

Pinnacle Chiropractic and Spinal Rehab Center

Dr. Aaron Casselman DC
4185 E Wildcat Reserve Pkwy #220
Highlands Ranch CO 80126
(303) 683-5060

Patient Application for Treatment

Today's Date: _____

Name: _____ How would you like to be addressed? _____

Date of Birth: ____/____/____ Age: ____ Gender: Male ____ Female: ____ SS# _____

Your Address: _____ City: _____ State: _____ Zip: _____

Home # _____ Wk# _____ Cell# _____ Email _____

Your Occupation: _____ Emergency Contact: _____

Marital Status: S M W D How Many Children do you have? _____ What are their ages? _____

Have you had Previous Chiropractic care? Y N Name of Chiropractor: _____

How long ago did you see your last Chiropractor? _____

The purpose or reason for this appointment? _____

Do you drink alcoholic beverages? Y N How Often? _____

Do you smoke? Y N How much? _____

Do you exercise Y N How often? _____
type? _____

Do you have any allergies? (specify): _____

Have you ever suffered from or been diagnosed as having:(Circle yes or no for each)

Y N *Broken or Fractured Bones	Y N *Osteoarthritis	Y N Eating Disorder
Y N Circulatory Problems	Y N Epilepsy	Y N Alcoholism
Y N *Rheumatoid Arthritis	Y N Pacemaker	Y N drug addiction
Y N Seizures/Convulsions	Y N strokes	Y N HIV Positive
Y N A Congenital Disease	Y N *Cancer	Y N Gall Bladder
Y N Excessive Bleeding	Y N Ulcers	Y N *Head Problems
Y N High/Low Blood Pressure	Y N Ruptures	Y N Depression
Y N *Diabetes	Y N coughing Blood	Y N Tumors

*Explanation: _____

When was your last physical exam? _____

Current Medications (more paper is available if needed)

Name of Med. and dose _____

Name of Med. and dose _____

Name of Med. and dose _____

Pain Medications _____ Number per week _____

For Doctor's use
only

General

NDRA

Drug Allergies:

See Meds
Addendum

Systems Review

In the left hand column, please indicate with a (C) conditions you have now or with a (P) the conditions you have had in the past. If neither apply, mark (NA), **don't leave any blanks.**

<p>High Blood Pressure _____</p> <p>Dizziness/ Fainting _____</p> <p>Insomnia _____</p> <p>Low Resistance _____</p> <p>Tension _____</p> <p>Confusion _____</p> <p>Fatigue _____</p> <p>Ulcers _____</p> <p>Eye/ Vision Problems _____</p> <p>Ear/ Hearing Problems _____</p> <p>Difficulty Breathing _____</p> <p>Heart Problems _____</p> <p>Loss of Bladder Control _____</p> <p>Constipation _____</p> <p>Diarrhea _____</p> <p>Digestion Problems _____</p> <p>Nausea _____</p> <p>Female Problems _____</p> <p>Prostate Problems _____</p> <p>Diabetes _____</p> <p>Hands/ Feet Cold _____</p> <p>Hand Tremors _____</p> <p>Loss of Memory _____</p> <p>Nervousness _____</p> <p>Sweaty Palms _____</p> <p>Speech Difficulty _____</p> <p>Anxiety _____</p> <p>Depression _____</p> <p>Irritability _____</p>	<p style="text-align: center;">FOR DOCTOR'S USE ONLY</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;">Dr.</th> <th style="width: 20%;">Reviewed 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Please identify all facilities/ providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s)				<p style="text-align: center;">FOR DOCTORS USE ONLY</p> <p>Reviewed External H P</p> <p>Release Records H P</p> <p>Request Records H P</p> <p>External Dx'd: _____</p> <p>_____</p> <p>Disabilities:</p> <p>Impairments:</p>
PROBLEM LIST				
Dr. Name/ Facility	Problem	Type of Treatment	From When To When	

Trauma History

This is an extremely important aspect of your patient history. It helps us determine when and how your problem began. Please take the time to think back and with the best detail you can give us the types of traumas you have had throughout your life, even back to childhood falls.

Auto accident history

Almost every person has been involved in an automobile accident. Even if you think you were not injured in an accident **please list all you have had, even if they were 5 miles per hour.**

MVA #1: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _____
Chiropractic Treatment after accident Y / N Approx. speed of other car: _____
Year of Accident: _____ Was the accident your fault Y N
Type of vehicle your were in _____ other vehicle type _____

MVA #2: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _____
Chiropractic Treatment after accident Y / N Approx. speed of other car: _____
Year of Accident: _____ Was the accident your fault Y N
Type of vehicle your were in _____ other vehicle type _____

MVA #3: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _____
Chiropractic Treatment after accident Y / N Approx. speed of other car: _____
Year of Accident: _____ Was the accident your fault Y N
Type of vehicle your were in _____ other vehicle type _____

MVA #4: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _____
Chiropractic Treatment after accident Y / N Approx. speed of other car: _____
Year of Accident: _____ Was the accident your fault Y N
Type of vehicle your were in _____ other vehicle type _____

Athletic Injuries/ Work Injuries / Childhood falls

If you have played athletics please list a few of the impacts you have sustained, if they were memorable. This includes all forms of activities from dance to cheerleading, contact sports, etc... If you have had stresses or strains at work list them here too. Think back to your childhood and remember any big falls you took, like off your bike, out of a tree, off a horse, etc...

