Peak Performance Chiropractic & Wellness

Dr. Darren Scott, D.C.
2297 N Hill Field Rd Suite 101, Layton, UT 84041
Phone: (801) 776-3200 Fax: (801) 825-4727
drdarren@comcast.net

"Discover How GOOD True Wellness Feels!"

Hello Friend!

Pull up a chair, grab big cup of your favorite beverage, and get to work!

I know there seems like a LOT of questions and information in this packet, but please fill out ALL of it—some may seem repetitious, but rest assured, it's all necessary!

This detailed information will help us to determine the ***EXACT*** causes of your problems, thereby eliminating the guesswork—and where YOUR health is concerned, we don't want to guess—we want to be CERTAIN!

Also, don't forget to gather any blood labs, MRI's, CT scans, or any other labs or tests from the past 3 months. Don't worry about going down to your doctor's office, just give them our fax number (801-825-4727) and have them fax it over. It's really that easy.

Lastly, watch the DVD it will answer some of your questions—you don't need to memorize it, but some familiarity will be good.

I look forward to helping you!

Dr. Darren Scott, D.C.

CHIROPRACTIC REGISTRATION INFORMATION

1 PATIENT INFORMATION

Date:________________

Name:____

Address:______________________________________

____
City State ZIP

Home Phone:________________Work:______________

Cell Phone:_________________Carrier:______________

Email:____

Sex: □M □ F □Age Birthdate:_____________

□Single □Married □Widowed

□Separated □Divorced

In case of emergency, contact:____________________
Name

_______________________ _________________
Relationship Phone

____
Address City State

Social Security #:________________________________

Driver's License #:_______________________________

Occupation:_____________________________________

Employer:_______________________________________

Employer's Address:______________________________

Spouse's Name:__________________________________

Spouse's Occupation:_____________________________

Spouse's Employer:_______________________________

Whom may we thank for referring you?:_____________

____

2 INSURANCE

Person responsible for payment:_____________________

Relationship to patient:___________________________

Are you insured? □ Yes □ No

Health insurance name:___________________________

Insurance Co's Phone:____________________________

Insurance Co's Address:___________________________

____

Policy holder's name:_____________________________

Birthdate:_____________SS#:________________________

Relationship to patient:___________________________

Group #:_______________________________________

Is patient covered by additional insurance? □ Yes □ No

Company name:__________________________________

Policy Holder:__________________________________

SS#:____

Group #:_______________________________________

3 ACCIDENT INFORMATION

Is condition due to an accident? □ Yes □ No

Type of accident: □ Auto □ Work □ Other:_______________

To whom have you reported it?

□ Auto Ins. □ Employer □ Other:_____________________

Attorney (If applicable):_________________________

4 PAYMENT IS EXPECTED AT THE TIME OF VISIT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Peak Performance Chiropractic & Wellness will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Peak Performance Chiropractic & Wellness will be credited upon receipt, however, I clearly understand and agree that any services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for services rendered me will be immediately due and payable.

Patient's Signature:______________________________________Date:_______________

Guardian's Signature:_____________________________________Date:_______________

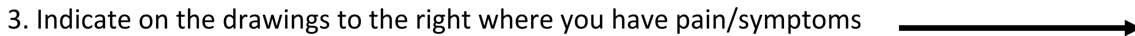
PATIENT INTAKE FORM

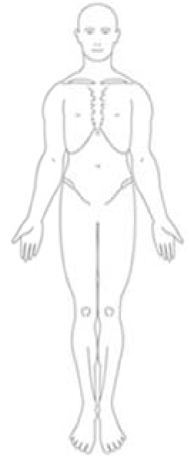
Patient Name:____Date:____________________________

1. Is today's problem cause by: □ Auto Accident □ Workman's Compensation □ Other:____________________________

2. What is your main complaint? _____________________ How long have you had it? ________________________

3. Indicate on the drawings to the right where you have pain/symptoms





5. How do you think your problem began?________________________________

6. 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)

