

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.

<input type="checkbox"/> Friend, Family or Co-Worker	Name: _____
<input type="checkbox"/> Doctor	Name: _____
<input type="checkbox"/> Yellow Pages	
<input type="checkbox"/> 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.

Payment

Colorado Center of Health & Nutrition requires payment at the time of service. We currently accept debit and credit cards (Visa, MasterCard and Discover) cash, and checks. Payment plans are available on an individual basis, 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 \$35 fee will be applied to the patient's account. 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:

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

How long have you had this condition?

- _____

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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Adult Review of Systems

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

