Colorado Center of Health and Nutrition
Dr. Kim Bruno, DC, CCN
313 W. Drake Rd. #210
Fort Collins, CO 80526
Clinic: 970-372-1277
drkimbruno@gmail.com

Welcome

Patient Account and Insurance Information

PATIENT INFORMATION	ACCOUNT INFORMATION
Legal Name:	Person Responsible:
Nickname: Male ___ Female ___	Relationship to Patient: __Self __Spouse __Parent/Guardian
Address:	Physical Address:
City, State & ZIP:	Mailing Address:
Home Ph: Work Ph:	City, State & ZIP:
Birthdate: Age:	Home Ph: Work Ph:
Social Sec. #:	Birthdate: Age:
Employer: Position:	Social Sec. #:
Email Address:	
Spouse Name: Work Ph:	

EMERGENCY CONTACT (not living with you)	
Name:	Relationship:
Phone:	Address:
	City, State & ZIP:

HOW DID YOU HEAR ABOUT US? Many of our patients are referred by their friends, family members, co-workers and other doctors. These individuals are concerned for your health and have shown their trust and confidence in our doctors and staff to provide you with the very best care possible. Please let us know how you heard about us so we can send them a "Thank You" for introducing you to us.

_____ Friend, Family or Co-Worker Name: _____
_____ Doctor Name: _____
_____ Yellow Pages
_____ Other (please specify) _____

Please carefully read the following and sign your acknowledgement below:

I do clearly understand that I am ultimately responsible for the payment of fees for services rendered to me, or my family at this clinic. I authorize the doctors and their assistants to administer such treatment as necessary. I do understand that no guarantees have been made as to the results of treatment. I confirm that I have come to this facility for help with my medical problems and have no intent to mislead or defraud my treating doctor, any insurance carrier, or other party.

_____ _____
Signature (*if under 18, signature of parent or Legal Guardian required*) **Today's Date**

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FINANCIAL AGREEMENT

We are glad you have entrusted our office with your health care. To provide you with quality, timely care, we need your cooperation with certain matters to make sure every patient has his/her needs met.

Insurance
Colorado Center of Health & Nutrition is not a participating provider with any insurance companies. Our office does not file or submit claims to any health insurance plan. **At your request, we can provide you with a receipt of services (Super-Bill) that you can send to your insurance company for your reimbursement** under your out-of-network plan.

Payments & Deposit **Pt. Initial**_____
Colorado Center of Health & Nutrition requires payment at the time of service. New patient appointments require a non-refundable $100 deposit that will be applied to the total fee. We currently accept debit and credit cards (Visa, MasterCard and Discover), cash, and checks. Payment plans are available on an individual basis, require a card on file, and need to be set up prior to service.

Cancellation and Missed Appointment Policy **Pt. Initial**_____
We require a minimum of 24 hours notice when a patient cancels or reschedules their appointment. When a patient does not show up for an appointment and/or cancels / reschedules with less than 24 hours notice, a $55 fee will be charged to the card kept on file. If short notice cancellations or no-shows are frequent you will be asked for payment at the time of scheduling.

Individual Consideration Contract
If there is a financial hardship associated with receiving care in our office, payment arrangements can be negotiated with Dr. Bruno, and MUST be done prior to the time of service.

Medicare
Dr. Bruno is not currently a participating provider for Medicare. If you choose to use your Medicare plan we will happy to refer you to a participating provider.

Past Due Accounts
If your account becomes past due, we will take necessary steps to collect this debt. Outstanding balances will be billed monthly and considered past due 10 days after the invoice date. We will pass along the fee of $35 our bank charges us for any returned checks. Balances beyond 30 days will be charged an additional 1.5% of your total balance per month plus any additional costs necessary to collect the balance owed.

If we have to refer your account to a collection agency, you agree to pay all of the collection agency fees or commissions that are incurred. We reserve the right to refuse future services until your account is in current status.

Workers Compensation
Dr. Bruno does not participate in workers compensation claims at this time. If you become injured on the job we would be happy to refer you for the appropriate care.

Agreement
This is the entire agreement between Dr. Bruno with Colorado Center of Health & Nutrition and the patient below. I have read this agreement, understand it and agree with its provisions.

Patient's Name: _____ Date: _____

Responsible Party's Signature: _____

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Name: _____

What is your primary reason for seeking care at our office: _____

How long has this been a problem: _____

What do you believe is wrong with you?

_____

_____

List any other current health conditions:	**How long have you had this condition?**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

List previous treatments you have received for each condition listed above:

1. _____
2. _____
3. _____
4. _____

List any current allergies: _____
Are you allergic to any medications? _____

List all prescribed medications you are now taking, the reason you are taking it, and who it was prescribed by:

Medication	Reason	Prescribed By	Medication	Reason	Prescribed By

List all over-the-counter medications/supplements you are now taking and the reason you are taking it:

Medication/Supplement	Reason	Medication/Supplement	Reason

Previous Auto Accidents: _____

_____

_____

Previous Work-Related Injuries: _____

_____

_____

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Please list any other past medical conditions, serious illness, injury or fractures:

Year	Illness or Injury

List below any other health information you feel is important: _____
_____
_____
_____

Have you ever been hospitalized?

Year	Illness or Operation

Childhood Diseases: Measles_____Mumps_____Chicken Pox_____Other_____

Unusual Childhood Diseases:_____

Is there anyone in your family with any of the following medical conditions?

