



Chiropractic - Physical Therapy - Massage
 13655 West Jewell Ave # 201B
 Lakewood, CO 80228
 (720) 440-3979

Thank you for choosing Denver Sports Medicine! Please complete this confidential patient form.

Patient Information

Date: _____

Name: _____ Date of Birth: _____
 Address: _____
 City: _____ State: _____ Zip: _____ Gender: _____
 Preferred Phone: _____ Email Address: _____
 Emergency Contact: _____ Relationship: _____
 Who may we thank for referring you to our office? _____

MEDICAL HISTORY

Have you RECENTLY noted any of the following (check all that apply)?

<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Numbness or tingling	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Fever/chills/sweats	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Nausea/vomiting	<input type="checkbox"/>	Dizziness/lightheadedness	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	Weight loss/gain	<input type="checkbox"/>	Heartburn/indigestion	<input type="checkbox"/>	Cough
<input type="checkbox"/>	Falls	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	Difficulty maintaining balance or poor coordination	<input type="checkbox"/>	Changes in bowel or bladder function (i.e., urgency, color or incontinence)	<input type="checkbox"/>	Headaches
<input type="checkbox"/>		<input type="checkbox"/>		Vision changes	

Have you EVER been diagnosed with or are experiencing any of the following conditions (check all that apply)?

<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Bone or joint infection	<input type="checkbox"/>	Skin problems
<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	Sinus problems
<input type="checkbox"/>	Chest pain/angina	<input type="checkbox"/>	Osteoporosis/osteopenia	<input type="checkbox"/>	Jaw or dental problems
<input type="checkbox"/>	High or low blood pressure	<input type="checkbox"/>	Rheumatoid arthritis	<input type="checkbox"/>	Parkinson's disease
<input type="checkbox"/>	Circulation problems	<input type="checkbox"/>	Other bone or joint condition	<input type="checkbox"/>	Multiple sclerosis
<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	Epilepsy or seizures
<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Bladder/Urinary tract infection	<input type="checkbox"/>	Eye or vision problem
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Kidney problem/infection	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	High cholesterol	<input type="checkbox"/>	Sexually transmitted infection/HIV	<input type="checkbox"/>	Head injury
<input type="checkbox"/>	Lung problem/disease	<input type="checkbox"/>	Pelvic inflammatory disease	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Liver problems/ infection	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Chemical dependency (i.e., alcoholism)
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	

Other: _____

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Heart disease	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Thyroid problems
<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	Autoimmune disease	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Blood clots	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Depression

WOMEN ONLY: Are you pregnant? Yes No

Please list all medications and supplements you are currently taking, including injections and skin patches:

Please list all allergies:

List all prior surgeries, hospitalizations and/or fractures and year:

LIFESTYLE

Occupation: _____

Activities that compromise your work day: _____

Hours of sleep each night: _____

Recreational activities and sports:

- | | | | | |
|-------------------------------------|-------------------------------------|--|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Golf | <input type="checkbox"/> Hockey | <input type="checkbox"/> Cycling | <input type="checkbox"/> Running | <input type="checkbox"/> CrossFit |
| <input type="checkbox"/> Tennis | <input type="checkbox"/> Basketball | <input type="checkbox"/> Mountain biking | <input type="checkbox"/> Marathon | <input type="checkbox"/> Martial Arts |
| <input type="checkbox"/> Volleyball | <input type="checkbox"/> Snowboard | <input type="checkbox"/> Hiking | <input type="checkbox"/> Triathlon | <input type="checkbox"/> Lifting |
| <input type="checkbox"/> Football | <input type="checkbox"/> Ski | <input type="checkbox"/> Walking | <input type="checkbox"/> Swimming | <input type="checkbox"/> Climbing |

Other hobbies and activities: _____

Do you smoke? Yes No If yes, how many packs per day: _____

How many alcoholic drinks do you consume per week: _____

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

REASON FOR TODAY'S VISIT:

Please rank the health concerns you would like to address today, and how long have you had symptoms?

