Denver Vitality Center

Dr. Mark Armbruster, D.C.

Pressure Wave Therapy - Case History

Name ____ **Sex** M F **Date**_____________________________

Address ____**State**_________ **Zip**________

H. Phone ________________________**W. Phone**_________________________

Email Address ____

Date of Birth ________________**Age**_______

Referred by ___________________________________ **Social Security** ____________________________________

Occupation ________________________________ **Employer**____

Have you ever received Chiropractic Care? Yes____ No____ **If yes, when?**__________________________________

Reasons for seeking treatment

Primary reason:

Secondary reason:

Additional reasons

History of Complaint

Please describe the nature of the complaint that you are seeking pressure wave therapy for:

Location of complaint:

What was the initial cause of this complaint? (injury, accident, etc.)

When did this complaint begin?

Are you presently under a doctor's care for this complaint? *(circle one)* Yes No
Doctor's name:

Please circle the Quality of the complaint/pain:
Dull Aching Sharp Shooting Burning Throbbing Deep Nagging

Other (please explain)

Does this complaint/pain radiate or travel (shoot) to other areas of your body? *(circle one)* Yes No
Where? ____________________________
Do you have any numbness or tingling in your body? *(circle one)* Yes No
Where? ____
Rate Your Pain Intensity/Severity *(0 = No pain)* 0 1 2 3 4 5 6 7 8 9 10 *(10 = Worst possible pain imaginable)*
How frequent is your complaint present, and how long does it last?

Does anything aggravate the complaint?

Does anything alleviate the complaint?

Does this complaint interfere with: work, home life, activities or sleep? *(circle one)* Yes No Somewhat
Please list any activities that you enjoy (sports and leisure)

Has this complaint limited your ability to pursue any of these activities? *(circle one)* Yes No Somewhat

Previous and current interventions

(Please list any therapies, treatments, medications, surgery, or care that you have previously sought for your complaint)

Past Health History

- **Previous illnesses you've had in your life:**
- **Previous injury or trauma:**
- **Have you ever broken any bones? Which?**
- **Allergies**:
- **Medications:**
- **Condition/s you are taking medications for:**
- **Surgeries and dates:**

On a scale of 1 – 10. How committed are you to resolving this complaint? ____

Are there any other health concerns you would like to address at this time?

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office to provide me with Pressure Wave Therapy treatments, in accordance with this state's statutes.

Signature ____ **Date** _____________

Doctor's Signature ____ **Date** _____________

Denver Vitality Center
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Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by Denver Vitality Center or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices
You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information
- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

____ ____________
Patient or Legally Authorized Individual Signature Date

____ ____________
Print Patient's Full Name Time

____ ____________
Witness Signature Date