Welcome to Quantum Chiropractic and Daniel B. Flemming, D.C.

Personal Information

Name: _____ Date: _____
First Last MI
Birthdate: _____ Age: _____ Male/Female SS#: _____
Mailing Address: _____ City: _____
State: _____ Zip: _____
Home Phone: _____ Work/Cell/Other Phone: _____
E-mail address: _____
Alt. E-mail _____
How did you hear about us? _____
Occupation: _____
Status: Minor Single Married Divorced Widowed Spouse's Name: _____
Do you have children? Yes No How many? _____

Reason for Visit

The reason for this visit is: _____
_____
Please describe the pain and location: _____
_____
When did it begin? _____ Is it getting worse? Yes No Constant Comes/goes
Is this condition the result of a work related injury or Auto accident? Yes No
Is this condition interfering with your daily routine? Yes No If yes, please explain:
_____
Have you had similar symptoms in the past? Yes No If so, please explain:
_____
What makes it better?
_____
What makes it worse?
_____
Have you ever been treated by a Chiropractor? Yes No
If so, whom? _____ Address or phone: _____
Any additional information you would like to include: _____
_____

Health History

Are you currently taking any medications? Yes No
If so, what? _____
For What Condition? _____

If you have had any of the following conditions, please circle:

Heart Attack	Stroke	Cong. Heart Defect	Alcohol Abuse
HIV+	Neck Pain	High Blood Pressure	Drug Abuse
Aids	Headaches	Low Blood Pressure	Shingles
Fainting	Seizures	Epilepsy	Diabetes Type I
Low Back Pain	Emphysema	Glaucoma	Diabetes Type II
Sinus Problems	Artificial Valves	Cancer	Psychiatric Problems
Anemia	Ulcers	Asthma	Arthritis

Other (please describe)_____

Health History Continued

Please list any hospitalizations or surgeries you have had with dates:
_____

_____

Have you had any significant falls, trauma, auto accidents (even minor fender benders) in the last 2 years? Yes No

If yes, please describe: _____

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other_____
Father's Side	O		O	O	O
Mother's Side	O		O	O	O

Do you take supplements or vitamins? Yes No
If so, what: _____

What is your typical exercise routine? _____

Are you on a special diet? Yes No If so, what is it? _____

Do you smoke? Yes No How much? _____ How Long? _____

For women: Are you taking Birth Control? Yes No

Are you pregnant? Yes No How long? _____ Nursing? Yes No

In Event of Emergency

Who should we contact? _____

Relationship to you? _____

Home Phone: _____ Work/Cell/Other Phone: _____

Who is your Medical Doctor? _____ Phone: _____

* We invite you to discuss with us any questions regarding our services.
* Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the front desk. We do not allow balances of more than $100 on any non-insurance (cash) case. Balance must be paid before further care is rendered
* I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider and or managed care organization, to release any information required to process insurance claims.
* I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____

