



Colburn  
Chiropractic

Phone: (860) 870-4100

131 New London Tpke, Suite 302  
Glastonbury, CT 06033

**Marla Colburn, DC**

**PERSONAL INFORMATION**

Today's Date:	Social Security Number:	Referred by:
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First Name:	Initial:	Last Name:	Nick Name:	Gender: Male      Female
Address:		City:	State:	Zip:

Home Telephone:	Work Telephone:	Cell Phone:
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Date of Birth:	Age:	Marital Status:	Number of Children:
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Family Physician:	Telephone:	Address:
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Occupation:	Employer:	Telephone:
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Primary Insurance Co:	ID:	Group#:
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Guarantor's Name:	Address:
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Secondary Insurance Co:	ID:	Group #:
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Address:
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Emergency Contact:	Relationship:	Telephone:	Cell Phone:
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If patient is under 18 years old – please complete below			
Parent's Name:	Home Telephone:	Work Telephone:	Cell Phone:
Parent's Name:	Home Telephone:	Work Telephone:	Cell Phone:

Assignment and Release: *I hereby authorize and direct my insurance benefits to be paid directly to Marla Colburn, DC and I understand I am financially responsible for any and all non-covered services provided by Marla Colburn, DC.*

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

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## CASE HISTORY

### COMPLAINT AREA 1

There is room on this page to list 2 different areas of complaint. If you have more than 2 areas of complaint, please ask for more forms. Thank you.

What is your current condition or problem?		Onset of problem?	Sudden	Gradual
What caused the problem?		Date Started:		
What makes the problem feel worse?				
What makes the problem feel better?				
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:			
Where is the primary site of the problem?				
Where does the problem refer to?	<i>(For example: neck pain that refers to the right arm.)</i>			
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed? Morning / Afternoon / Night		
Other associated symptoms?				
What is the status of the condition?	Improving / Same / Worsening	Explain:		

### COMPLAINT AREA 2

What is your current condition or problem?		Onset of problem?	Sudden	Gradual
What caused the problem?		Date Started:		
What makes the problem feel worse?				
What makes the problem feel better?				
How is the problem described?	Achy / Burning / Cold / Fatigue / Hot / Numb / Pins & Needles / Sharp / Tense / Weak / Other:			
Where is the primary site of the problem?				
Where does the problem refer to?	<i>(For example: neck pain that refers to the right arm.)</i>			
How often do you notice the problem?	Come and Go / Constant	When is the problem noticed? Morning / Afternoon / Night		
Other associated symptoms?				
What is the status of the condition?	Improving / Same / Worsening	Explain:		

