ELEVATION SPORTS MEDICINE CLINIC

(DTC): 6841 S. YOSEMITE ST. #105 (DENVER) 2727 BRYANT ST #B3
O: 303-521-0130 F: 866-662-5701 E: elevation.sportsmed@gmail.com
www.elevation-sportsmed.com

LAST NAME:_____, FIRST NAME:_____

ADDRESS: _____

CELL#_____ EMAIL:_____

DATE OF BIRTH: _____ AGE: _____ GENDER: M / F

EMERGENCY CONTACT NAME: _____ CELL:_____

OCCUPATION: _____

Name of your insurance company: _____

PLEASE HAND US YOUR INSURANCE CARD (if applicable) and LICENSE.

MAJOR COMPLAINT(S): headaches, neck, back, low back(pain), upper / lower extremity

Other: _____

IS THIS "PAIN" FROM AN AUTO ACCIDENT? Y / N FROM WORK INJURY? Y / N

(If yes) DATE OF ACCIDENT? _____

WHO MAY WE THANK FOR REFERRING YOU? _____

*WOMEN ONLY: ARE YOU PREGNANT? Y / N DATE OF LAST MENSTRUAL CYCLE:*_____

CONSENT TO CARE: I hereby authorize the doctor to examine me, including X-Rays if indicated by my exam and to administer the appropriate tests, diagnosis and analysis. I further authorize treatments deemed necessary by the findings, including but not limited to: adjustments, EMS, dry needling, TFM, activator, arthrositm, K-taping, heat/ice, exercises, therapies and other rehab unique to the condition. I also understand that in rare cases, underlying physical defects deformities or pathologies may render the patient susceptible for injury. If there are any contraindications to care, the doctor will disclose those indications. I agree and certify to the accuracy of the medical history I listed. I have also read and agree to this and to the full consent to care form the possible risks of treatments and therapies and its information including Privacy Practices found at http://www.elevation-sportsmed.com/consent-payment-policy/

PAYMENT POLICY: I understand payment from insurance is not a guarantee and I am responsible for paying the fees for services AT THE TIME OF SERVICE, NO EXCEPTIONS, regardless of insurance coverage. If insurance does cover chiropractic care, this office will submit claims to your insurance company and you the patient authorize payments be made directly to Dr. J. Alvarez from your insurance company. If insurance sends payments to me (the patient) I will inform Dr. Alvarez and sign those payments over to Dr. J. Alvarez. I have also read and agree to the payment policy found at http://www.elevation-sportsmed.com/consent-payment-policy/

PATIENT SIGNATURE _____ DATE _____

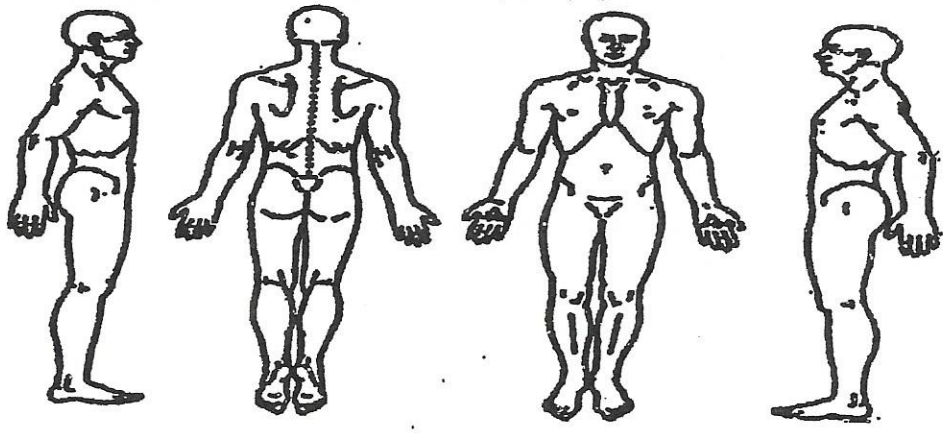
If a minor: Parent or legal guardian signature: _____

