Braden O'Dell DC | Whole Health Center

9370 S Colorado Blvd A-10 | Highlands Ranch, CO 80126 | (303) 471-9355 |
DrBraden@WholeHealthCenters.com

PATIENT INFORMATION

Legal Name_____Last Name_____

Preferred Name/Nickname _____

Date of Birth_____ Age_____

Gender assigned at birth ▢ M ▢ F Preferred Gender Identity ▢ M ▢ F ▢ Non-binary
Preferred pronouns: ▢ They/Them/Theirs ▢ Her/Hers ▢ Him/His

Contact Information:

Home Address_____

City _____ State _____ Zip Code _____

Phone _____ ▢ C ▢ H ▢ W

2nd Phone _____ ▢ C ▢ H ▢ W ▢ N/A

Email _____
What Is your preferred method of communication? ▢ Phone ▢ Text ▢ Email

Employer _____

Work Address _____

City _____ State _____ Zip Code _____

Emergency Contact Information:

Emergency Contact _____

Emergency Contact Phone _____ ▢ C ▢ H ▢ W Are you Medicare Eligible? ▢ Yes ▢ No

Do you have a Health Savings Account (HSA) or Flexible Spending Account (FSA)?
▢ Yes ▢No

How did you first hear about Dr. Braden O'Dell/Whole Health Center?

If you were referred by someone, please tell us who so we may thank them:

I AGREE that Whole Health Center, and/or Dr. Braden O'Dell can email me at the email address above, or call or text message me at the 1st phone number above, even if I am on a federal or state do not call registry, for any purpose, including marketing. Message and data rates may apply. I agree that the calls and text messages may be generated using an automatic telephone dialing system and may contain pre-recorded or artificial voice messages. I understand that consenting to receive calls or texts is not required to receive this service.

_____ _____

(Patient or Legal Guardian Signature) **(Date)**

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Chief Concern/History Statement

First Name:_____Last Name:_____ DOB: _____

Height: _____feet _____inches Weight: _____ Assigned Birth Gender: M F Gender Identity: M F Non-Binary

Occupation: _____How Long? _____ Have you had Chiropractic care before: yes no If yes, when?:_____

Reason for Today's visit:

Pain Discomfort Stiffness Wellness Previous Injury (Describe):_____

Recent Injury (describe): _____

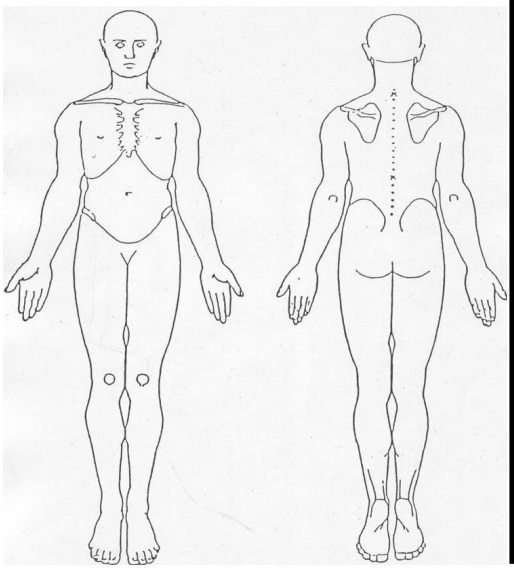
Other (describe): _____

When did your concern(s) begin?_____ Today, is your concern Better Worse The same

What alleviates/reduces your symptoms:_____

What aggravates your symptoms: _____

Mark the location of your symptoms on the body chart below:



Check all applicable locations below	Where is/are your concerns located TODAY?	Rate your PAIN/ DISCOMFORT 0 - 10 0 = no pain 10 = I Need to go to Hospital	CHECK the type/quality of pain:									Frequency	
			Radiating	Sharp	Dull	Aching	Grabbing/ Presure	Numbness	Tingling	Burning	Swollen/ Inflammed	Constant	Intermittent
	Headache/Migraine												
	Neck												
	Shoulder(s)												
	Arm(s)												
	Elbow(s)												
	Wrist(s)/Hand(s)												
	Upper Back												
	Middle Back												
	Lower Back												
	Hip(s)												
	Sciatica												
	Knee(s)												
	Ankle(s)												
	Foot/Feet												

