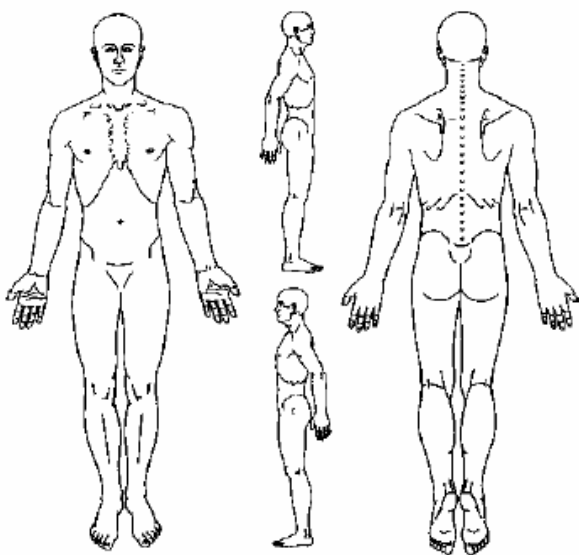


CONTACT INFORMATION

Name: _____			Occupation: _____		
Address: _____			Employer: _____		
City: _____	State: _____	Zip: _____	Spouse's Name: _____		
Phone (H): _____			Spouse's Occupation: _____		
Phone (Cell): _____			Emergency Contact: _____		
Phone (W): _____			Relationship: _____		
Email: _____			Phone (Cell): _____		
Date of Birth: _____	Age: _____		Phone (Other): _____		
Gender: _____	<input type="checkbox"/> Female	<input type="checkbox"/> Male	Would you like us to check your Insurance? <input type="checkbox"/> YES <input type="checkbox"/> NO		
Marital Status	S	M	D	W	Company: _____ SS #: _____
Referred by: _____					

CURRENT/PRESENT HEALTH HABITS & PROBLEMS



Please Mark

- Present Complaint(s): _____
- When did the pain/problem start: _____
- What is the type of pain you are experiencing?
 Sharp Dull Aching Numbness Throbbing Other
- What is the severity of your pain?
 Least Pain - 1 2 3 4 5 6 7 8 9 10 - Severe Pain
- Is your problem worse at certain times of the day?
 Morning Afternoon Evening Night Other
- Are there any activities/movements that are painful to perform?

- Is this condition getting progressively worse? YES NO
- Does the problem/condition refer anywhere? (Ex: into right arm)

- What have you done for the problem/condition? (Ex: ice/heat)

How many times have you visited a Chiropractor in your lifetime? _____ Never

When was your last complete spinal examination including x-rays? _____ Never

Have you ever been told that you have a spinal curvature, arthritis, or inherited spinal problem? YES NO

Rate your stress level over the last 90 days. [Low - 1 2 3 4 5 6 7 8 9 10 - High]

Is today's visit related to any one of the following: Work Related Auto Accident Home Injury Fall Other

Do/Did you smoke? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you drink coffee/caffeine? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you exercise regularly? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you eat fast-food? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you have stress? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you consume white sugar? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you drink alcohol? <input type="checkbox"/> YES <input type="checkbox"/> NO	Do you use artificial sweeteners? <input type="checkbox"/> YES <input type="checkbox"/> NO

Patient Signature: _____

Date: _____

FAMILY HEALTH HISTORY

It is well known that families who maintain strong healthy, well-aligned spines have much improved health.

Spouse Name:	Age:	Health Challenge: (ex: Fatigue)
Child Name:	Age:	Health Challenge: (ex: Hyperactivity)
Child Name:	Age:	Health Challenge: (ex: ADHD)
Child Name:	Age:	Health Challenge: (ex: Bedwetting)
Child Name:	Age:	Health Challenge: (ex: Allergies)

Please Mark the Following:

	Father	Mother	Spouse	Siblings	Children
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches/Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scoliosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus & Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE EXPERIENCED IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL CODE

- Arm Pain
- Difficulty Chewing
- General Stiffness
- Herniated Disk
- Jaw Pain/Clicking Jaw
- Joint Pain/Stiffness
- Low Back Pain
- Neck Pain
- Pain Between Shoulders
- Walking Problems

C-V-R CODE

- Chest Pains
- Ankle Swelling
- Asthma
- Heart Problems
- High/Low Blood Pressure
- Irregular Heartbeat
- Lung Problems/Congestion
- Shortness of Breath
- Stroke
- Varicose Veins

NERVOUS SYSTEM CODE

- Cold/Tingling Hands or Feet
- Confusion/Depression
- Dizziness
- Fainting
- Forgetfulness
- Loss of Balance
- Loss of Memory
- Loss of Smell
- Loss of Taste
- Nervousness
- Numbness
- Pinched Nerves
- Pins and Needles
- Stress/Tension

GENITO-URINARY CODE

- Bladder Trouble
- Discolored Urine
- Painful/Excessive Urination

EENT CODE

- Sinus Problems
- Dental Problems
- Ear Aches
- Ears Ring
- Hearing Difficulty
- Sore Throat
- Visual Problems

GEN CODE

- Fatigue
- Allergies
- Fever
- Headaches
- Loss of Sleep
- Migraines

GASTRO-INTESTINAL CODE

- Abdominal cramps
- Constipation
- Excessive Thirst
- Frequent Nausea
- Gall Bladder Problems
- Gas/Bloating After Meals
- Heartburn/Indigestion
- Liver Problems
- Poor/Excessive Appetite
- Ulcers
- Vomiting
- Weight Problems

FEMALES ONLY

- Menstrual Irregularity
 - Trouble Getting Pregnant
 - Menstrual Cramps
 - Miscarriage
- Are you pregnant?
- YES NO Unsure

HAVE YOU BEEN DIAGNOSED WITH HAVING:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> *Broken Fractured Bones | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures/Convulsions |
| <input type="checkbox"/> *Cancer | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> *Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> *Osteoarthritis | <input type="checkbox"/> Excessive/Bleeding Disorder | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> *Rheumatoid Arthritis | <input type="checkbox"/> Gout | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Hernia | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Other: |

*Explanation:

LIST MEDICATIONS:

Patient Signature: _____

Date: _____

Privacy Notice

Kristina R. Ring D.C. & Mark L. Botha D.C.

