

**Waterbury Chiropractic Wellness**  
**Confidential History**

1332 Linden Street, Ste 1  
303-485-7117

Longmont, Colorado  
80501

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Gender: M F Height \_\_\_\_\_ Weight \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver License Number \_\_\_\_\_

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed Number of Children \_\_\_\_\_

Employer \_\_\_\_\_ Type of Work \_\_\_\_\_

Name of Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Referred to this Office by \_\_\_\_\_

Major Surgery(s)/Operations & Dates: \_\_\_\_\_

Major Accidents or Falls: \_\_\_\_\_

Drugs You Now Take: \_\_\_\_\_ Nerve Pills \_\_\_\_\_ Pain Killers/Muscle Relaxers \_\_\_\_\_ Blood Pressure Medication \_\_\_\_\_  
Insulin \_\_\_\_\_ Other Please list \_\_\_\_\_

Please list your reason(s) for  
this visit of your condition(s)  
in order of importance:

Date you  
first  
noticed:

Using a scale in which "0" is none (no  
pain or symptoms) &  
"10" is severe pain or symptoms, circle  
the number that best reflects your  
condition:

↓ None.....to .....Severe ↓

0 1 2 3 4 5 6 7 8 9 10  
0 1 2 3 4 5 6 7 8 9 10  
0 1 2 3 4 5 6 7 8 9 10  
0 1 2 3 4 5 6 7 8 9 10

Please check the box below that best  
represents how much of the time you  
feel your pain or symptoms for the  
listed reason(s):

☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%  
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%  
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%  
☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

**For each of the reason(s) or condition(s) listed above, please mark how it happened:**

1. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other \_\_\_\_\_ ☐ I don't know  
2. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other \_\_\_\_\_ ☐ I don't know  
3. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other \_\_\_\_\_ ☐ I don't know  
4. ☐ Developed over time ☐ Illness ☐ Injury ☐ Auto Accident ☐ Other \_\_\_\_\_ ☐ I don't know

**Please check the box that best describes whether your pain or symptom(s) limit normal activities:**

Activity	Somewhat Severely				Somewhat Severely		
	Normal	Limited	Limited		Normal	Limited	Limited
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Resting in Bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Computer work/typing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Normal Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Household Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational Activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other List Below:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
				_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME \_\_\_\_\_

DATE \_\_\_\_\_

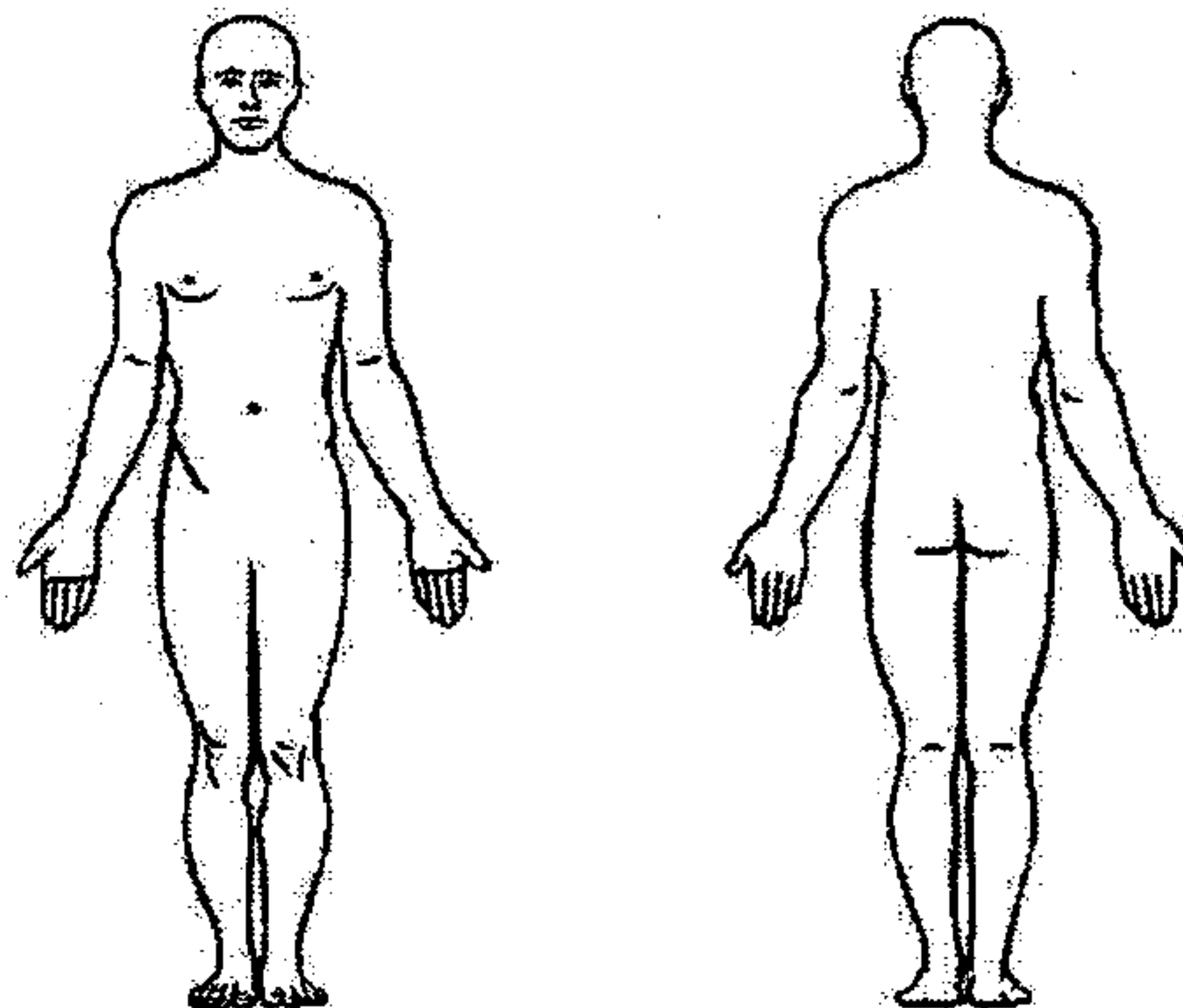
Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan and possibility of being accepted for care.

### CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- |                                       |  |  |  |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Alcoholism   | <input type="checkbox"/> Diabetes      | <input type="checkbox"/> Lumbago         | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia       | <input type="checkbox"/> Diphtheria    | <input type="checkbox"/> Malaria         | <input type="checkbox"/> Scarlet Fever   |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Eczema        | <input type="checkbox"/> Measles         | <input type="checkbox"/> Shingles        |
| <input type="checkbox"/> Arthritis    | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Sleep Apnea     |
| <input type="checkbox"/> Asthma       | <input type="checkbox"/> Goiter        | <input type="checkbox"/> Mumps           | <input type="checkbox"/> Small Pox       |
| <input type="checkbox"/> Cancer       | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pleurisy        | <input type="checkbox"/> Tuberculosis    |
| <input type="checkbox"/> Chicken Pox  | <input type="checkbox"/> Hepatitis     | <input type="checkbox"/> Pneumonia       | <input type="checkbox"/> Typhoid Fever   |
| <input type="checkbox"/> COPD         | <input type="checkbox"/> Influenza     | <input type="checkbox"/> Polio           | <input type="checkbox"/> Whooping Cough  |

### CHECK ANY OF THE FOLLOWING YOU HAVE OR HAVE HAD IN THE PAST 6 MONTHS:

- |   |   |   |
|---|---|---|
| <b>MUSCULO-SKELETAL CODE</b><br><input type="checkbox"/> Arm Pain<br><input type="checkbox"/> Difficult Chewing / Clicking Jaw<br><input type="checkbox"/> Joint Pain / Stiffness<br><input type="checkbox"/> Low Back Pain<br><input type="checkbox"/> Neck Pain<br><input type="checkbox"/> Pain Between Shoulders<br><input type="checkbox"/> Walking Problems   | <b>GENERAL CODE</b><br><input type="checkbox"/> Allergies<br><input type="checkbox"/> Fever<br><input type="checkbox"/> Loss of Sleep<br><br><b>GENITO-URINARY CODE</b><br><input type="checkbox"/> Bladder Trouble<br><input type="checkbox"/> Discolored Urine<br><input type="checkbox"/> Painful/Excessive Urination  | <b>EENT CODE</b><br><input type="checkbox"/> Dental Problems<br><input type="checkbox"/> Ear Aches<br><input type="checkbox"/> Hearing Difficulty<br><input type="checkbox"/> Sore Throat<br><input type="checkbox"/> Stuffy Nose<br><input type="checkbox"/> Vision Problems<br><br><b>MALE / FEMALE CODE</b><br><input type="checkbox"/> Breast Pain / Lumps<br><input type="checkbox"/> Menstrual Cramping<br><input type="checkbox"/> Menstrual Irregularity<br><input type="checkbox"/> Vaginal Pain / Infections<br><input type="checkbox"/> Prostate / Sexual Dysfunction<br><input type="checkbox"/> Genital Herpes |
| <b>NERVOUS SYSTEM CODE</b><br><input type="checkbox"/> Cold / Tingling Extremities<br><input type="checkbox"/> Confusion / Depression<br><input type="checkbox"/> Convulsions<br><input type="checkbox"/> Dizziness<br><input type="checkbox"/> Fainting<br><input type="checkbox"/> Forgetfulness<br><input type="checkbox"/> Numbness<br><input type="checkbox"/> Paralysis   | <b>C-V-R CODE</b><br><input type="checkbox"/> A-Fib<br><input type="checkbox"/> Ankle Swelling<br><input type="checkbox"/> Blood Pressure Problems<br><input type="checkbox"/> Chest Pain<br><input type="checkbox"/> Heart Problems<br><input type="checkbox"/> Irregular Heartbeat<br><input type="checkbox"/> Lung Problems / Congestion<br><input type="checkbox"/> Short Breath<br><input type="checkbox"/> Varicose Veins | <b>FEMALES ONLY:</b><br>When was your last period? _____<br>Are you pregnant?<br><input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Maybe  |
| <b>GASTO-INTESTINAL CODE</b><br><input type="checkbox"/> Abdominal Cramps<br><input type="checkbox"/> Black / Bloody Stools<br><input type="checkbox"/> Colitis<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Excessive Thirst<br><input type="checkbox"/> Frequent Nausea<br><input type="checkbox"/> Gall Bladder Problems<br><input type="checkbox"/> Gas / Bloating After Meals<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Hemorrhoids<br><input type="checkbox"/> Liver Trouble<br><input type="checkbox"/> Poor / Excessive Appetite<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Weight Trouble |   |   |