7. How would you describe the type of pain?

□ Sharp □ Dull □ Diffuse □ Achy

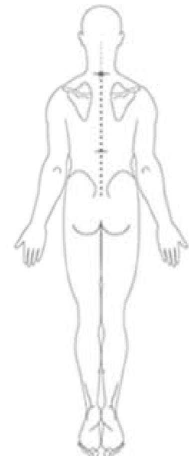
□ Burning □ Shooting □ Stiff □ Numb

□ Tingly □ Sharp with motion □ Shooting with motion □ Electric-like with motion

□ Other:____________________________

8. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better



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

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

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

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

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

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

12. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician

□ ER Physician □ Orthopedist □ No one

□ Massage Therapist □ Physical Therapist □ Other:____________

13. Who is your primary care physician?____

14. Have you had any spinal x-rays, MRI, CT Scan? □ No □ Yes Dates taken:____________________________________

15. Do you consider this problem to be severe?

□ Yes □ Yes, at times □ No

16. What aggravates your problem?____

17. What alleviates your problem?____

18. What concerns you the most about your problem; what does it prevent you from doing?________________________

____

19. How would you rate your overall health?

□ Excellent □ Very Good □ Good □ Poor

20. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

21. Indicate if you have any immediate family members with any of the following:

□Rheumatoid Arthritis □Diabetes □Lupus

□Heart Problems □Cancer □ALS

22. 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 the condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pain	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependence
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	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
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:________________						

23. List all prescription medications and over-the-counter medications you are currently taking:

____

24. List all surgical procedures you have had:

____

25. What activities do you do outside work?

____

26. Have you ever been hospitalized? □ No □ Yes

If yes, why:____

27. Have you had significant past trauma? □ No □ Yes

TREATMENT EXPECTATIONS

28. Overall, what are you hoping Dr. Scott is able to do for you? ________________ ________________________________

____

29. If Dr. Scott is extremely confident that the program will significantly help you, how important is it to you to get your case accepted and start care? ____

30. If your insurance doesn't cover all of your treatment expenses, are you willing to pay some out-of-pocket?

____

Patient Signature:____Date:_________________________

RF Questionnaire

Peak Performance Chiropractic & Wellness
2297 N Hill Field Rd. Suite 101, Layton, UT 84041

Name: ____Date:_____________________

Please take several minutes to answer these questions so we can help you get better faster. (**Please circle as many that apply**)

1. How have you taken care of your health in the past?

a) Medications e) Routine Medical
b) Exercise f) Nutrition/Diet
c) Holistic Care g) Vitamins
d) Chiropractic g) Other (please specify): ___________________

2. How did the previous method(s) work out for you?

a) Bad results e) Did not get worse
b) Some results f) Did not work very long
c) Great results g) Still trying
d) Nothing changed h)Confused

3. How have others been affected by your health condition?

a) No one is affected
b) Haven't noticed any problem
c) They tell me to do something
d) People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a) Job f) Sleep
b) Kids g) Time
c) Future ability h) Finances
d) Marriage i) Freedom
e) Self-esteem

5. Are there health conditions you are afraid this might turn into?

a) Family health problems g) Fibromyalgia
b) Heart disease h) Depression
c) Cancer i) Chronic Fatigue
d) Diabetes j) Need surgery
e) Arthritis

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
Give 3 examples

1.
2.
3.

What are you most concerned with regarding your problem?

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

What would be different/better without this problem? Please be specific

What do you desire most to get from working with us?

What is that worth to you, if we could improve your condition?

IMPORTANT

REQUIREMENTS BEFORE YOUR APPOINTMENT

We require the following in preparation for your appointment:

1. Watch the DVD – You and ALL persons directly involved with your care (i.e. spouse, parent, etc.) need to watch this DVD.

2. Complete the paperwork ENTIRELY and have them returned the business day prior to your appointment. Answering all the questions will make your consultation with Dr. Darren as productive as possible in determining whether or not this recovery program will work for you.

3. Submit (or have your doctor(s) submit) medical history, test results, and images (x-rays/MRIs) to our office. These records can be faxed to **(801) 825-4727**.

4. Schedule your appointment when your spouse, guardian or significant other can be with you. During these consultations we will be discussing important issues regarding your health and it is vital that those directly involved in decisions being made about your health are present.

5. Bring or wear shorts and a T-shirt to your appointment. This will make portions of the exam during your first visit easier to perform.

I understand the above requirements in preparing for and scheduling an appointment with Dr. Darren.

I, along with ALL other persons directly involved in my care have watched the DVD.

Patient:

______________________________ ____________________________ _____________

Patient Name Signature Date

Spouse/Guardian/Significant Other:

______________________________ ____________________________ _____________

Print Name Signature Date

Thank you for taking the time to complete these requirements for your appointment. Your health and improving your quality of life are my priorities. Being prepared before your first consultations will help us be more productive in determining whether or not this recovery program will work for you and the most effective approach to get you healthy quickly.

I look forward to seeing you in our office and helping you to improve the quality of your life.

Yours in health,

Dr. [illegible]