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION PLEASE READ IT CAREFULLY AND SIGN. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted by law. We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time.

Uses And Disclosures Of Protected Health Information Based Upon Your Written Consent

You will be asked by your chiropractor to sign this consent/acknowledgment form. By signing the consent/acknowledgment form, your chiropractor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you may also use and disclose your protected health information to pay your health care bills and to support the operation of the chiropractor's office.

Following are examples of the types of uses and disclosures of your protected health care information that the chiropractor's office is permitted to make once you have signed this consent/acknowledgment form:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your chiropractic care and any related services. This includes the coordination or management of your chiropractic care with a third party that has already obtained your permission to have access to your protected health information.

Payment: Your protected chiropractic information will be used, as needed, for your chiropractic services. This may include certain activities that your chiropractic insurance plan may undertake before it approves or pays for the chiropractic services we recommend for you such as; making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your chiropractor's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of chiropractic students, substitute chiropractors, doctors who observe our practice, licensing, marketing, fundraising activities, and conducting or arranging for other business activities.

In addition we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting or adjusting room. We may use your health information to call you to remind you of, cancel or re-schedule an appointment. We may leave a message on your answering machine or voice mail. To promote a less stressful, family friendly and time efficient environment, most office visits are performed in an open area where complete privacy of your name and health information will be respected but cannot be guaranteed. Special appointment times are available by request for discussion of private or confidential matters. We may mail appointment reminders, announcement or greeting cards to your home. Your name or picture may be used on a "Thank You for Referring", "Welcome to Our Office" or office bulletin board unless you specifically request us not to do so. Your private information will be used when we bill insurance claims for you or need to collect an outstanding balance using an outside collection agency.

We may share your protected health information with third party "business associates" that perform various activities (e.g., billing transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Contact to request that these materials not be sent to you. Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your chiropractor or the chiropractic practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your protected health care information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your chiropractor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

NOTICE OF PRIVACY PRACTICES (continued)

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your chiropractic care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: We may use or disclose your protected health information in an emergency treatment situation. If this happens, your chiropractor shall try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If your chiropractor or another chiropractor in the practice is required by law to treat you, and the chiropractor has attempted to obtain your consent, but is unable to obtain your consent, he or she may still use or disclose your protected health information to treat you.

Communication Barriers: We may use and disclose your protected health information if your chiropractor or staff member in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the chiropractor or staff member determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

We may use or disclose your protected health information in the following situations without your consent or authorization:

When required By Law, Public Health, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration, Legal Proceedings, Law Enforcement, Funeral Directors, and Organ Donation, Criminal Activity, Military Activity, Inmates and National Security:

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance.

You have the right to inspect and copy your protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, health operations or additional uses listed above in paragraph 8. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your chiropractor is not required to agree to a restriction that you request. If your chiropractor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your chiropractor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for this request. Please make this request in writing to our Privacy Contact. You may have the right to have your chiropractor amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint. The terms of this Notice may change. If the terms do change you may receive a revised Notice by contacting our Privacy Contact.
Privacy Contact: Kristina R. Ring, Office Manager (303) 321-2252

I have received a copy of this office's Notice of Privacy Practices and consent to the use and disclosure of protected health information by Mark L. Botha D.C. & Kristina R. Ring, D.C., staff and business associates for treatment, payment, health care operations and additional uses listed above. I have reviewed, acknowledge, and understand the content of the Notice of Privacy Practices.

"You May Refuse To Sign This." THIS NOTICE WAS PUBLISHED AND BECOMES EFFECTIVE ON APRIL 14, 2003.

Printed Patient Name: _____

Signature: _____

Date: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____



Terms of Acceptance

When a person seeks Chiropractic care and we accept a person for such care it is essential for both to be working towards the same objective. Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent confusion.

Adjustment: A specific application of forces to facilitate the body's correction of the vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebrae in the spine resulting in nerve dysfunction, resulting in the lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease. Our focus in this office is the vertebral subluxation. However, if we encounter non-chiropractic or unusual findings we will advise you. If you desire advice, diagnoses or treatment for those findings we recommend that you seek another healthcare provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. Our **ONLY** practice objective is to locate, analyze and correct vertebral subluxation by specific adjustments.

I, _____ have read and fully understand the above statements.
(print name)

All questions regarding the chiropractors' objectives to my care in this office have been answered to my complete satisfaction. I therefore accept care on this basis.

Signature _____ Date _____

CONSENT TO EVALUATE AND ADJUST A MINOR

I, _____ being the parent or legal guardian of _____ have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive Chiropractic care.

Signature _____ Date _____

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his staff have my permission to perform X-ray. Date of last menstrual period: _____

Signature _____ Date _____