- 1: _____
- 2: _____
- 3: _____
- 4: _____
- 5: _____

Have you been treated by any other health care professional for the above concerns? Yes No

Name of facility or practitioner: _____

Treatment received: _____

Have you ever seen a chiropractor / physical therapist before? Yes No

If yes, when was your last appointment? _____

Please list any imaging or special tests performed for this problem (X-ray, CT scan, MRI, labs, etc.):

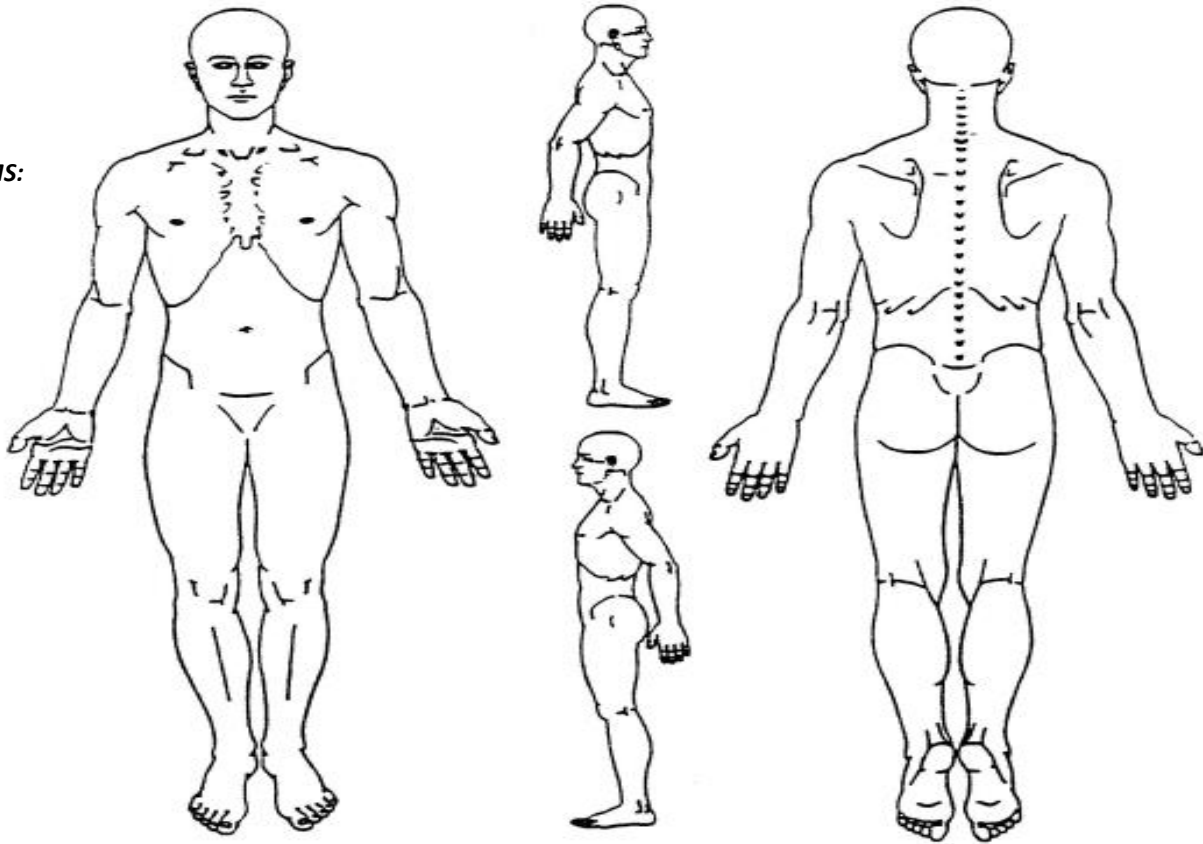
CURRENT SYMPTOMS:

Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms:

↓ Shooting/sharp pain

○ Dull/aching pain

= Numbness or tingling



Using the 0 to 10 the scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:

Your current level of pain while completing this survey: _____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

How are you currently able to sleep at night due to your symptoms?

No problem sleeping Difficulty falling asleep Awakened by pain Sleep only with medication

When are your symptoms worst?

Morning Afternoon Evening Night After exercise or activity

When are your symptoms the best?

Morning Afternoon Evening Night After exercise or activity

I should not do physical activities that might make my pain worse:

Agree Disagree Unsure

What do you think is the cause of your current symptoms? _____

I certify that I have read and understood the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I understand that my chiropractic, physical therapy insurance carrier may cover only a portion of or not cover all of the services rendered. I agree to be ultimately responsible for all fees for services rendered and that fees are payable when services are rendered.

