

Dear treasured clients,

Welcome to 2026! We are excited to continue being an integral part of your healing journey so you can participate in your life more fully! Please note the following policies/recommendations:

**\*All cancellations need to be made by calling the office.** A late cancellation is defined as an appointment not cancelled 24 hours prior to your scheduled appointment. If you have a Monday appointment that needs to be rescheduled, please call and leave a message on our office message machine 970-256-8449.

*Please initial* \_\_\_\_\_

\*Your first late cancellation or no-show appointment in each calendar year will not be charged as we certainly understand things happen in life that make it impossible or pose a significant hardship to keep our agreed session time to focus on your health. *Please initial* \_\_\_\_\_

\*After the first "free" late cancellation or no-show appointment in a calendar year, clients will be charged for the full rate of the appointment. *Please initial* \_\_\_\_\_

\*After using your first "free" late cancellation or no-show appointment **and** paying for a late cancellation or no-show appointment, we will ask that you have a credit card on file for scheduling future appointments. We will notify you of the late cancellation or no-show appointment and the amount prior to charging your card.

*Please initial* \_\_\_\_\_

\*Also, we respectfully recommend you do not smoke cigarettes or be under the influence of any recreational mind-altering substance the day of your service so that you may reap the full benefits of the service rendered.

With gratitude and appreciation,  
Your Healing Horizons Healing Team

2026

Signature \_\_\_\_\_

Date \_\_\_\_\_



# Integrated Health Solutions

## Welcome to Healing Horizons Integrated Health Solutions CHIROPRACTIC CARE CONSENT

Thank you for choosing Healing Horizons. We look forward to providing quality healthcare to assist you in achieving your health-related goals. To serve you as efficiently as possible, please answer all the following questions and read and sign all forms. All information will be held in the strictest of confidence.

Name \_\_\_\_\_ Age \_\_\_\_\_ DOB \_\_\_\_\_ M F Marital Status \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Cell \_\_\_\_\_ If we may send you information, please provide your email \_\_\_\_\_

Occupation \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Who referred you to Healing Horizons? \_\_\_\_\_ May we thank him/her? Y N

\*I voluntarily request and consent to be treated by Adam Henby, DC, for the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible).

\*I understand and I am informed that, as with all healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

\*I understand that chiropractic care involves hands-on touching of my body and can include sensitive areas including hips, sacrum, coccyx (tail bone), pubic bone, collar bones and ribs, lymph nodes in the armpits as well as palpation of muscles of both the upper and lower body. Some contact may need to be performed skin-to-skin, but most will be performed over my clothing. If at any time throughout the care I feel uncomfortable, or do not want contact made to a specific body part, I will let my practitioner know so that other arrangements for care may be made. **Please initial** \_\_\_\_\_

\*I understand that Chiropractic adjustments and supportive treatments are designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure.

\*I understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatory, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery.

\*I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

\*At times you may wish to contact Healing Horizons via email, or vice versa, for communication which may contain protected health information. **Please initial for consent** \_\_\_\_\_

\*I understand that the following providers will be present at Healing Horizons collaborative care meetings in which my care may be discussed: *April Schulte-Barclay, DAOM, LAc; Joseph Ellerin, LAc, LMT, Dip. Hom, CST; Kimberly Brown, LAc, WEMT; Paula King, PhD; Mariel Steel, LMT; April Ordaz, LMT; Adam Henby, DC; Judith Olesen, BA; Markus Wettstein, MD.* I also understand that other methods of collaboration, such as confidential email and private electronic group communication, may be used to coordinate my care in accordance with HIPAA regulations. **Please initial for consent** \_\_\_\_\_

**\*I understand payment is due at the time of service and I agree to address any financial concerns with Healing Horizons prior to treatment. Healing Horizons gladly accepts cancellations up to 24 hours in advance without penalty. The first late cancel or missed appointment is without penalty. Subsequent late cancel or missed appointments will be charged 100% of the scheduled treatment. Please initial** \_\_\_\_\_

**\*I have carefully read and I understand all of the above information. I appreciate that it is not possible to consider every possible complication to care. I am fully aware of what I am signing.**

