain
___	___	Inability to Lose Weight
___	___	Food Cravings
___	___	Binge Eating
___	___	Water Retention

Name:_____ DOB:_____