



PATIENT INFORMATION

Please allow our staff to photocopy your driver's license and all available insurance cards.

WELCOME! PLEASE PRINT.

Full Name \_\_\_\_\_ Gender: M F Home Phone \_\_\_\_\_

Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Age \_\_\_\_\_ Birth Date \_\_\_\_\_

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

Marital Status (circle one): S M W D Sep No. Children \_\_\_\_\_ Names of Children \_\_\_\_\_

Do You Have Health Insurance? (Y) (N) Email Address \_\_\_\_\_ Driver's Lic # \_\_\_\_\_

Your Employer \_\_\_\_\_ Your Occupation \_\_\_\_\_ Years on Job \_\_\_\_\_

Emergency Contact (Spouse or Parent?) \_\_\_\_\_ Best # to reach them? \_\_\_\_\_

If parent, their address \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

"I wish to have a wellness check" ( )

MEDICARE PATIENTS: Dr. Ranae is a non participating provider for Medicare. Please ask us how this works for you!

Describe the major complaints that bring you to our office \_\_\_\_\_

The pain interferes with ( ) Work ( ) Sleep ( ) Walking ( ) Sitting ( ) Hobbies

Is your condition due to an accident? ( ) No ( ) Yes ( ) Auto ( ) Work ( ) Other Date of your accident \_\_\_\_\_

Do you change the oil in your car regularly? ( ) Yes ( ) No Do you go to the Dentist for regular checkups? ( ) Yes ( ) No

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or non-covered. Dr. Beard is a contracted provider for Blue Cross health plan, I understand I am responsible for all copayments and non-covered services. I understand and agree to pay all copays and fees for services prior to seeing the doctor. We do offer a time of service discount when services are paid in full at the time of the visit. Payment plan options are available as well. Payment is expected at the time of the visit unless other arrangements have already been made. We accept the following forms of payment: Cash, personal checks, Visa, MasterCard and Discover. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually). Any account where no payment has been received for sixty (60) days may be sent to a third party collection agency. Any additional collection fees will be the responsibility of the patient, not Access to Health.

I (we) authorize the doctor and staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Please feel free to ask us any financial questions you may have. Our intent is to provide you with the highest level of service as well as care.

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

Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

# SYMPTOMS

\*Check any symptoms you are experiencing or have experienced

## General

- Nervousness
- Irritable
- Depressed
- Fatigue
- Feel run-down
- Loss of sleep
- Loss of taste
- Loss of balance

## HEAD

- Headache
- Entire head
- Back of head
- Forehead
- Temples
- Migraine
- Head feels heavy
- Loss of memory
- Dizziness
- Ringing in ears
- Buzzing in ears

## NECK

- Pain in neck
- Neck pain with movement
- Neck feels out of place
- Stiff neck
- Muscle spasm in neck
- Grinding sounds in neck
- Popping sounds in neck

## SHOULDERS

- Pain in shoulder joint(R / L)
- Pain across shoulders
- Can't raise arm (R / L)
- Above shoulder level
- Over head
- Tension in shoulders
- Muscle spasms in shoulder

## ARMS & HANDS

- Pain in arm (R / L)
- Pain in fingers (R / L)
- Pins & needles in arm (R / L)
- Pins & needles fingers (R / L)
- Fingers go to sleep (R / L)
- Cold hands (R / L)
- Joints swollen in fingers (R / L)
- Loss of grip strength (R / L)

## CHEST

- Chest pain
- Shortness of breath
- Pain around ribs

## MID-BACK

- Mid-back pain
- Pain between the shoulders
- Stabbing pain mid-back
- Muscle spasms

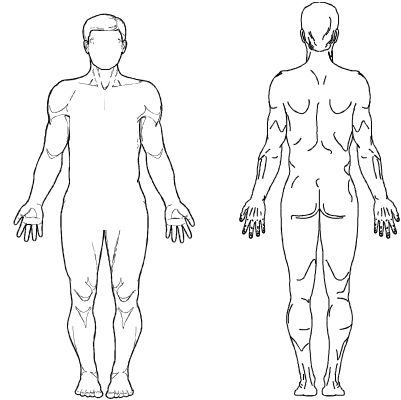
## LOW-BACK

- Low back pain
- Pain worse when:
- Working
- Lifting
- Stooping
- Standing
- Bending
- Coughing
- Sitting
- Normal housework
- Back feels out of place
- Muscle spasms