**Signature (Patient/Parent/Guardian)** \_\_\_\_\_

**Date** \_\_\_\_\_

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# Integrated Health Solutions

## Health History

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_ Phone: \_\_\_\_\_

Minor? Yes No Marital Status \_\_\_\_\_

Employer: \_\_\_\_\_

Spouse or patients guardian name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

### Past Medical History/Illness

Have you been diagnosed with a disease? \_\_\_\_\_ Types: \_\_\_\_\_

Previous injuries (specific please) \_\_\_\_\_

### Patient Social History

Use of Alcohol: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_

Use of Tobacco: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_

Use of Drugs: Never: \_\_\_\_\_ Rarely: \_\_\_\_\_ Moderate: \_\_\_\_\_ Daily: \_\_\_\_\_

Over the counter medications: \_\_\_\_\_

Medications: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Disorders (please circle): Fibromyalgia IBS Migraine Insomnia Acid Reflux Neuropathy

### Family Medical History:

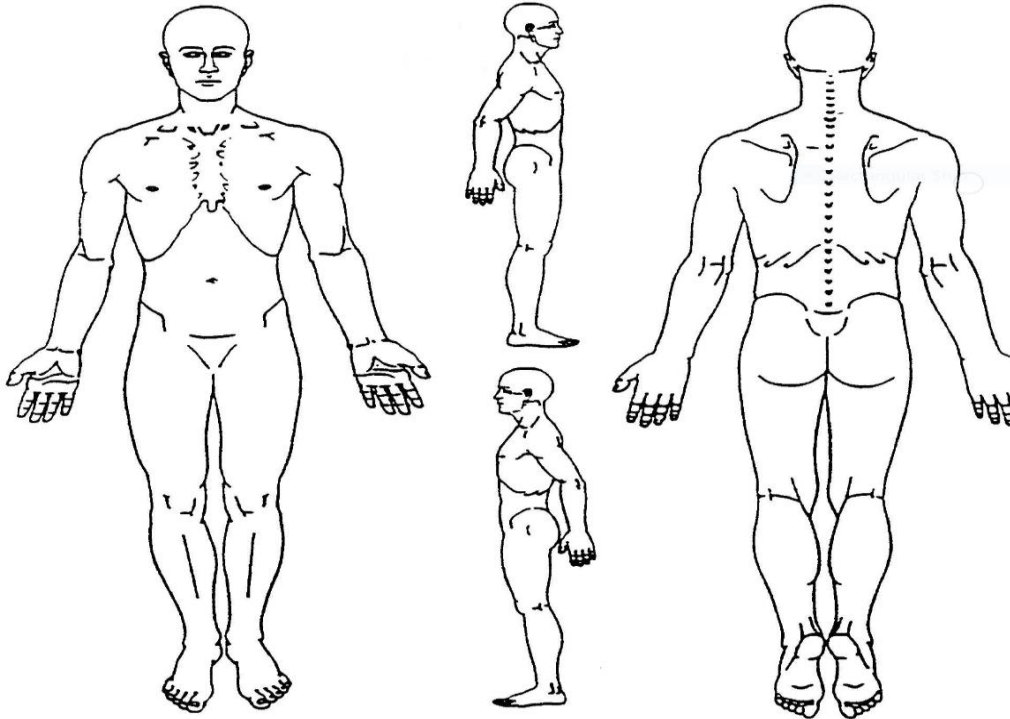
Father: \_\_\_\_\_ Mother \_\_\_\_\_ Siblings \_\_\_\_\_ Children \_\_\_\_\_

**Chief Complaint:** \_\_\_\_\_

History of present illness: \_\_\_\_\_

Location of problem: \_\_\_\_\_

*Please draw and explain accurately, descriptions below:*



What does your pain feel like? \_\_\_\_\_

Is your symptom constant? \_\_\_\_\_

Have you been diagnosed by anyone? \_\_\_\_\_

Why do you think your problem exists? \_\_\_\_\_

How did your problem start? \_\_\_\_\_

Did you have an injury first? \_\_\_\_\_

Did your symptoms "come out of nowhere"? \_\_\_\_\_

What do you do to help control the symptoms? \_\_\_\_\_

When do the symptoms come on? \_\_\_\_\_

Have you recognized any connection between when the pain starts and what you are doing right before? \_\_\_\_\_

