

## **Get Moving Chiropractic**

Dr. Katy R. Mooberry DC and Dr. Isaac A. Mooberry DC  
2942 Evergreen Parkway, Suite 305 Evergreen, CO 80439 Phone: 303-670-7777 Fax: 303-482-1946

### ***Patient Registration***

Patient Name \_\_\_\_\_ Accident/Injury Date \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State/Zip \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F Marital Status S  M  W  D

Phone Number: Home \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_ Credit Card # \_\_\_\_\_ Exp \_\_\_\_\_

Social Security # \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Spouse's cell \_\_\_\_\_

In case of Emergency, who can we notify, besides your spouse: \_\_\_\_\_

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

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

How did you find our office?  Medical Doctor  Internet  News Paper  Other \_\_\_\_\_

**If you were referred, who may we thank?** \_\_\_\_\_

#### **Insurance Information**

We will make a copy of your insurance card/s. However, please complete the following information.

Are you the policyholder? Y  N  If no, who is the policy holder:  Spouse  Parent  Employer  Other

Policy Holder's Name \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder's Social Security # \_\_\_\_\_ Policy Holder's Birth Date \_\_\_\_\_

Do you have secondary insurance coverage? Y  N  If yes, please let us know as well.

**If this is an auto accident/work related accident please fill out the following:**

Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_

Claim #: \_\_\_\_\_ Billing Address: \_\_\_\_\_

Name of the Insured: \_\_\_\_\_ Contact/Claim Agent: \_\_\_\_\_

#### **Health Attitude**

Your attitude and belief about your health is as important to us as is the specific reason you've consulted this office. Listed below are the 3 most prevalent health attitudes. *Please CHECK the one that most accurately and closely reflects your personal values.*

- ACUTE SYMPTOM CARE**: I am only concerned about relief of symptoms for my current problem.
- REHABILITATIVE/CORRECTIVE CARE**: I am concerned about symptom relief AND preventing the return of symptoms in the future.
- PREVENTATIVE, WELLNESS AND FAMILY CARE**: I am interested in relief of symptoms, prevention, and life style changes to maximize my potential for health and the health of my family members.
- I would like to schedule a comprehensive nutritional analysis.
- I'M NOT SURE; I WOULD LIKE TO TALK WITH THE DOCTOR ABOUT THIS.**

**Signature:** \_\_\_\_\_

\*To be completed by the guardian if the patient is a minor under 18 years old. I hereby authorize Get Moving Chiropractic to treat (minor's name): \_\_\_\_\_

**Guardian's signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Confidential Health Questionnaire

PLEASE ANSWER EVERY QUESTION: If something does not apply to you put "N/A".

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

### Chief Complaint:

Pain in:  Head  Neck  Mid back  Low back  
 Arm  Leg  Shoulder  Other \_\_\_\_\_

### History of Present Illness:

When did you pain begin? \_\_\_\_\_ Work-related?  Yes  No

How did your pain begin?  
 Bending  Lifting  No apparent reason  
 Fall  Car Accident  Fall  Other \_\_\_\_\_

Have you had a similar episode before?  Yes  No

Have you been told what is wrong?  No  Yes, explain \_\_\_\_\_

Has your pain:  Improved  Worsened  Not changed

Is your pain:  Constant  Intermittent

Is your pain:  Sharp  Achy  Numb  Tingly  Shooting  Dull

### What Level would you Rate your Pain Right Now? (Please circle)

None 0 1 2 3 4 5 6 7 8 9 10 Most severe Worse pain \_\_\_/10

### Prior Treatment for your CURRENT Problem:

Ibuprofen  Celebrex  Tylenol  Aspirin

Other  How many per day \_\_\_\_\_ Results \_\_\_\_\_

Cortisone pills  Cortisone injection Results \_\_\_\_\_

Other medications \_\_\_\_\_ Results \_\_\_\_\_

Surgery: Year/Procedure/Results \_\_\_\_\_

Physical therapy: Year/Procedure/Results \_\_\_\_\_

Chiropractic: Year/Procedure/Results \_\_\_\_\_

Other treatment: Year/Procedure/Results \_\_\_\_\_

### How do the Following Affect your Pain?

	Worse	Better	No change
Cough/sneeze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sit to stand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending forward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending backward	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nighttime	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afternoon	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Looking up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Turning head	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### Date/Results of Last:

X-ray \_\_\_\_\_

MRI \_\_\_\_\_

CT \_\_\_\_\_

Lab \_\_\_\_\_

Other \_\_\_\_\_

Physical/Ob-GYN \_\_\_\_\_

### Current Work Status:

Regular duty  Limited/light duty – Date light duty began \_\_\_\_\_

Off work – Date you began not working \_\_\_\_\_

### **FOR PROVIDER USE ONLY**

Loc/Ref \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

O \_\_\_\_\_

C \_\_\_\_\_

Q \_\_\_\_\_

ADL \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Job \_\_\_\_\_

Sleep \_\_\_\_\_

↑P \_\_\_\_\_

\_\_\_\_\_

↓P \_\_\_\_\_

\_\_\_\_\_

AS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**PATIENT AUTHORIZATION FOR THE USE AND  
DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby authorize the Get Moving Chiropractic Clinic, PC to the use and/or disclosure of my protected health information by the above chiropractor for the purpose of analyzing, diagnosing, or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of a chiropractor. I understand that analysis, diagnosis, or treatment of me by the above chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have a right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. The above chiropractor is not required to agree to the restrictions that I may request. However, if the above chiropractor agrees to a restriction that I request, the restriction is binding on the chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that the chiropractor has taken action in reliance on this consent.

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

I have been provided with a copy of the Notice of Privacy Practices by the above chiropractor and understand it prior to my signing this document. The Notice of Privacy Practices describes the types of use 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 the chiropractor. This notice is also posted at the office at 2942 Evergreen Parkway, Suite 305 Evergreen, CO 80439. This notice of privacy practices also describes my rights and duties of the above chiropractor with respect to my protected health information.

The chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practice by calling the office of the above chiropractor and requesting a revised copy be sent in the mail or at the time of my next appointment.

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Signature of Patient or Guardian

Printed Name of Patient/Guardian

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Date of Signing

Description of Guardian

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**New Patient Consent Form**

\*Please read the following carefully and initial each statement on the line provided.

\_\_\_\_ **Financial Policy and Agreement:** Payment is required for all office services on the day of service and may be paid by cash, check or credit card. There is a \$30 fee for all returned checks. Payment on the day of service is eligible for a cash discount if you have a zero balance. If you have insurance that pays for chiropractic care, we will be glad to bill them for you. You must pay deductibles and co-payments, if applicable, at the time of service. If you need assistance or need to make special arrangements please talk with us. **I understand that I am financially responsible for all charges whether or not paid by insurance and if I terminate or suspend my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I will be responsible for any costs of collections, attorney’s fees or court costs required to collect my bill. If my bill is turned over to collection, I will pay for the charge added to my account.**

Insurance is billed by code; payment varies by plan.

\_\_\_\_ **Patient Release and Agreement:** I authorize the release of any information including diagnosis and the records of any treatment rendered to me or my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to Get Moving Chiropractic all medical benefits otherwise payable for medical services. I authorize the use of this signature on all my insurance submissions and to obtain medical records.

\_\_\_\_ **Consent and Agreement:** Chiropractic examination and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. Occasionally, however, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are small, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, temporary worsening of symptoms, broken bones and strokes. The more serious complications are extremely rare. Additional information on side effects and complications is available upon request. It is also our policy to inform you of the procedure being performed and the risks and alternative treatments available. If your physician does not explain to your satisfaction, please ask for more information.

I have read and understand the above statements regarding treatment side effects and I also understand that there is no guarantee for a cure for any symptom, condition or disease as a result of treatment in this office. An attempt to provide you with the very best care is our goal and if the results are not acceptable, we will refer you to another provider who we feel can assist you further.

**THERE IS A 24 HOUR CANCELLATION POLICY OR YOUR ACCOUNT WILL BE CHARGED \$25.00.**

**I have read all three of the above agreements and I accept these terms and conditions.**

\_\_\_\_\_  
Patient signature or Guardian if patient is under 18 years of age

\_\_\_\_\_  
Date