## WOMEN ONLY

- Menstrual pain
- Cramping
- Irregularity
- Hot Flashes

## PLEASE MARK THE AREAS OF PROBLEMS OR PAIN WITH AN "X"



## HIPS, LEGS & FEET

- Pain in buttock (R / L)
- Pain in hip joint (R / L)
- Pain down leg (R / L)
- Leg cramps
- Pins & needles in leg (R / L)
- Numbness of leg (R / L)
- Numbness of feet (R / L)
- Numbness of toes
- Feet feel cold
- Cramps in feet
- Swollen ankles
- Swollen feet
- Painful joints in toes
- Painful knee joints (R / L)

## ABDOMEN

- Nervous stomach
- Nausea
- Gas
- Constipation
- Diarrhea
- Heartburn

Please place a **slash mark** to show where you rate your pain right now.

1<sup>st</sup> area of complaint \_\_\_\_\_  
 Absent \_\_\_\_\_ Severe

2<sup>nd</sup> area of complaint \_\_\_\_\_  
 Absent \_\_\_\_\_ Severe

3<sup>rd</sup> area of complaint \_\_\_\_\_  
 Absent \_\_\_\_\_ Severe

# CASE HISTORY

Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present. **An understanding of your health history will help us to determine appropriate care.**

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_ HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

## Review of Systems

1. Do you have skin, hair and/or nail problems? Yes No \_\_\_\_\_
2. Do you have mouth and/or throat problems? Yes No \_\_\_\_\_
3. Do you have nose and/or sinus problems? Yes No \_\_\_\_\_
4. Do you have ear problems? Yes No \_\_\_\_\_
5. Do you have eye problems? Yes No \_\_\_\_\_
6. Do you have chest and/or lung (breathing) problems? Yes No \_\_\_\_\_
7. Do you smoke? Yes No Amount \_\_\_\_\_ How Long \_\_\_\_\_
8. Do you have heart and/or blood vessel problems? Yes No \_\_\_\_\_
9. Do you have blood and/or lymph node problems? Yes No \_\_\_\_\_
10. Do you have digestive problems? Yes No \_\_\_\_\_
11. Do you have genital problems (e.g. prostate, testicular, vaginal)? Yes No \_\_\_\_\_
12. Do you have urinary (including kidney or bladder) problems? Yes No \_\_\_\_\_
13. **Females**, have you had menstrual problems? Yes No \_\_\_\_\_  
Have you ever taken birth control pills? Yes No How long \_\_\_\_\_  
Is there any chance you are currently pregnant? Yes No \_\_\_\_\_  
Do you have breast problems? Yes No \_\_\_\_\_
14. Do you have nervous system disease and/or mental health problems? Yes No \_\_\_\_\_
15. Do you have gland and/or hormone problems? Yes No \_\_\_\_\_
16. Do you have allergy and/or immunity problems? Yes No \_\_\_\_\_
17. Do you have muscle, tendon and/or ligament problems? Yes No \_\_\_\_\_
18. Do you have bone and/or joint diseases (e.g. osteoporosis, arthritis)? Yes No \_\_\_\_\_

## Past History

19. List any diseases you have had in the past, including childhood diseases: \_\_\_\_\_
20. Tell us if you have ever been diagnosed with a particular condition such as diabetes, cancer, AIDS, etc: \_\_\_\_\_
21. Have you suffered any physical injuries such as falls or blows, concussions or head injuries, automobile accidents, whiplash, lacerations, sprains, strains, dislocations, broken or cracked bones? Yes No \_\_\_\_\_
22. List any surgeries you have had (do not forget appendix, tonsils, ear tubes, wisdom teeth, etc):  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_
23. Have you ever been hospitalized for any reason other than surgery? Yes No \_\_\_\_\_