Please outline on the diagram the area of your discomfort.



Dr. Robin Waterbury, DC  
1332 Linden Street, Suite 1  
Longmont, CO 80501  
Phone 303.485.7117

PLEASE READ AND SIGN BELOW:

Check the type of care desired so that we may be guided by your wishes whenever possible.

- ☐ Relief Care                      ☐ Corrective Care                      ☐ Comprehensive Care
- ☐ Check here if you want the doctor to select the type of care appropriate for your condition.

*I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.*

*I hereby authorize the Doctor to treat my condition as she deems appropriate through the use of manipulation throughout my spine. It is understood and agreed the amount paid, for x-rays, is for examination only and the x-ray negative(s) will remain the property of this office, being on file where they may be seen at any time, during office hours, while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed condition, nor for any medical diagnosis.*

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\* \* \* \* \*

Minor Patient's Name: \_\_\_\_\_

Guardian Authorizing Care

Guardian's Name \_\_\_\_\_ Date: \_\_\_\_\_

Print Guardian's Name \_\_\_\_\_ Relationship \_\_\_\_\_

# WATERBURY CHIROPRACTIC WELLNESS

Effective Date: August 21, 2015

## NOTICE OF PRIVACY PRACTICE SUMMARY – ACKNOWLEDGEMENT

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This summary discloses how health information about you may be used. A full notice of your privacy rights has also been made available to you.

Waterbury Chiropractic uses health information about your treatment, to obtain payment, for treatment with your authorization as required, for administrative purposes and to evaluate the quality of care that you receive.

Waterbury Chiropractic will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Waterbury Chiropractic may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations. You have the right to request restrictions, review and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request an accounting of your health records, for which a fee may be charged.

You may complain to the Privacy Officer and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Waterbury Chiropractic must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by the terms of the notice, to notify you if it was unable to agree to the requested restrictions on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted by law.

If you have any questions or complaints, please contact Waterbury Chiropractic Wellness at: 303-485-7117.



# WATERBURY CHIROPRACTIC WELLNESS

## NOTICE OF PRIVACY PRACTICE SUMMARY – ACKNOWLEDGEMENT

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The **Health Insurance Portability and Accountability Act (HIPPA)** require us to give you a notice of our privacy practices and to acknowledge your receipt of this notice.

### What is the NOTICE OF PRIVACY ACT PRACTICES?

The NOTICE OF PRIVACY PRACTICES explains how your health information may be used and or disclosed by us. In addition, it explains your rights with regard to your protected health information, as well as our legal responsibilities.

I have been provided with a copy of the **Notice of Privacy Practices Summary**:

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May we share your medical information with others listed below to appropriately care for you?

YES \_\_\_\_\_

\_\_\_\_\_ Spouse Name: \_\_\_\_\_

NO \_\_\_\_\_

\_\_\_\_\_ Children Name: \_\_\_\_\_

\_\_\_\_\_ Other Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

May we leave appointment information on your home/cell voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

May we leave DETAILED medical information on your home/cell voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

May we leave appointment information on your work/office voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

May we leave DETAILED medical information on your work/office voicemail?