Date: _____

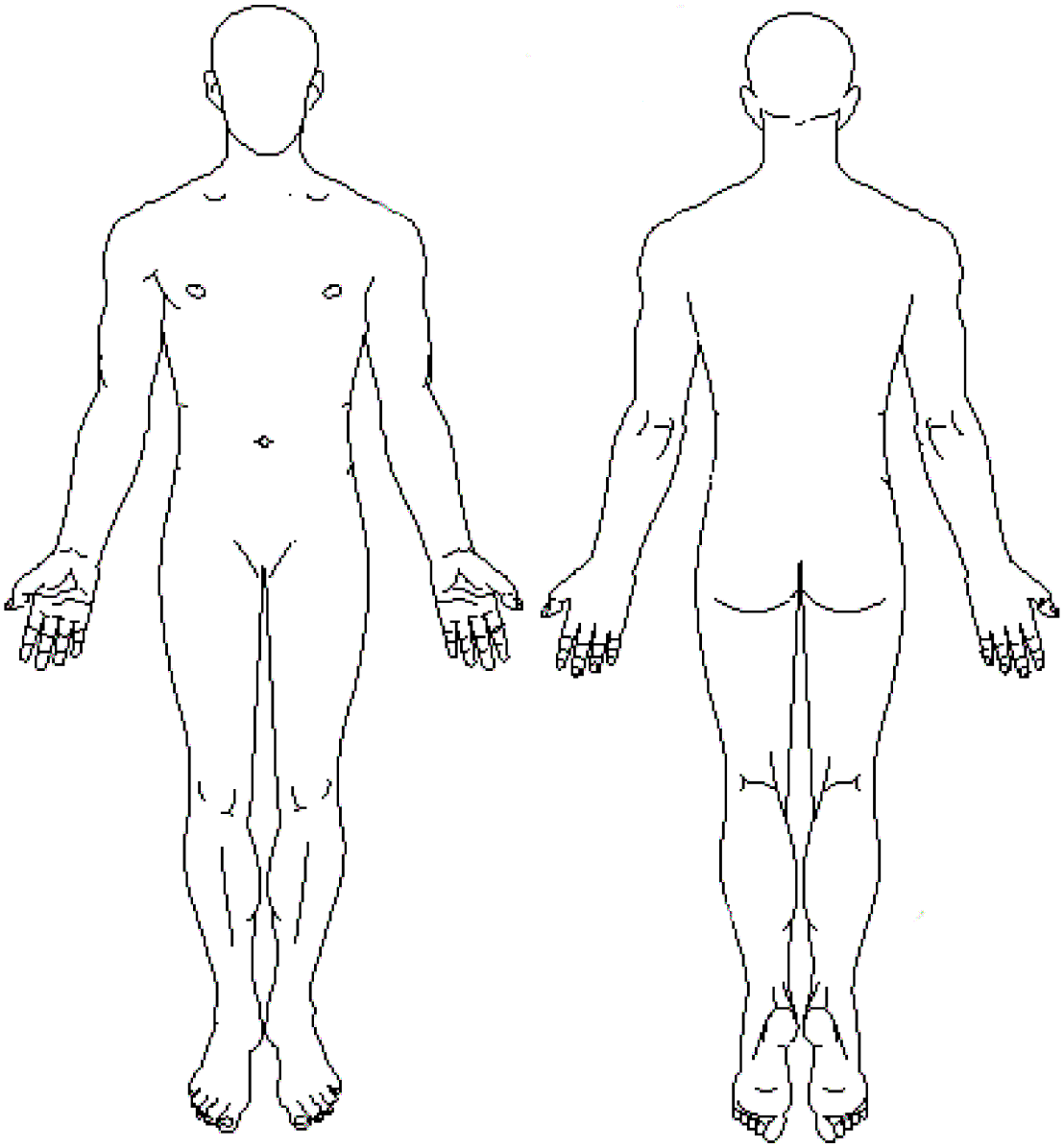
DANIEL B. FLEMMING, D.C. - PAIN DRAWING

PATIENT: _____

AGE:_____ DATE: _____

WHERE IS YOUR PAIN NOW?
Mark the areas on your body where you feel the described sensations. Use the appropriate symbol. Mark the areas of radiation. Include all affected areas. Just to complete the picture, please draw in your face.

ACHE ^ ^ ^ NUMBNESS o o o PINS & NEEDLES _ _ _ BURNING x x x RADIATING PAIN / / /



PLEASE MARK ON THE LINE:
How bad is your pain now? 1-10 (10 BEING WORST)

|_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
NO PAIN INTERMEDIATE PAIN WORST PAIN

PRIVACY PRACTICES ~ PATIENT RECEPTION FORM

I have received or reviewed the privacy practice notice (6 pages) for Quantum Chiropractic, and understand the situations in which this practice may need to utilize or release my medical records. I also understand that I agreed to the use of those records when I initially applied for care at this office (my new patient forms) on my first visit, whenever that may have occurred.
I understand that this office will properly maintain my records, and will use all due means to protect my privacy as outlined in this privacy practices statement. I also understand that I may be treated in an open environment where conversations can be overheard. It is my responsibility to state if I need more privacy than that at any particular time.

_____
Patient Signature Date

_____
Print the Patient Name

CONSENT TO BE TREATED

We use the most cutting edge treatments in our practice that we can find and learn about. This includes techniques such as muscle testing, cold laser, homeopathics, emotional release techniques, contact reflex analysis and many others. The Colorado chiropractic board requires that you be informed that some of these techniques are considered to be "unproven".
By signing below you acknowledge that you have been informed of this and do consent to be treated by these type techniques as well as more "standard" chiropractic adjustments. I have also been informed that there are alternatives such as medical, osteopath, physical therapy, or simply doing nothing.

_____
Patient Signature