PATIENT INTAKE FORM

Patient Name: _____ Date: _____

1. Is today's problem caused by: ☐ Auto Accident ☐ Workman's Compensation Other _____

2. Indicate on the drawings below where you have pain/symptoms



3. How often do you experience your symptoms?

☐ Constantly (76-100% of the time) ☐ Occasionally (26-50% of the time)
☐ Frequently (51-75% of the time) ☐ Intermittently (1-25% of the time)

4. How would you describe the type of pain?

☐ Sharp ☐ Numb
☐ Dull ☐ Tingly
☐ Diffuse ☐ Sharp with motion
☐ Achy ☐ Shooting with motion
☐ Burning ☐ Stabbing with motion
☐ Shooting ☐ Electric like with motion
☐ Stiff ☐ Other:_____

5. How are your symptoms changing with time?

☐ Getting Worse ☐ Staying the Same ☐ Getting Better

6. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

7. How much has the problem interfered with your work?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

8. How much has the problem interfered with your social activities?

☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

9. Who else have you seen for your problem?

☐ Chiropractor ☐ Neurologist ☐ Primary Care Physician
☐ ER physician ☐ Orthopedist ☐ Other:_____
☐ Massage Therapist ☐ Physical Therapist ☐ No one

10. How long have you had this problem? _____

11. How do you think your problem began?

_____

12. Do you consider this problem to be severe?

☐ Yes ☐ Yes, at times ☐ No

13. What aggravates your problem (makes it worse)?

_____

14. What concerns you the most about your problem (is it getting worse, affecting work, social activities, sleep, etc)?

_____

15. What is your: Height_____ **Weight**_____ **Age**_____
Occupation_____

16. How would you rate your overall Health?
□ Excellent □ Very Good □ Good □ Fair □ Poor

17. What type of exercise do you do?
□ Stenuous □ Moderate □ Light □ None

18. Indicate if you have any immediate family members with any of the following:
□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

19. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ Dizziness	□	□ Diabetes
□	□ Neck Pain	□	□ High Blood Pressure	□	□ Frequent Urination
□	□ Heart Attack	□	□ Smoking/Tobacco Use	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Drug/Alcohol Dependance
□	□ Mid Back Pain	□	□ Stroke	□	□ Allergies
□	□ Low Back Pain	□	□ Angina	□	□ Depression
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Systemic Lupus
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Epilepsy
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Dermatitis/Eczema/Rash
□	□ Hand Pain	□	□ Painful Urination	□	□ HIV/AIDS
□	□ Hip Pain	□	□ Loss of Bladder Control		
□	□ Upper Leg Pain	□	□ Prostate Problems	Other	_____
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Ulcer	□	□ Hormonal Replacement
□	□ Joint Swelling	□	□ Hepatitis	□	□ Pregnancy
□	□ Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Rheumatoid Arthritis	□	□ Cancer or Tumor		
□	□ General Fatigue				
□	□ Muscular Incoordination				
□	□ Visual Disturbances				

20. List all prescription medications you are currently taking:
_____

21. List all of the over-the-counter medications and vitamin supplements you are currently taking:
_____

22. List all surgical procedures you have had and their approximate date:
_____

23. What activities do you do at work?

□ **Sit:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Stand:**	□ Most of the day	□ Half the day	□ A little of the day
□ **Computer work:**	□ Most of the day	□ Half the day	□ A little of the day
□ **On the phone:**	□ Most of the day	□ Half of the day	□ A little of the day

24. What activities do you do outside of work?
_____

25. Have you ever been hospitalized? □ No □ Yes
if yes, why _____

26. Have you had significant past trauma (Car Accident, Sport Injury, Broken Bones, etc.)?
□ No □ Yes If yes, Explain _____

27. Have you seen a chiropractor before? __ No __ Yes

28. Anything else pertinent to your visit today?_____

Patient Signature_____ **Date:**_____

NOTICE OF PRIVACY PRACTICES

This summary discloses how health information about you may be used.

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

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

Elevation Chiropractic may use your information to provide appointment reminder, information about treatment alternatives or other health related issues.

Elevation 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, government functions in order to comply with workers compensation and laws and regulations.