# CASE HISTORY

FULL NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Medications and/or Nutritional Supplements

24. Please list all medications (prescription and non-prescription) or nutritional supplements you are currently taking or take on an occasional basis: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

25. Your diet is:      Balanced      Fair      Poor      Excessive      Restricted

## Family History

26. Are there any diseases or conditions that are common among your family members (i.e. inherited diseases or conditions)?    Yes    No \_\_\_\_\_  
\_\_\_\_\_

## Social History

27. In what position do you usually sleep, and how well? \_\_\_\_\_

28. Do you exercise on a regular basis?      Yes    No \_\_\_\_\_

29. How do you spend your spare time (hobbies, etc)? \_\_\_\_\_

30. Do you use:    Caffeine      Tobacco      Nicotine      Alcohol      Recreational Drugs

31. Please describe your work.

Type:    Professional    Physical Labor    Driver      Clerical      Factory    Homemaker

Physical demands:      Heavy      Moderate    Mild      Sedentary

Stress level:              High      Medium    Low

## Additional Questions

32. Do you have problems with recurring headaches?    Yes    No \_\_\_\_\_

33. Are you losing weight without trying?              Yes    No \_\_\_\_\_

34. Does your pain wake you up at night?              Yes    No \_\_\_\_\_

35. Have you had a change in bowel or bladder habits?    Yes    No \_\_\_\_\_

36. Have you had a sore that does not heal?              Yes    No \_\_\_\_\_

37. Have you recently had any unusual bleeding or discharge?      Yes    No \_\_\_\_\_

38. Do you have a thickening/lump in the breast or elsewhere?      Yes    No \_\_\_\_\_

39. Do you have indigestion and/or difficulty swallowing?      Yes    No \_\_\_\_\_

40. Have you had an obvious change in a wart or a mole?      Yes    No \_\_\_\_\_

41. Do you have a nagging cough and/or hoarseness?      Yes    No \_\_\_\_\_

42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history which was not requested, please fill it in below. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

43. Please describe your current complaint. In other words, what brought you here? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

44. Who is your medical doctor? \_\_\_\_\_

# PATIENT HEALTH SURVEY

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Have you ever (at any time) experienced any of the following?

Difficulty urinating	Y	N	Claustrophobia (fear of small spaces)	Y	N
Loss of bladder control	Y	N	Spinal surgery	Y	N
Loss of bowel control	Y	N	Common cold/flu	Y	N
Temporary loss of vision, one eye	Y	N	Carotid artery surgery	Y	N
Blood in urine	Y	N	Breast removal	Y	N

## Have you ever been diagnosed with or told you have one of the following?

Detached retina	Y	N	Rheumatoid Arthritis	Y	N
Stroke	Y	N	Fractured/broken vertebra	Y	N
Slipped disc	Y	N	Bleeding disorders	Y	N
Herniated disc	Y	N	High blood pressure	Y	N
Osteoporosis	Y	N	Blood in stool	Y	N
TIA's (mini stroke)	Y	N	Cancer	Y	N
Drop attacks (collapsing, but not faint)	Y	N	AIDS	Y	N
Hardening of the arteries	Y	N	Kidney disease	Y	N
Partial or complete paralysis	Y	N	Prostate disease	Y	N

## Do you currently have, or could you be, any of the following?

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy	Y	N
<input type="checkbox"/> Male <input type="checkbox"/> Female		
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker (1 or more packs a day)	Y	N
Surgical/medical implanted devices:		
Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants (ear)	Y	N
Other implanted devices:		
Metal fragments (head, eye, skin)	Y	N
Bullets/shrapnel	Y	N
Body piercing	Y	N
Tattoos	Y	N

## In the past 14 days (2 weeks), have you experienced any of the following?

Nausea	Y	N
Vomiting	Y	N
Vertigo (spinning)	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness or other sensory complaints	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea/Constipation	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
An auto accident	Y	N
A work injury	Y	N
Loss of strength	Y	N
Pain in moving bowels	Y	N
Head trauma	Y	N
Abnormal period	Y	N



## ENTRANCE RECORD

The purpose of chiropractic is to restore and maintain the integrity of the spinal cord and it's nerve roots. Misalignments of the spinal bones which interfere with the nervous system are called SUBLUXATIONS. Subluxations come from many causes and prevent various organs, glands, tissues and muscles from functioning properly.