Have you experienced similar symptoms in the Past?: yes no If yes, when?:_____

Are you pregnant? yes no If yes, how many weeks?:_____

Are you experiencing any of the following:

Nausea/Vomiting Rapid Eye Movement Numbness On One Side of the Face/Body Fainting/Lightheadedness Dizziness

Difficulty Walking Difficulty Speaking Difficulty Swallowing The Worst Headache/Migraine You have Ever Had Double Vision

Loss of Balance/Coordination/Dropping Objects Changes in Bowel/Bladder Control Pain/Color Change With Urination

Shortness of Breath/Chest Pressure Pain with inspiration/deep breath Persistent Chest Pain

If yes, please describe:_____

Please Continue Health History and Family Health History on the Next Page

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Health History and Family Health History

Current prescriptions or over-the-counter medications: _____

Past History: Musculoskeletal Conditions (Check all that apply):

Headache/Migraine Hip Pain/Discomfort Arthritis Neck Pain/Discomfort Sciatica Fused/Fixed Joints Herniated disc
Shoulder Pain/Discomfort Elbow Pain/Discomfort Upper Back Pain/Discomfort Middle Back Pain/Discomfort
Low Back Pain/Discomfort Wrist Pain/Discomfort Knee Pain/Discomfort Ankle Pain/Discomfort Osteoporosis Osteopenia
Inflammation/Swelling:_____

Current/Past Medical Conditions (check all that apply):

Cancer Tumors Stroke Seizure Disorders High Blood Pressure Pacemaker Allergies Heart Disease AIDS/HIV
Diabetes Hepatitis Heart/Cardiovascular Disease Heart Attack Stroke Seizure Disorders Bleeding Disorder
Blood Thinners Other: _____

Surgeries:

No Yes: When: _____ Describe: _____

Accidents/Broken Bones:

No Yes: When: _____ Describe: _____

Hospitalizations:

No Yes: When: _____ Describe: _____

Family Health History:

Cancer Tumors Stroke Seizure Disorders High Blood Pressure Heart Attack Diabetes Heart Disease
Other:_____

Signature:_____ Date: _____

Reviewed By: _____Date: _____

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TERMS OF ACCEPTANCE

AS USED IN THESE DOCUMENTS, THE TERMS "WE," "OUR" AND/OR "US" REFERS TO BRADEN O'DELL DC, and WHOLE HEALTH CENTER.

EXPLANATION OF SERVICES:

Routine activities may regularly cause joint restrictions and myofascial dysfunction of the spine and extremities. Joint dysfunction, reflects the nervous system's various resting tones, which in turn create patterns of myofascial engagement. Posture (standing, seated, laying), or body shape/structure is one such example, dynamic movement patterns, such as walking or writing is another. These patterns (technically called engrams) develop based on one's environment, repetitive motions and behaviors, injury and injury compensation movements. Imbalance and dysfunction in this system may cause decreased joint motion, pain, discomfort and/or a lessening of the body's mechanical ability to function properly. Chiropractic therapy focuses on altering this kind of neurologic dysfunction by treating restricted/dysfunctional joints, myofascial and or motor pattern function, and the effects of these disorders on musculoskeletal health.

Our primary focus is providing patients with access to differential diagnosis of musculoskeletal complaints, conserative care and through manual therapy consisting of maintenance/preventative care and injury rehabilitation. Our number one concern is the health and safety of the people we serve.

Therefore, we only accept those patients determined to have the potential to benefit from our care. To receive the most from the services provided, it is important to better understand what we do and don't do:

WHAT WE DO

- We provide the public with an affordable and convenient portal of entry to wellness and injury recovery through chiropractic care, often resulting in better function, improved joint motion, and a healthier, more active lifestyle.
- We accomplish our goal through the gentle application of a targeted movement, where and when indicated by licensed doctors of chiropractic, to improve motion of the body's spinal column and extremities. This is commonly referred to as an adjustment or manual manipulation.
- Soft tissue manipulation including myofascial release, pin and stretch, and muscle energy techniques may also be utilized to further affect the nervous system, muscle resting tone and to help with pain reduction and improved range of motion.
- Physical conditioning and rehabilitative procedures may be recommended as well as physiotherapy modalities including: electrotherapy, therapeutic ultrasound, cryotherapy and/or hot packs.