Condition	Who and type of illness if known	Condition	Who and type of illness if known
Cancer		diabetes	
arthritis		stroke	
High blood pressure		Heart disease	
Lung disease/ asthma		Mental illness	
Kidney disease		Liver disease	
High cholesterol		other	

Indicate below your usage of each item listed:

	Soda Pop	Coffee	Pain relievers	Drugs	Exercise	Sleep
Heavy						
Moderate						
None						

Do you currently use Tobacco products? Yes _____ No _____ Have you ever? _____

Please list products used and how much/often: _____

Do you drink alcoholic beverages? Yes _____ No _____ How often: _____

When was your last visit to Physician: (MD/DO) (Date) _____**For What?** _____

Do you have a primary medical physician: _____

Have you ever been seen by a Chiropractor? (Date) _____ **For What?**_____

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Name: _____

Please check any item you have currently or have had in the past.
If you are unsure please leave it blank and ask the doctor for clarification.

Constitutional
__chills
__fatigue
__fever
__ night sweats
__weight gain (unintentional)
__weight loss (unintentional)

Eyes
__blurred vision
__glasses/contacts
__sensitivity to light

Ears/Nose/Throat
__ear pain
__hearing problems
__ringing in ears
__nose bleeds (frequent)
__periodontal disease
__hoarseness
__sore throat
__thrush
__tooth pain

Cardiovascular
__chest pain
__pain/cramping in legs
__dizziness
__difficulty breathing when lying down
__palpitations
__leg swelling
__episodes of rapid heart beat
__varicose veins

Respiratory
__cough
__shortness of breath
__exposure to TB
__coughing up blood
__wheezing

Gastrointestinal
__abdominal pain
__acid reflux
__anorexia
__bloating
__difficulty swallowing

Gastrointestinal (continued)
__constipation
__diarrhea
__heartburn
__vomiting blood
__red blood in stool
__hemorrhoids
__dark tar-like stools
__nausea
__vomiting
__change in frequency or form of stool

Genitourinary
__painful periods
__painful intercourse
__painful urination
__genital lesions
__blood in urine
__frequent urinary tract infections
__history of vaginosis
__irregular menstrual cycle
__excessive menstrual flow
__waking at night to urinate
__frequent urination
__post-menopausal bleeding
__urinary incontinence
__vaginal discharge
__vaginal itching

Musculoskeletal
__joint pain
__back pain
__joint stiffness
__limp pain
__muscle spasm

Skin and Breast
__acne
__atypical mole(s)
__dry skin
__rashes
__breast mass
__breast skin change
__breast tenderness
__nipple discharge
__self breast exams

Neurological
__fainting
__headaches
__memory loss
__numbness and/or tingling
__seizure
__tremor
__vertigo
__weakness

Hematologic/Lymphatic
__easy bruising
__excessive bleeding
__swollen lymph nodes

Endocrine
__hair loss
__heat/cold intolerance
__abnormal hair growth
__hot flashes
__infertility
__excessive thirst
__excessive hunger
__excessive sweating

Allergic/Immunologic
__seasonal allergies
__food allergies/sensitivities
__other allergies
__frequent respiratory infections
__autoimmune disease

Psychiatric
__anxiety
__depression
__feeling stressed
__mood swings
__personality changes
__PMS (premenstrual syndrome

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For Women Only:

List the first day of your last period: _____ **How long are your periods?** _____

Are your cycles regular? _____ **How long is your cycle?** _____

Date of last PAP smear: _____ **Any abnormal results?** _____

Birth control methods: _____

Number of pregnancies: _____ **How many deliveries?** _____

Any complications during labor and delivery? _____ **Can you Explain?** _____

_____

If you are post menopausal, are you taking any hormone replacement? _____

For Men Only:

Have you ever had a prostate exam (digital rectal exam)? _____

When was your last exam: _____

Have you ever had a PSA blood test? _____ **Date of last test:** _____

Have you had any alteration in urinary frequency, flow or caliber of urine stream? _____

Please explain if necessary? _____

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Nutritional Information

Please indicate what you eat in a typical week Breakfast Lunch Dinner #Snacks_____
Indicate the estimated number of servings of each of the following items consumed in a typical week

____Eggs	____Fish	____Butter
____Cheese	____Beans	____Olive Oil
____Milk	____Tofu/Soy	____Margarine
____Yogurt	____Nuts/Seeds	____Sugar substitute
____Sour Cream	____Nut butter	____Spicy Food
____Ice Cream	____Fruit	____"Junk" Food
____Red Meat	____Vegetables	____Desserts
____Pork/Ham/Bacon	____Rice	____Other _____
____Chicken/Turkey	____Bread/Cereal	____Other_____

Any foods not listed that you consume regularly_____

Indicate the estimated number of servings (6-8 oz cups) of the following consumed in a typical day

____Caffeinated coffee	____Regular soft drinks	____Water
____Decaffeinated coffee	____Diet soft drinks	____Fruit Juice
____Regular tea	____Diet drinks/aids	____Sports Drinks
____Herbal tea	____Energy drinks	____Other
____Green tea		

Any drinks not listed above that are consumed regularly_____

On a scale of 1-10 (10 being extremely healthful). How do you rate your diet? _____/10

If you try to follow a specific diet, please describe it and why you follow this type of diet?_____
_____
Indicate any specific nutritional goals_____
_____
Please give any other insight and/or information that you feel might be helpful in your health maintenance_____
_____
What do you hope to better enjoy when you regain your health?_____
_____

Doctor only

_____
_____
_____
_____
_____