The goal of chiropractic is to adjust vertebral subluxations for the purpose of allowing the body to function properly and to heal itself.

Chiropractic does not treat disease or symptoms. The doctor of chiropractic's only goal is to allow the body to function properly and her only means is the vertebral subluxation.

Please understand that chiropractic is NOT a substitute for medical treatments of any kind. Also NO statement of the chiropractor is intended as medical diagnosis and should not be confused as such. Chiropractic is not intended to be a treatment of the symptoms of a medical condition or to treat the causes of a medical condition.

When you take a drug or medication there is a risk of dangerous side effect. When any medical test or procedure is performed certain risk is involved. When you walk down stairs, drive in a car, or play sports, there is always risk. On that note, chiropractic adjustments, which are always extremely safe and effective (a typical chiropractors malpractice costs less than her car insurance), pose a very tiny degree of risk in certain situations. The most common side effects seen in a small percentage of people are post adjustment muscle soreness. This is comparative to post exercise soreness. This typically subsides quickly. If you do experience any post adjustment sensations please tell the doctor on your next visit. If you have any questions concerning the safety of chiropractic in certain situations, please explain this to Ranae Beard, DC . She will do her utmost to care for you in the safest and most effective manner, just as she would her own family.

Please PRINT OR WRITE CLEARLY:

I, \_\_\_\_\_ have read the above, understand it fully and undertake Chiropractic care on this basis.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

# *Access To Health, PC*

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Ranae Beard, D.C.  
(970) 530-0981

3113 S. Taft Hill Rd.  
Fort Collins, CO 80526

## NOTICE OF PRIVACY PRATICES

**This notice describes how Chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.**

In the course of your care as a patient of Access to Health, we MAY use or disclose personal and health related information about you in the following ways:

1. Your personal health information, including your clinical records, maybe disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
2. Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO, or your employer (if your employer is responsible for the payment of your services.)

Under federal law, we are also permitted to disclose your health information WITHOUT your consent or authorization in the following circumstances:

1. If we are providing health care services to you based on the orders of another health care provider.
2. If we provide health care services to you in an emergency.
3. If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
4. If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care.
5. If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as described in the examples outlined above, will only be made upon your written authorization.

We normally provide information about your health care to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home, please advise us in writing as to your preferences.

You have the right to inspect or copy your health information for seven years from the date that record was created or for as long as the information remains in our files. In addition, you have the right to request an amendment to your health information. Requests to inspect, copy or amend your health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and protected health information therein. We are also required to provide you with this notice of our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person or persons to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices, or any aspect of our privacy activities you should direct your complaint to one of our doctors. If you would like further information about our privacy policies and practices, please contact Access to Health.

This notice is effective as of today. This notice and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice if I have requested one.

\_\_\_\_\_  
Name (Please print.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## **PATIENT AUTHORIZATIONS**

If you choose not to authorize this information for official use, your decision will have no adverse effect on your care from Access to Health. These authorizations may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our system to be completed.

1. It is our desire for our staff to use your name, address and telephone number for the purpose of contacting you to remind you about scheduled appointments, re-exams or other appointment related issues. A voice message may be left if unable to contact you in person. The use of this information is intended to make your experience with our office more efficient and productive and to further enhance your access to quality health care. Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (Print please.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

2. It is our desire for our staff to use your name, address and e-mail address for the purpose of contacting you to send birthday cards, holiday letters and our monthly newsletter from the doctor and staff. The use of this information is intended to make your experience with our office more efficient and productive and to further enhance your access to quality health care. Your e-mail is not sold or shared. Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (Print please.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

3. It is our desire to express our thanks to you when you refer in a patient by writing your name on our bulletin board in the reception room or in the newsletter. The use of this information is intended to enhance your experience in our office. Your signature indicates your authorization of this activity.

\_\_\_\_\_  
Name (Print please.)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date