WHAT WE DON'T DO / LIMITATION OF SERVICES

- We do not offer to treat any disease or condition other than joint dysfunction, sprains/strains, muscle spasm/muscle imbalances associated with the spine and extremities, and/or peripheral nervous system disorders such as radiculopathy, spinal stenosis or peripheral nerve entrapment/neuropathy. We may work with your healthcare team in engaging in the differential diagnosis process for other conditions and the management of certain complaints/conditions.
- **We do not accept or bill insurance, Medicare, and/or any third party carrier for payment.**
- We do not have extensive diagnostic or on-site x-ray equipment, provide invasive testing/treatment on-site or collect blood/urine specimens. However, you may be referred out for x-ray, MRI, diagnostic ultrasound, blood work, urine analysis or other diagnostic testing as part of the differential diagnosis process.

Our services are limited to the reparative/preventative effects of chiropractic care by improving joint and myofascial mobility and function in the spine and extremities, as well as postural and motor patterns of the nervous system.

In the doctor's professional opinion, should any of our patients need x-rays, additional diagnostic testing, or other forms of health care services, they will be referred to an appropriate provider or facility, when indicated. **Unless referred by your primary care physician, your insurance may not cover the expense associated with this testing and you may be required to pay 'out-of-pocket' for the appropriate service.**

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FINANCIAL RESPONSIBILITY:

At the patient's discretion, payment options are available after a Doctor of Chiropractic has determined that chiropractic care is appropriate and has established a treatment plan.

All patients acknowledge that they are financially responsible to remit payment in full for all services provided to them or any minor(s) or dependent person(s).

All patients further understand and agree that we will not submit any billing data or related claim(s) for, or on, their behalf to any private insurance program, Medicare or any Secondary Medicare Insurance Program carrier with whom they have insurance coverage, or otherwise required by applicable law.

TERMS OF ACCEPTANCE AND FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT AND AUTHORIZATION

All questions regarding the doctor's objectives pertaining to my care have been answered to my complete satisfaction. I acknowledge I am financially responsible for any out-of-pocket expenses and that neither Whole Health Center, nor Braden O'Dell DC will bill my insurance. I therefore accept all chiropractic care and services provided to me by Braden O'Dell DC at Whole Health Center based upon these guidelines.

_____

(Patient **Printed Name)**

_____ _____

(Patient **Signature**) (Date)

CONSENT TO EVALUATE AND TREAT A MINOR OR DEPENDENT:

_____(**PATIENT INITIALS):** I have been given, have read, acknowledge and fully understand the **Terms of Acceptance and Financial Responsibility** statements.

The person acknowledging these terms is accepting full legal responsibility as guardian or legally appointed person signing, and by signing are claiming they have legal authority to do so, and acknowledge that they are accepting legal responsibility if they do not in fact have the legal permission.

All questions regarding the doctor's objectives pertaining to my child's/dependent's care have been answered to my complete satisfaction. I therefore authorize all chiropractic care provided to me by Braden O'Dell, DC based upon these guidelines, and hereby grant permission for my child(ren) to receive chiropractic care.

_____ _____

(**Print** name: Parent or Legal Guardian) (**Print** Name: Child)

_____ _____

(Parent or Legal Guardian **Signature**) (Today's Date)

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INFORMED CONSENT TO CHIROPRACTIC CARE

Joint adjustments/manual manipulations are delivered through the application of a targeted movement, where and when indicated, by a licensed Doctor of Chiropractic to improve motion of the body's joint, myofascial and neurological systems.

Chiropractic treatment, including spinal adjustment, soft tissue manipulation and therapeutic exercises, have been the subject of government reports and multidisciplinary studies conducted over many years and has been demonstrated to be an effective treatment for many neck and back conditions involving pain, numbness, muscle spasm, loss of mobility, headaches and other similar symptoms. Chiropractic treatment can facilitate recovery from injury and injury prevention, result in better function, improved joint motion, and a healthier, more active lifestyle. **Guaranteed outcomes or results are not possible as individual responses are varied to Chiropractic Interventions; a person's response may be different after subsequent treatments.**

However, there are some risks associated with chiropractic adjustments, most tissue manipulation and therapeutic exercises including, but not limited to the possibility of **increased soreness, bruising, sprains, dislocations and fractures.** In addition:

1. While rare, some patients may experience **short term aggravation of symptoms (most common)**, muscle and ligament strains or sprains, or rib/other fractures/dislocations as a result of manual therapy techniques including: chiropractic manipulation, soft tissue manipulation/massage, and rehabilitative exercises.
2. There are reported cases of stroke associated with neck movements, this may include adjustments of the upper cervical spine. Albeit, a temporal link of stroke happening days to months after receiving chiropractic care has been suggested. **Current medical and scientific evidence does not establish a definite cause-and-effect relationship between upper cervical spine adjustment and the occurrence of stroke**; **The association is weakly correlated.** However, you are being warned of this possible association because a stroke may cause serious neurological impairment and result In injuries including paralysis.
3. There are reported cases of disc injuries following cervical and lumbar spinal adjustments or other chiropractic treatment. However, **disc herniation may progress over days or weeks, and may already be in progress despite receiving chiropractic adjustments/treatment**.

_____**(Patient Initials)** I understand and am informed that some risks are associated with chiropractic therapy as described above in line points 1-3; I have had the opportunity to ask the Doctor questions regarding these risks.

The risk of Injuries or complications from chiropractic treatments are substantially lower than that associated with many medical or other treatments, medications, and surgical procedures given for the same treatments.

Common alternatives to adjustments/manipulations, soft tissue and rehabilitative exercises include interventions such as: medication(s), physical therapy, "wait-and-watch", acupuncture, massage, other medical treatments and/or surgery provided by physicians and surgeons. **You have the right to utilize certain interventions listed above, and not utilize others.**

By signing this Informed Consent, I acknowledge that I have discussed, or have had the opportunity to discuss, with my Doctor of Chiropractic the nature and purpose of chiropractic treatment in general and my treatment in particular (including spinal and extremity adjustments), the benefits, risks and alternatives to chiropractic treatment.

I consent to the chiropractic treatments offered or recommended to me by my Doctor of Chiropractic, including manual therapy: spinal adjustments, therapeutic massage and soft tissue manipulation (cupping, instrument assisted soft tissue manipulation) and therapeutic exercise, when indicated and discussed with my Chiropractic Physician. I intend this consent to apply to all my present and future chiropractic care received from Braden O'Dell, DC at Whole Health Center.

_____

Patient Printed Name:

_____ _____

(**Patient or Legal Guardian Signature**) (Date)

_____ _____

Witness / Employee Signature) (Date) (Date)

HIPAA Agreement

As your health care provider, we use your health information for evaluation and treatment, as well as to obtain payment for treatment. If you are referred to another health care provider, or at your request, your medical records may be shared with those providers. We may use your health care information without your authorization for the following reasons

- Public health safety
- Auditing purposes
- Emergencies
- At the request of your insurance carrier
- When required by law

In all other circumstances, we will ask your written permission to release your medical information in the form of a "Release of Medical Records" form. If you choose to sign such a form, you have the right to revoke that authorization at any time. If you would like to review our "Notice of Privacy Practices," please request a copy at the front desk. Whole Health Center reserves the right to change the privacy practices that are described in the "Notice of Privacy Practices." You may obtain a revised "Notice of Privacy Practices" by notifying the office of Whole Health Center and requesting a revised copy.

You have the right to view and obtain a copy of your medical record. You also have the right to know to whom we have disclosed your medical records. If you believe the information in your medical record is not correct or missing information, you have the right to request that such information is corrected or added to your medical record.

If you have any questions or concerns about your medical records, please contact Whole Health Center, or you can file a written complaint with the U.S. Department of Health and Human Services. Whole Health Center is required by law to protect your medical information and provide this notice to you, along with your signature acknowledging your receipt of this information.

Our office sends thank you cards for referrals, periodic newsletters, and participates in other non-private contact. This may be via email or postal service. Reminders of your appointments may be via email or telephone.

Consent

I understand that I have a right to read the "Notice of Privacy Practices" prior to signing this form. The "Notice of Privacy Practices" describes the types of uses 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 at Whole Health Center. This "Notice of Privacy Practices" also describes my rights, as well as the duties of the practitioner with respect to my protected health information.

I consent to the use or disclosure of my protected health information by Whole Health Center for the purpose of analyzing, diagnosing, or providing treatment, as well as obtaining payment for my health care bills or to conduct health care operations. I understand that analysis and treatment by Whole Health Center practitioners may be conditioned upon my consent as evidenced by my signature below.

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

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

Patient's Name (please print): _____

_____ _____

Signature of Patient or legal guardian Date