Injury #1 _____ approx. date _____

Injury #2 _____ approx. date _____

Injury #3 _____ approx. date _____

Injury #4 _____ approx. date _____

Injury #5 _____ approx. date _____

Injury #6 _____ approx. date _____

PATIENT HISTORY

1. What is your **main complaint**? _____
2. On the scale below, please circle the **severity** of your **main complaint** (At it's worst)

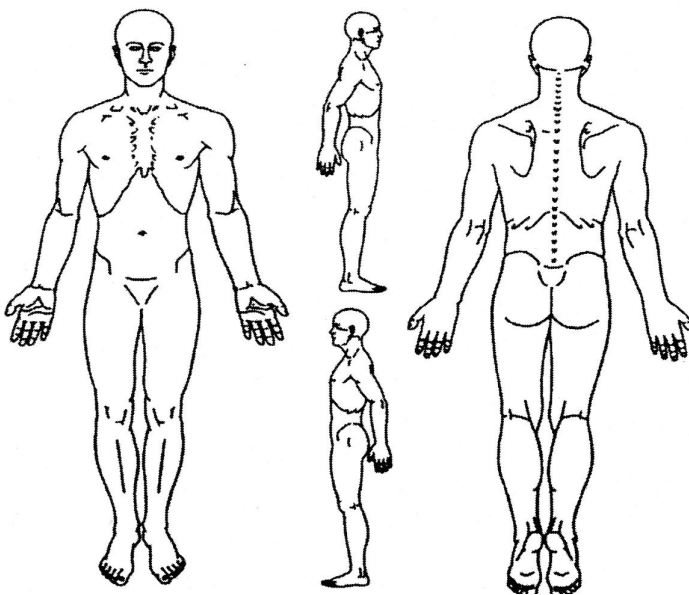
None	Slight		Mild		Moderate		Severe		
1	2	3	4	5	6	7	8	9	10

3. On the scale below please circle the **percentage of time** you experience you **main complaint**:

Occasional			Intermittent			Frequency		Constant		
0	10	20	30	40	50	60	70	80	90	100

4. How **long** have you been experiencing your **main complaint**? _____
5. On the diagram below, please show **where** you are experiencing **all** of your present complaints using the following letters:

A: ache B: burning pain C: cramping D: dull ache R: throbbing pain N: numbness T: tingling



6. When do you notice it most? AM PM
How long does it last? _____ Minutes _____ Hours
7. What makes it feel better? _____
8. What makes it feel worse? _____
9. Have you ever had this problem in the past? Yes No
10. I have been hospitalized been treated by another chiropractor
 been treated by another specialty provider never received care for this problem.
11. Have you lost time from work because of it? Yes No
Dates? _____ to _____
12. Are you pregnant? Yes No
13. What was the first day of your last menstrual cycle? _____
14. Number of pregnancies? _____ Miscarriages? _____

Do you have pain and/ or difficulty performing any of the following activities: (Check)

Personal Care _____

Lifting _____

Reading _____

Concentrating _____

Work _____

Driving _____

Sleeping _____

Recreation _____

Walking _____

Sitting _____

Standing _____

Social Life _____

Patient Signature

Date: ____/____/____

PAYMENT/OFFICE POLICIES:

1. **Payment for all services rendered are due at the completion of your first office visit, regardless of insurance coverage. If you have questions or financial concerns please speak directly to the doctor.**
2. **Please make sure we have a copy of your insurance card if applicable.**
3. **WE TYPICALLY DO NOT ADJUST PATIENTS ON THEIR FIRST VISIT. Please advise the doctor if you have any concerns regarding this matter.**
4. **During your second consultation, the doctor will explain your findings and options for care. Financial arrangements and any insurance coverage will also be discussed at these times.**

Assignment and Release:

I authorize the release of information to family physicians and employer.

I authorize the release of information to insurance companies.

I authorize the taking of photographs and x-rays to be used for treatment purposes.

I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.

I authorize my insurance benefits to be paid directly to:

Pinnacle Chiropractic and Spinal Rehab Center
4185 E Wildcat Reserve Parkway Suite 220
Highlands Ranch CO 80126

I acknowledge that I am financially responsible for all services rendered to me in this office.

I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be due immediately, unless other financial arrangements have been made.

Signature: _____ **Date:** _____

Acknowledgement of Receipt of
Notice of Privacy Practices and
Pinnacle Chiropractic and Spinal Rehab Center Health Care Authorization Form

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices and Health Care Authorization Form

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement, but acknowledgement could not
Be obtained because: () Individual refused to sign () Communications barrier
() Emergency Situation () Other _____