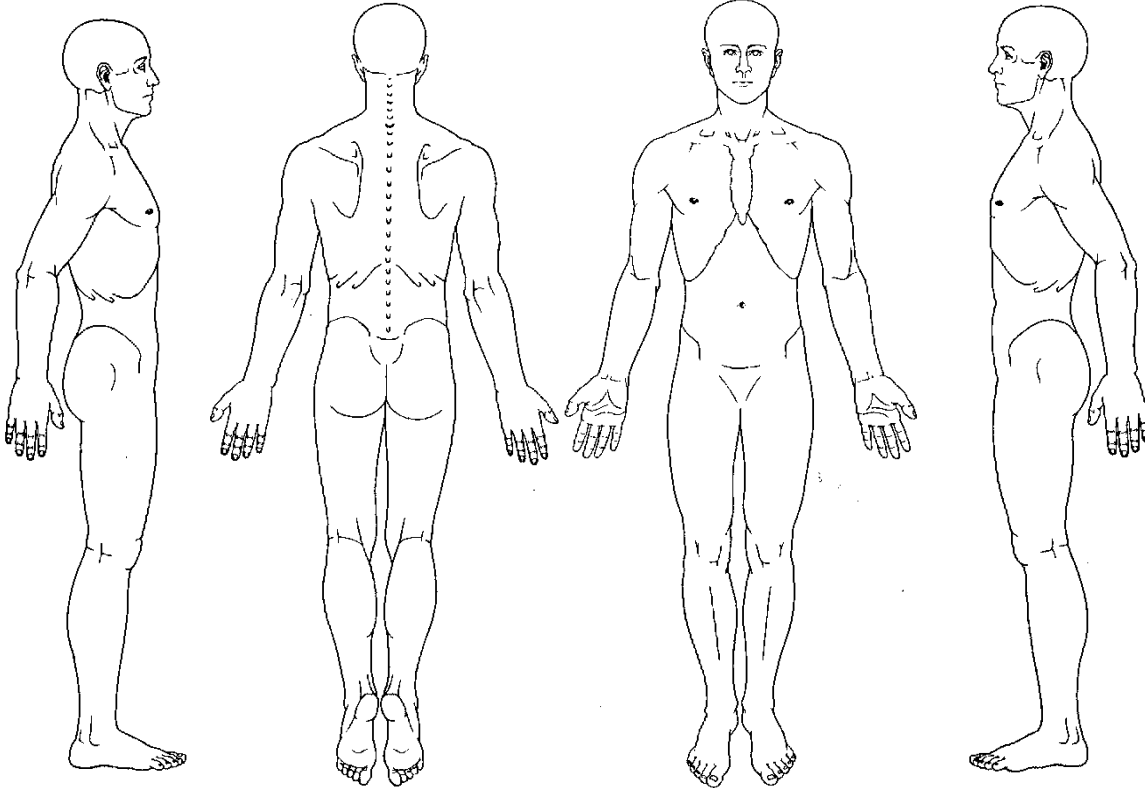
Name: \_\_\_\_\_

Date: \_\_\_\_\_

## SYMPTOM DRAWING

**Mark the area on your body where you feel the following sensations**

Aches: AAAA      Cramping: CCCC      Pins & Needles: PNPN      Stabbing: /////  
Burning: XXXX      Numbness: +++++      Sensitive: SSSSS      Other: OOOOO



**Rate the severity of your symptom(s) from 0 to 10 by marking "X" at the appropriate point on the line.**

(Example: 0 \_\_\_\_\_ X \_\_\_\_\_ 10)  
                    No Symptoms                      5                      Worst possible, Unbearable

- ( ) Rate your head symptom(s)                      0 \_\_\_\_\_ 10
- ( ) Rate your neck symptom(s)                      0 \_\_\_\_\_ 10
- ( ) Rate your mid back symptom(s)                      0 \_\_\_\_\_ 10
- ( ) Rate your low back symptom(s)                      0 \_\_\_\_\_ 10
- ( ) Rate your arm symptom(s)                      0 \_\_\_\_\_ 10
- ( ) Rate your leg symptom(s)                      0 \_\_\_\_\_ 10

Name: \_\_\_\_\_

Date: \_\_\_\_\_

## PAST HISTORY & SYSTEM REVIEW

### PAST AND/OR CURRENT CONDITIONS

Circle (P) Past or (C) Current for any diseases, conditions or symptoms. Please explain in space provided at the end.