How long can you walk without *any symptoms*? \_\_\_\_\_

What activities cause the most symptoms? \_\_\_\_\_

Do quick movements cause more symptoms? \_\_\_\_\_

Can you still run/jump/squat/kneel? \_\_\_\_\_

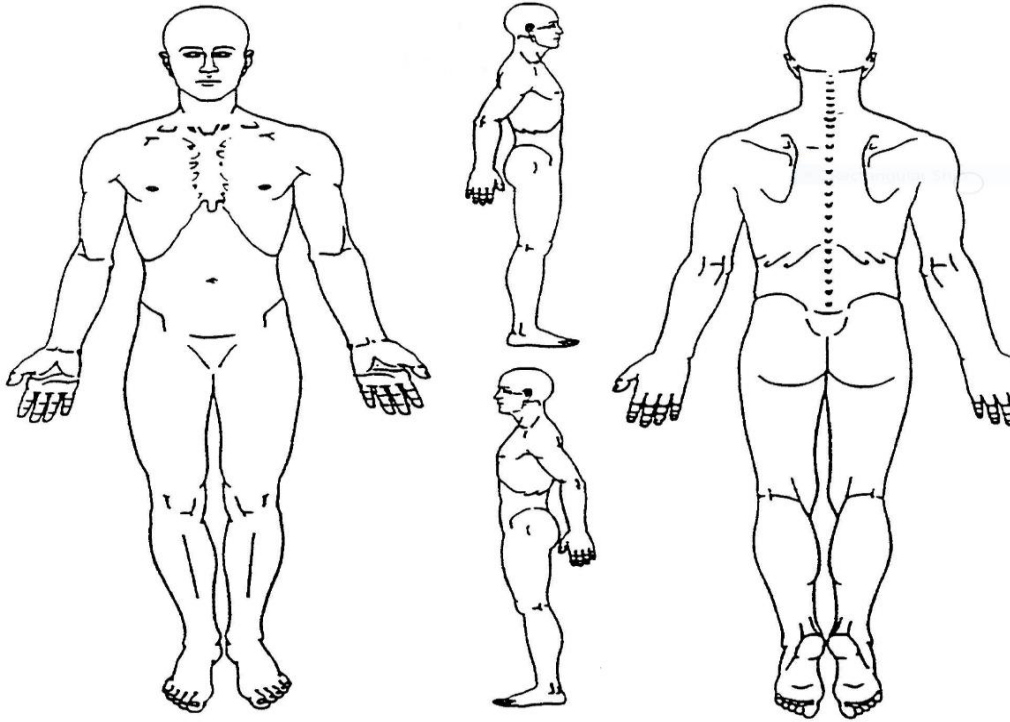
*We will likely discuss all these ideas deeper during your exam. Thank you*

**Second Complaint:** \_\_\_\_\_

History of second complaint: \_\_\_\_\_

Location of problem: \_\_\_\_\_

*Please draw and explain accurately, descriptions below:*



What does your pain feel like? \_\_\_\_\_

Is your symptom constant? \_\_\_\_\_

Have you been diagnosed by anyone? \_\_\_\_\_

Why do you think your problem exists? \_\_\_\_\_

How did your problem start? \_\_\_\_\_

Did you have an injury first? \_\_\_\_\_

Did your symptoms "come out of nowhere"? \_\_\_\_\_

What do you do to help control the symptoms? \_\_\_\_\_

When do the symptoms come on? \_\_\_\_\_

Have you recognized any connection between when the pain starts and what you are doing right before? \_\_\_\_\_

How long can you walk without *any symptoms*? \_\_\_\_\_

What activities cause the most symptoms? \_\_\_\_\_

Do quick movements cause more symptoms? \_\_\_\_\_

Can you still run/jump/squat/kneel? \_\_\_\_\_

*We will likely discuss all these ideas deeper during your exam. Thank you*