Patients/Guardian Signature

Date

HIPAA Privacy Practices – Patient Reception Form

I authorize the doctor to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such chiropractic, physical therapy and massage care to third party payers and or health practitioners. I have received or reviewed the privacy practice notice for Denver Sports Medicine, 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 initiated care at this office 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.

Patients/Guardian Signature

Date

Print Patient Name

I allow the doctors and staff at Denver Sports Medicine to discuss my treatment and diagnosis with the following doctors, health care professionals, coaches, lawyers, spouses, etc.

Name, Title

INFORMED CONSENT TO TREAT

I request and consent to the performance of chiropractic , physical therapy and massage treatments; including any diagnostic tests performed by the physicians employed by Denver Sports Medicine, who now or in the future treat me.

I understand and am informed that in the practice of medicine there are some risks to treatment; including, but not limited to: fractures, disc injuries, strokes, dislocations, falls, dizziness, headaches, burns with modalities and sprains, and muscle soreness. I do not expect the physicians to be able to anticipate and explain all risks and complications, and I wish to rely on the physicians to exercise judgement during the treatment based upon the facts then known, in my best interests.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature (Or Patient Representative)
(Indicate relationship if signing for patient)

Date

APPOINTMENT AND CANCELLATION POLICY

At Denver Sports Medicine, our goal is to provide quality treatment for all our patients. Our cancellation policy enables us to better utilize available appointments for our patients in need of medical care.

Cancellations of Appointments

Please be courteous and call Denver Sports Medicine promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your appointment we require that you give at least **24 hours notice**. Available appointments are in high demand and your early cancellation will give another person the ability to have access to timely care. Remember, your attendance will directly impact your recovery. Research shows that patients who are compliant with their appointments will recover faster.

We understand that emergencies arise in which you must cancel your appointment. Therefore, your first cancellation is on on us!

Going forward from this cancellation, any appointments that are not cancelled within our 24 hour notice policy will be charged a **fee of \$50.** This fee will not be billed to insurance.

How to Cancel Your Appointment

To cancel and/or change appointments call Denver Sports Medicine at 720-440-3979

No Show Policy

A “no show” is someone who misses an appointment without canceling it one (1) working day in advance. No-shows inconvenience those individuals who need access to medical care in a timely manner. A failure to present at the time of a schedule appointment will be recorded in the patient's’ chart as a “no show”. Three “no shows” may result in the temporary suspension of services.

Appointment and Cancellation Policy Acknowledgement

I acknowledge that I have received and understand the appointment and cancellation policy. Should I have any questions about the policy, I will notify a Denver Sports Medicine staff member immediately.

Patient (or Guardian) Signature

Date

Printed Name



Media Consent Form

I _____ hereby grant my permission to Denver Sports Medicine to use photographs and/or video of me taken during my treatment in publications, online and in other communications.

Name: _____

Date: _____

Signature: _____

Signature of parent if patient is under 18: _____



Denver Sports Medicine Trigger Point Dry Needling Consent Form

Trigger point dry needling (TDN) involves placing a small needle into the muscle at the trigger point in order to cause the muscle to contract and then release. This response improves the flexibility of the muscle and therefore decreases muscular-based symptoms. TDN is not intended to stimulate any distal or auricular acupuncture points. TDN is a valuable treatment for musculoskeletal pain. Like any treatment there are possible complications. While these complications are rare in occurrence, they are real and must be considered prior to giving consent to treatment.

Risks of TDN The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to several weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. Other risks may include excessive bleeding (causing a bruise), infection and nerve injury. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from TDN is unlikely. The needles are sterile and our therapists utilize clean blood borne pathogen precautions in order to minimize the chance of infection.

Please consult with your practitioner if you have questions regarding the treatment above.

I have read, or been read, and understand the above information, and hereby give consent for Trigger Point Dry Needling procedures to be performed on me by a TDN trained Denver Sports Medicine therapist. All TDN trained therapists have met the requirements set by the Colorado Department of Regulatory Agencies for the safe use of this intervention technique. This consent may be revoked at any time verbally or in writing.

Please Print Name

Please Sign Name

Date