Elevation Chiropractic will be adjusting your spine and or extremities in an open adjusting room where it is possible for others to be present, near, or by the treatments. As a result it is possible other patients or bystanders will be able to hear information about your particular case. Given such, Elevation Chiropractic will do its best to keep the conversations as directly one on one as possible. You do have the right to request the adjustments and dialogue be kept private, and that request will be honored.

You have the right to request restrictions, report 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. You may file a complaint with the privacy officer and or to the Department of Health and Human Services if you believe your rights have been violated. You will not be retaliated against for filing a complaint.

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

Any questions or complaints, contact Elevation Chiropractic at 303-521-0130
fax: 720-836-3174

PATIENT SIGNATURE _____ DATE _____

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment:
The doctor will use their hands or a mechanical device in order to move your joints of your spine and or extremities. You may hear a "click" or "pop" such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures such as, but not limited to, hot or cold packs, electrical muscle stimulation, therapeutic ultrasound, exercises, rehabilitation, physical therapies, nutritional advice, and blood labs.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fracture of bone, muscle strain, ligamentous sprain, dislocation of joint(s) or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury/accident (CVA) or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary treatments could produce skin irritation, burns, soreness, or minor complications

Probability of risks occurring:
The risks of complications due to chiropractic treatments have been described as "rare". The risk of a CVA or stroke has been estimated as one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction do to ancillary procedures is also considered rare.

Other treatment options which could be considered may include the following

- Over the counter analgesics. The risks of these medications include to stomach, liver and kidney's, and other side-effects in a significant number of cases
- Medical care: typically anti-inflammatory drugs, tranquilizers, and analgesics. Risk of these drugs include a multitude of undesirable effects and patient dependencies in a significant number of cases.
- Hospitalizations in conjunction with medical care adds risk of exposure to anesthesia as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated:
Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes.

These changes can further reduce skeletal muscle mobility (limiting range of motion) and may get worse over time if left untreated. This can induce chronic pain cycles. It is quite probable the delay of treatment will complicate the condition and make future rehabilitation more difficult.

This disclosure is not meant to scare or alarm you, it is simply an effort to make you better informed so you may give or with hold your consent to treatment.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and herby give my full consent to a history, examination, necessary tests and treatments. 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 may seek treatment.

Patients Name	Signature	Date

FUNCTIONAL DRY NEEDLING® CONSENT AND REQUEST FOR PROCEDURE

Functional Dry Needling® (FDN) involves inserting a tiny monofilament needle in a muscle or muscles in order to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension, and will promote healing. This is not traditional Chinese Acupuncture, but is instead a medical treatment that relies on a medical diagnosis to be effective. Your Doctors training was in accordance with requirements dictated by this facility and by the U.S. state of this practitioner's licensure.

FDN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are *rare* in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: A pneumothorax, injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My Doctor has also discussed with me the probability of success of this procedure, as well as the probability of side effects. Multiple treatment sessions may be required/needed, thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form. I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I authorize Dr. J. Alvarez DC to perform Functional Dry Needling

- for my diagnosis of: Musculoskeletal hypertonia, tendonitis, trigger point, myofascial pain syndrome, strain of the muscle, other: _____
- Causing: referred pain, pain, headaches, decreased muscle function, restricted ROM, painful ROM, other_____

Please answer the following questions:

Are you pregnant? Yes No **If yes, how many weeks?** _____. **Are you immunocompromised?** Yes No

Are you taking blood thinners? Yes No

_____ _____

Patient Name Date

_____

Patient Signature

Doctor Affirmation: I have explained the procedure indicated above and its attendant risks and consequences to the patient who has indicated understanding thereof, and has consented to its performance.