YES \_\_\_\_\_ NO \_\_\_\_\_

Printed Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Authorized Representative (Parent or legal guardian): \_\_\_\_\_

Patient Social Security Number: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

Full Address: \_\_\_\_\_

Patient Phone Number: \_\_\_\_\_

Signature of Staff: \_\_\_\_\_ Date entered into Patient chart: \_\_\_\_\_

This form will be retained in your health record at: Waterbury Chiropractic Wellness



# Waterbury Chiropractic Wellness

## MEDICAL COST AGREEMENT TO PAY

We are committed to providing you with the best possible care. In order to achieve these goals, we need your assistance and understanding of our payment policy. If you have medical insurance, we will assist you in receiving your maximum allowable benefits. Payments for services are due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept Cash, Checks, Visa and MasterCard.

We will be happy to file all primary insurance for you as a courtesy. However you must realize:

1. Not all services are covered by insurance contracts, i.e. radiology reports, some blood work, massage, etc. If your insurance determines your visit and/or massage are not medically necessary, you will be responsible for services rendered.
2. All charges are your responsibility for the date/dates the services are rendered.
3. All co-pays are due at the time of service.
4. There is a \$41 charge for returned checks. (fee subject to change)
5. Patient balances over 60 days old will be assessed a 1.5% per month charge on outstanding balances.
6. There will be a \$30 missed appointment fee charged to your account without 24 hour notice of cancellation.

The Patient and the Responsible Party hereby agree to be fully responsible for any and all amounts and charges submitted by the Physicians in the course of treatment or any of their agents, employees, or contractors. Patient and the Responsible Party acknowledge that the charges may exceed the amount your insurance carrier may define as "usual and customary, or reasonable", (does not include insurances that have their own set fee schedules) but the Patient and Responsible Party agree to pay the amount of such billed charges.

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Signature of Patient

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Name of Patient

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Signature of Responsible Party if not Patient

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Name of Responsible Party

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Relationship to Patient

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Date

*This form will be retained in your health record.*



# Waterbury Chiropractic Wellness

## CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTH CARE OPTIONS

I consent to the use or disclosure of my protected health information by Waterbury Chiropractic Wellness Center for the purposes of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Waterbury Chiropractic.

I understand that diagnosis or treatment of me by Waterbury Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or health care operations of the practice. Waterbury Chiropractic is not required to agree to the restrictions that I may request. However, if Waterbury Chiropractic agrees to a restriction that I request, the restriction is binding on Waterbury Chiropractic.

I have the right to revoke this consent, in writing, at any time, except to the extent that Waterbury Chiropractic has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

The office's Notice of Privacy Practices has been provided to me. I understand I have a right to review Waterbury Chiropractic's Notice of Privacy Practices prior to signing this document.

The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Waterbury Chiropractic.

The Notices of Privacy Practices also describes my rights and the duties of Waterbury Chiropractic with respect to my protected health information.

Waterbury Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office (303.485.7117) and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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Signature of Patient or Personal Representative

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Name of Patient or Personal Representative

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Description of Personal Representative's Authority

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Date

*This form will be retained in your health record.*

## FAMILY HEALTH HISTORY

PATIENT NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

Please review the diseases and conditions listed below and indicate those that are current health problems of a family member by the designation **C** under the appropriate column. The designation **P** should be used to indicate a past problem. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form.

CONDITION	FATHER AGE ____	MOTHER AGE ____	SPOUSE AGE ____	<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER AGE ____	<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER AGE ____	<input type="checkbox"/> BROTHER <input type="checkbox"/> SISTER AGE ____	CHILD AGE ____	CHILD AGE ____	CHILD AGE ____
ARTHRITIS									
ALLERGIES									
ASTHMA									
BACK TROUBLE									
BURSITIS									
CANCER									
CONSTIPATION									
COPD									
DIABETES									
DISC PROBLEM									
EMOTIONAL PROBLEMS									
EMPHYSEMA									
EPILEPSY									
HEADACHES									
HEART TROUBLE									
HIGH BLOOD PRESSURE									
INSOMNIA									
KIDNEY TROUBLE									
LIVER TROUBLE									
MIGRAINE									
NERVOUSNESS									
NEURITIS									
PINCHED NERVE									
SCOLIOSIS									
SINUS TROUBLE									
STOMACH TROUBLE									
OTHER									

If any of the above family members are deceased, please list their age at death and cause

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