<p><b>Childhood</b></p> <p>Chicken Pox            P    C</p> <p>Measles                P    C</p> <p>Mumps                 P    C</p> <p>Rubella                P    C</p> <p>Other                    P    C</p> <p><b>Constitutional</b></p> <p>Addiction(alcohol, smoke, etc)    P    C</p> <p>Habits (alcohol, smoke, other)    P    C</p> <p>Eating disorder                    P    C</p> <p>General fatigue/ weakness        P    C</p> <p>Fevers/ chills                        P    C</p> <p><b>Eyes</b></p> <p>Glaucoma                P    C</p> <p>Vision problems        P    C</p> <p><b>Ears</b></p> <p>Ear infections/ earaches            P    C</p> <p>Hearing loss                P    C</p> <p> ringing                    P    C</p> <p><b>Nose</b></p> <p>    P    C</p> <p><b>Sinus</b></p> <p>Sinusitis/ infection                P    C</p> <p>Pain                        P    C</p> <p><b>Mouth</b></p> <p>Jaw click or mal-position            P    C</p> <p>Grinding                    P    C</p> <p><b>Throat</b></p> <p>    P    C</p> <p><b>Cardiovascular</b></p> <p>Heart disease            P    C</p> <p>Arteriosclerosis        P    C</p> <p>Murmur                    P    C</p> <p>Varicose veins            P    C</p> <p>Arm and/or leg swelling            P    C</p> <p>Chest pain/ pressure                P    C</p> <p>Cold hands and/or feet                P    C</p> <p>High or low blood pressure            P    C</p> <p>High cholesterol                        P    C</p> <p>Leg pains or cramps                    P    C</p> <p>Palpitations                P    C</p>	<p><b>Respiratory</b></p> <p>Lung disease            P    C</p> <p>Asthma                    P    C</p> <p>Emphysema                P    C</p> <p>Pneumonia                P    C</p> <p>Chronic cough            P    C</p> <p>Difficulty breathing/ tightness                    P    C</p> <p><b>Gastrointestinal</b></p> <p>Esophagus disease                    P    C</p> <p>Stomach disease                        P    C</p> <p>Gall bladder disease                    P    C</p> <p>Liver disease                            P    C</p> <p>Intestinal disease                        P    C</p> <p>Hernia                        P    C</p> <p>Peptic ulcer                                P    C</p> <p>Bowel movement changes            P    C</p> <p>Heartburn/ constriction                P    C</p> <p>Indigestion/ nausea                    P    C</p> <p>Jaundice                                  P    C</p> <p>Stools bloody/ dark                    P    C</p> <p>Regurgitation/ vomiting                P    C</p> <p><b>Genitourinary</b></p> <p>Bladder disease                        P    C</p> <p>Kidney disease                            P    C</p> <p>Stones                                        P    C</p> <p>Urinary tract infections                P    C</p> <p><b>Male Reproductive</b></p> <p>Prostate disease                        P    C</p> <p>Testicular disease                        P    C</p> <p>Sexually transmitted disease            P    C</p> <p><b>Female Reproductive</b></p> <p>Ovary disease                            P    C</p> <p>Uterus disease                            P    C</p> <p>Sexually transmitted disease            P    C</p> <p>Menstrual symptoms                    P    C</p> <p>Menstrual cycle # days                _____</p> <p>Pregnancies                                _____</p> <p>Deliveries                                  _____</p> <p>Birth control                                P    C</p> <p><b>Musculoskeletal</b></p> <p>Arthritis                                    P    C</p> <p>Braces/ Supports/ Orthotics            P    C</p> <p>Joint pain/ swelling/tightness            P    C</p> <p>Neck pain                                    P    C</p> <p>Back pain                                    P    C</p>	<p><b>Integument (skin)</b></p> <p>Skin disease/ rashes/ sores            P    C</p> <p>Eczema                                        P    C</p> <p>Dryness                                        P    C</p> <p><b>Neurological</b></p> <p>Neurological disease                    P    C</p> <p>Convulsions/ seizures                    P    C</p> <p>Dizziness/ fainting                        P    C</p> <p>Severe headaches                        P    C</p> <p>Migraines                                    P    C</p> <p>Sleep problems                                P    C</p> <p><b>Psychological</b></p> <p>Mental illness                                P    C</p> <p>Depression                                    P    C</p> <p>Mood swings                                    P    C</p> <p>Nervousness                                    P    C</p> <p><b>Breasts</b></p> <p>Breast disease                                P    C</p> <p>Pain or discomfort                        P    C</p> <p>Self-exam                                    P    C</p> <p><b>Endocrine</b></p> <p>Endocrine gland disease                    P    C</p> <p>Thyroid disease                                P    C</p> <p>Diabetes                                        P    C</p> <p>Osteoporosis                                    P    C</p> <p>Thirst- excess/ reduced                    P    C</p> <p>Weight change                                P    C</p> <p><b>Blood</b></p> <p>Anemia                                        P    C</p> <p><b>Immunity</b></p> <p>Allergies                                        P    C</p> <p>Cancer                                         P    C</p> <p>Cold sores                                        P    C</p> <p>Lyme's disease                                P    C</p> <p><b>Any Other Condition</b>                    P    C</p>
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Name: \_\_\_\_\_

Date: \_\_\_\_\_

**DESCRIPTION OF PAST AND/OR CURRENT CONDITIONS**

CONDITION	AGE	CONDITION(S) BRIEFLY DESCRIBE

**IMMUNIZATION HISTORY**

Describe immunizations received over the past year: \_\_\_\_\_

\_\_\_\_\_

**HEALTH SCREENING HISTORY**

Indicate the last time you were examined or screened for the following (Leave blank if never, ? mark if date in Unknown)

Exam	Date	Exam	Date	Exam	Date
History & Physical		Blood Pressure		Bone Density	
Breast		Cholesterol		Other	
Pelvic & Pap Smear		Mammogram			
Rectal		Prostate			

Results: \_\_\_\_\_

\_\_\_\_\_

**MEDICINES & SUPPLEMENTS**

List all current medicines, nutrients, herbs, botanicals, etc. consumed:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



Name: \_\_\_\_\_

Date: \_\_\_\_\_

**HEALTH CARE PROVIDERS**

List health care providers currently seen for your current problem(s) and any condition.

Name/ Address/Phone	Last Visit	Diagnosis	Treatment
1.			
2.			
3.			
4.			