Dr. J. Alvarez DC _____

Dr. J. Alvarez BS, DC, FDN Date

EXAMINATION

Patient Name _____ # _____ Date _____ By _____

PALPATION

	Sub	Code
Occ	L R	Sp P R TP SW
C1	L R	Sp P R TP SW
C2	L R	Sp P R TP SW
C3	L R	Sp P R TP SW
C4	L R	Sp P R TP SW
C5	L R	Sp P R TP SW
C6	L R	Sp P R TP SW
C7	L R	Sp P R TP SW
T1	L R	Sp P R TP SW
T2	L R	Sp P R TP SW
T3	L R	Sp P R TP SW
T4	L R	Sp P R TP SW
T5	L R	Sp P R TP SW
T6	L R	Sp P R TP SW
T7	L R	Sp P R TP SW
T8	L R	Sp P R TP SW
T9	L R	Sp P R TP SW
T10	L R	Sp P R TP SW
T11	L R	Sp P R TP SW
T12	L R	Sp P R TP SW
L1	L R	Sp P R TP SW
L2	L R	Sp P R TP SW
L3	L R	Sp P R TP SW
L4	L R	Sp P R TP SW
L5	L R	Sp P R TP SW
Sac	L R	Sp P R TP SW
PSIS	L R	Sp P R TP SW
PIIS	L R	Sp P R TP SW
Coc	L R	Sp P R TP SW

Sp=spasms P=pain R=restricted
TP=trigger point SW=swelling

STRUCTURAL

L R Occiput Rotation
L R Head Tilt
L R High Shoulder
____ Lifts/Orthotics
L R High Ilium
L R Short Leg
↑ ↓ AP Cervical Curve
↑ ↓ AP Dorsal Curve
↑ ↓ AP Lumbar Curve
____ Antalgic

NEURO

L	R	
__	__	Patella reflex
__	__	Achilles Reflex
__	__	Biceps Reflex
__	__	Triceps Reflex
__	__	BrachRad Reflex

_____

_____

Blood Pressure ____/____

Pulse _____

Cervical Range-of-Motion		
Flexion	90 80 60 40 20 0	PN A R P
Extension	30 20 15 10 5 0	PN A R P
R Lat Flexion	40 30 20 10 0	PN A R P
L Lat Flexion	40 30 20 10 0	PN A R P
R Rotation	90 80 60 40 20 0	PN A R P
L Rotation	90 80 60 40 20 0	PN A R P
Lumber Range-of-Motion		
Flexion	90 80 60 40 20 0	PN A R P
Extension	30 20 15 10 5 0	PN A R P
R Lat Flexion	30 20 15 10 5 0	PN A R P
L Lat Flexion	30 20 15 10 5 0	PN A R P
R Rotation	20 15 10 5 0	PN A R P
L Rotation	20 15 10 5 0	PN A R P

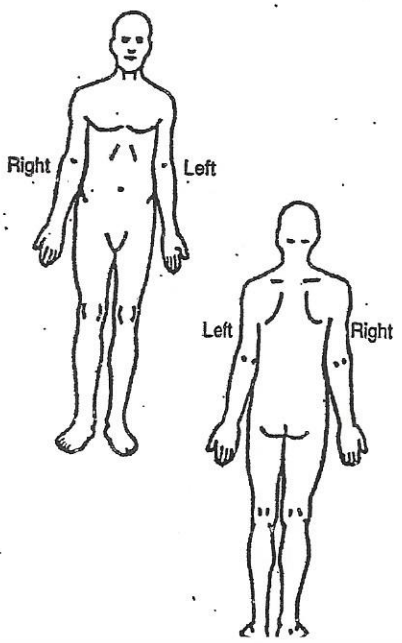
PN=pain A=active R=resistive P=passive

ORTHO

L R Test Name

Rhomberg's Test
Kemp's Test _____
Adam's Test
George's Test
Valsalva's _____
Max Cerv Compression
Jackson's Compression
Shoulder Depression
Wright's Test
Adson's Test
Eden's Test
Allen's Test
Cerv Dist (PN REL)
Solo-Hall _____
Milgram's _____
SLR _____ °L _____ °R
Goldthwait's Test
Braggard's Test
Patrick-Faber Test
Homan's Test
Nachlas' Test
Ely's Test
Hibb's Test
Yeoman's Test
Minor's Sign _____

