



Ramos Chiropractic & Massage

Burlington & Limon, Colorado

New Patient Paperwork

Welcome! Please complete the forms in this packet before your first visit — it saves time at check-in and helps us take the best possible care of you. This packet includes:

1 Informed Consent to Care

2 Arbitration Agreement

3 Patient Intake Form

*Bring the completed packet with you, or ask us about completing it electronically ahead of time.
Questions before your visit? Call us at 720-989-9377.*

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately, a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major G.I. events of the entire (upper and lower) G.I. tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date: _____

Parent / Guardian: _____ Signature: _____ Date: _____

Witness: _____ Signature: _____ Date: _____

Ramos Chiropractic & Massage — 1490 Martin Avenue, Burlington, CO 80807 — 720-989-9377

Arbitration Agreement

Article 1: Agreement to Arbitrate. It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must Be Arbitrated. It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouses, of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider, including those working at the health care providers clinic or office whether signatories to this form or not. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and / or the health care providers associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief or punitive damages.

Article 3: Procedures and Applicable Law. A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred approved by the neutral arbitrator, not including counsel fees, witness fees or other expenses incurred by a party for such party's own benefit. Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The party's consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount of payable as benefit to the patient to the maximum extent permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments, shall apply to disputes within this Arbitration Agreement. The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision. All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation. This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY A NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Patient Signature: _____ Date: _____

Office Signature: _____ Date: _____

Ramos Chiropractic & Massage — 1490 Martin Avenue, Burlington, CO 80807

Patient Intake Form



Update: _____
Date: _____
Initial: _____

Update: _____
Date: _____
Initial: _____

Update: _____
Date: _____
Initial: _____

Name: _____

Date of Birth: _____
(dd/mm/yr)

Address: _____

Phone #: home: _____ work: _____

Please complete this form in order to assist us in becoming familiar with your health history, and to ensure that massage therapy services provided are not contraindicated for you. Patient information contained within this form is considered strictly confidential.

1. Are you currently receiving treatment from any of the following healthcare practitioners?

☐ Chiropractor, ☐ Massage Therapist, ☐ Medical Doctor, ☐ Physiotherapist, ☐ Other: _____

2. Are you over the age of 16? ☐ Yes ☐ No

Please note: Massage therapy **cannot** be given if you are under the age of 16 years without the consent of a parent or legal guardian.

3. Are you presently involved in a workman's compensation or litigation / claim involving an injury? ☐ Yes ☐ No

4. Have you had a reaction to heat or cold? ☐ Yes ☐ No

5. How did you hear about our clinic?

☐ Friend, ☐ Student, ☐ Co-worker, ☐ Family, ☐ Website, ☐ Advertising, ☐ Other: _____

Please check ☒ if any of the following apply to you:

General

- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Headaches
- ☐ Loss of sleep
- ☐ Nervousness
- ☐ Weight loss / gain

Muscle / Joint

- ☐ Arthritis / rheumatism
- ☐ Muscle weakness
- ☐ Low back pain
- ☐ Neck pain
- ☐ Mid back pain
- ☐ Joint pain

Skin

- ☐ Bruise easily
- ☐ Dryness
- ☐ Hives
- ☐ Rash
- ☐ Varicose veins
- ☐ Psoriasis

Cardiovascular

- ☐ High/Low blood pressure
- ☐ Hardening of the arteries
- ☐ Irregular pulse
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles

Respiratory

- ☐ Chest pain
- ☐ Chronic cough
- ☐ Difficulty breathing
- ☐ Hay fever

Gastrointestinal

- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult digestion
- ☐ Bloating abdomen
- ☐ Hernia

Genitourinary

- ☐ Bladder infection
- ☐ Prostate trouble

Women only

- ☐ Hot flashes
- ☐ Lumps in breast
- ☐ Menopause
- Are you pregnant? ☐ yes, ☐ no
- If yes, how many months?

- How many children do you have? _____

Check any of the conditions you have or have had:

- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibromyalgia
- ☐ Heart burn
- ☐ Heart disease
- ☐ HIV/AIDS
- ☐ Multiple Sclerosis
- ☐ Numbness/tingling
- ☐ Pace maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease

Please turn over →

Patient Intake Form (side 2)

Give a brief detailed description of the problem you are currently experiencing: _____

• How long have you had this condition? _____ Is it getting worse? ☐ yes, ☐ no _____

• Does it bother you (check appropriate box): ☐ work, ☐ sleep, ☐ other: _____

• What seemed to be the initial cause: _____

• Are you currently satisfied with your...

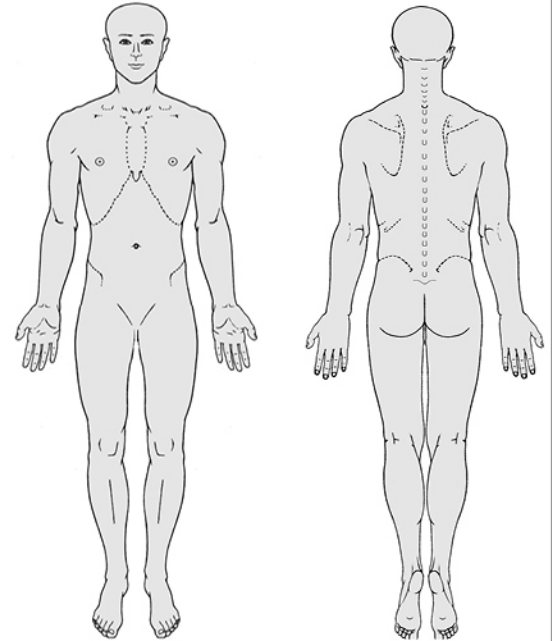
... physical health & fitness? ☐ Yes ☐ No

... mental & emotional happiness? .. ☐ Yes ☐ No

... diet? ☐ Yes ☐ No

... ability to relax? ☐ Yes ☐ No

Please mark on the figure below any areas of pain or concern.



Past Health history

- | | Yes | No | If yes, explain briefly |
|---|--------------------------|--------------------------|-------------------------|
| • Have you ever... | | | |
| ... been hospitalized in the last 5 year? | ☐ | ☐ | _____ |
| ... had any mental conditions? | ☐ | ☐ | _____ |
| ... had any broken bones? | ☐ | ☐ | _____ |
| ... had any strains or sprains? | ☐ | ☐ | _____ |
| ... used orthotics? | ☐ | ☐ | _____ |
| • Do you exercise regularly | ☐ | ☐ | _____ |
| • How is most of your day spent? ☐ standing, ☐ sitting, ☐ other: | | | _____ |
| • How old is your mattress? | | | _____ |
| • When was your last physical exam? | | | _____ |

Please list any medication you are currently taking and why:

Is there anything else your health care provider should know?

Consent and Release

I acknowledge that the above information is accurate and true to the best of my knowledge. This clinic, its employees, servants and agents (the "Clinic"), do not accept liability for any claim as to the method or manner of treatment given, or any complaint related to supposed conditions arising from therapy. In good and valuable consideration, the undersigned does hereby release and forever discharge the Clinic, its successors and assignees, from any other legal obligations and compensation of whatsoever kind and howsoever arising from or out of any treatment which will be provided to the undersigned.

Please sign below to show that you fully understand and agree to the above disclaimer and stated conditions of receiving treatment at this clinic.

Signature: _____ Date: _____