**FAMILY HISTORY**

Please list the occurrence of any disease or condition WITHIN YOUR FAMILY such as:

Addictions and Habits (Drugs, alcohol, smoking), Allergies, Anemia, Arthritis, Asthma, Cancer, Dental Disease, Diabetes, Emotional Condition, Epilepsy, Gallbladder Disease, Heart Disease, High Blood Pressure, High Cholesterol, Kidney Disease, Liver Disease, Mental Illness, Osteoporosis, Ulcer, Stroke, Thyroid Disease, Tuberculosis, Any Other Conditions

Relative	Alive/ Deceased	Age	Describe Condition(s), Illnesses, Etc.
Mother			
Father			

**PAST SURGERIES**

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## CONSENT FOR USE OR DISCLOSURE OF HEALTH INFORMATION

### Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Along with this consent form, you will be given a copy of our privacy notice that describes our privacy policies in detail. You have the right to review that notice before you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail.

#### Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

#### Your right to revoke your authorization

**You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.**

I have read your consent policy and agree to its terms. I am also acknowledging that I have received a copy of this consent form and a copy of your privacy notice (Notice of Privacy Practices for Protected Health Information).

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

## INFORMED CONSENT TO CHIROPRACTIC TREATMENT

Chiropractic care is a system of health care delivery. As with many health care disciplines, we cannot promise a cure for any symptom, disease or condition as a result of treatment. We will promise to give you our best to achieve good health and well-being the natural way.

The doctor will primarily provide chiropractic adjustments or manipulation during the course of treatment. This is done with the use of his/her hands and/or a mechanical device upon your body in order to move your joints in certain directions. This procedure may cause a "pop" or "click" to be heard from the area treated and should not be a cause for alarm. There are some material risks involved in these procedures and include:

1. Pain: Treatment may result in temporary increased soreness in the area treated.
2. Rib fractures: These are rare and may occur in patients with osteoporosis or weakened bones. Evidence of osteoporosis or weakened bones may be noted on x-ray. If detected, treatment is modified to assure a gentle and effective adjustment is provided. Gentle treatment is applied to all patients. Specialized care is provided to young, frail, and elderly individuals.
3. Disc injury: Chiropractic treatment is appropriate for many types of spinal related conditions, including disc conditions. Occasionally, treatment may aggravate a problem if the disc is in a severely weakened state. This occurs so rarely that statistics to quantify the probability are unavailable, but estimates place the risk of serious injury at one per 100 million spinal manipulations.
4. Stroke: The incidence of stroke in the general population is 2 per 1000 people. Manipulation of the neck has been implicated as a cause for stroke in the past. Upon review of the literature and data, the incidence is one per 5 million manipulations. Usually, the type of manipulation is violent, not specific, to the area requiring treatment and delivered by a non-chiropractic provider. In comparison, the risk of death from taking non-steroidal anti-inflammatory drugs (aspirin, ibuprofen, naproxen, motrin, etc) is 4 per 100,000 patients. The risk of serious complications or death from spinal surgery of the back is 11.25 per 1000 patients. The risk of chiropractic treatment is far less than the risk of medical and surgical treatment. Even though the risk of injury is very low, we include procedures and tests that may help us reduce the potential for stroke or other complications.
5. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I (We) \_\_\_\_\_ hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures on me or on \_\_\_\_\_, by COLBURN CHIROPRACTIC, LLC and/or other licensed doctors of chiropractic or other health care providers who may be employed by or engaged in practice of their respective discipline in the office of COLBURN CHIROPRACTIC, LLC.

I have had an opportunity to discuss with the doctor, or other clinical personnel, the nature and purpose of chiropractic adjustments and other procedures. I understand that the practice of neither chiropractic nor medicine is an exact science and that my care may involve the making of judgments based upon facts known to the doctor at the time; that it is not reasonable to expect the doctor to be able to anticipate or explain all risks and complications; that an undesirable result may not necessarily indicate error in judgment; that no guarantee as to results has been made to nor relied upon me, and I wish to rely on the doctor to exercise judgment during the course of the procedure which he/she feels at the time, based upon the facts then known, is in my best interests.

I have been advised that although the incidence of complications associated with chiropractic services is very low, anyone undergoing adjusting or manipulative procedures should know the possible hazards and complications which may be encountered or result. These include, but are not limited to, fractures, disc injuries, strokes, dislocations and sprains, and which may be related to physical aberrations unknown to or reasonably undetectable by the doctor.

I have read or have had read to me the above Consent. I have also had an opportunity to ask questions about its content, and by signing below, agree to the named procedures.

\_\_\_\_\_  
Patient's Name

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/ Guardian Name

\_\_\_\_\_  
Parent/ Guardian Signature