_____
_____
_____
_____



X-RAYS, OTHER Rx EXAMS

72010 ☐	Full Spine		72052 ☐	Davis-Cervical	
72040 ☐	AP Open Mouth	(8x10)	72040 ☐	AP Open Mouth	(8x10)
72040 ☐	AP Cervical	(8x10)	72040 ☐	AP Cervical	(8x10)
72040 ☐	Lat Cervical	(8x10)	72040 ☐	Lat Cervical	(8x10)
72070 ☐	AP Thoracic	(14x17)	72050 ☐	Extension	(8x10)
72070 ☐	LAT Thoracic	(14x17)	72050 ☐	Flexion	(8x10)
72100 ☐	AP Lumber	(14x17)	72050 ☐	Right Oblique	(8x10)
72100 ☐	Lat Lumbar	(14x17)	72050 ☐	Left Oblique	(8x10)

Other Prescribed Exams or Special Views

_____
_____
_____
_____
_____
_____
_____

Ordered by: _____ Taken by: _____

I am authorizing you to take my x-rays.

I am not pregnant nor think I might be.

REPORT OF PATIENT'S CONDITON

Patient Name_____ Date _____

1. PATIENTS CHIEF COMPLAINT: (please circle)

NECK PAIN	MID-BACK PAIN	LOWER BACK PAIN	DIZZINESS
HEADACHES	SHOULDER PAIN	HIP PAIN	WRIST PAIN
ARM PAIN	LEG PAIN	KNEE PAIN	FOOT PAIN
TMJ	OTHER:_____		

2. ACTIVITIES INTERFERED WITH: (please list)_____

_____

3. DIAGNOSIS:

	CERVICAL
G54.0	BRACHIAL PLEXUS LESIONS
G56.01	CAPRAL TUNNEL SYNDORME
M26.60	TMJ DISORDER
M50.30	CERVICAL IVD DEGENERATION
M48.00	CERVIAL STENOSIS
M54.2	CERVICALIGIA
M53.1	CERVICOBRACHIAL SYNDROME
M43.6	TORTICOLLIS
G44.1	CEPHALGIA
M79.603	FOREARM PIAN
S13.4XXA	CERVICAL STRAIN/PAIN
S14.2	INJURY TO CERVICAL NERVE ROOT
M99.01	CERVICAL SUBLUXATIONS AT_____

	THORACIC
M47.014	THORACIC OUTLET SYNDROME
M51.44	THORACIC SCHMORL'S NODE(S)
M51.34	THORACIC IVD DEGENERATION
M54.14	THORACIC RADICULOPATHY
S23.3XXA	THORACIC STRAIN/PAIN
M99.12	THORACIC SUBLUXATIONS AT_____

	LUMBAR
M51.36	LUMBAR IVD DEGENRATION
M54.5	LUMBALGIA
M54.30	SCIATIC NEURALGIA
M54.16	LUMBAR RADICULOPATHY
M54.08	FACET SYNDROME
M41.9	SCOLIOSIS
Q72.899	LEG LENGTH INEQULITY
S83.90XA	SPRAIN/STRAI OF KNEE OR LEG
S98.40	SPRAIN/STRAIN OF ANKLE
S93.6	SPRAIN/STRAIN OF FOOT
S33.5XXA	SPRAIN/STRAIN OF LUNBAR
M99.13	LUMBAR SUBLUXATIONSAT____

	PELVIS/SACRUM/COCCYX
S76.919A	STRAIN/SPRAIN OF HIP/THIGH
S33.8XXA	STRAIN/SPRAIN OF SACRUM
S33.8XXA	STRAIN/SPRAIN OF COCCYX
M99.14	SACRUM SUBLUXATIONS AT___
M99.07	UPPER EXTREMITY SEG DYSFUN
M99.06	LOWER EXTREMITY SEG DYSFUN

COMPLICATING FACTORS FOR ABOVE NOTED DIAGNSIS:

MUSCLE SPASMS	SPONDYLOSIS	DISC DEGENERATION	SEGMENTAL DYSFUNCTION
SPONDYLOLISTHESIS	HYPOLORDOSIS	COMPRESSION FACTORS	KYPHOSIS
OSTEOARTHROSIS	OSTERPOROSIS	CONGENITAL ADNORMALITIES	SCOLIOSIS