



Welcome To Our Office

Beginning chiropractic care is the first and most important step on your journey towards good health. Please answer all questions on this form completely and honestly. This information will help your doctor of chiropractic determine the best treatment plan for your condition. If you have any questions concerning this form or your future care with our office, please do not hesitate to ask any of our staff members.

Contact Information

Patient Name _____ Female Male
Date of Birth _____ Age _____ Social Security # _____ - _____ - _____
What would you prefer to be called? _____ Home Phone _____
Address _____ Cell Phone _____
City _____ State _____ Zip Code _____
Email Address _____
Marital Status: Single Married Divorced Separated Widowed Spouse's Name _____

Emergency Contact Information

Name _____ Home Phone _____
Relationship to You _____ Work Phone _____

Employment Information

Place of Employment _____
Address _____ Work Phone _____
City _____ State _____ Zip Code _____
Position/Job Duties _____
My Job Requires: Heavy Lifting Bending/Twisting ___ Standing [or] ___ Sitting For Long Periods
 Frequent Traveling [___ Car/Truck ___ Airplane] Frequent Typing

Referral Information

We would like to personally thank the person, physician, or attorney who referred you to our office.

I was referred by:

Existing Patient My Physician My Attorney My Insurance The Yellow Pages Other: _____
Her/His Name _____ Phone Number _____
Address _____ City _____ State/Zip _____

Release [This Section is Optional]

This section allows access to part or all of your medical information to a family member, friend, or representative of your choosing.

This release will not expire unless you cancel it in writing. You may do so at any time.

Name _____ Relationship to Patient _____
Address _____ Phone _____
City _____ State _____ Zip Code _____

I would like this person to have access to:

Full Access Medical Records Only Billing/Statements Only Canceling/Scheduling My Appointments Only
 Other: _____
Signature _____ Date _____

Billing Information

Person Ultimately Responsible for Account: _____

Relationship to Patient: Self Parent Legal Guardian Other: _____

Address _____ Phone _____

City _____ State _____ Zip Code _____

Social Security # _____ - _____ - _____ CO License _____

Employer _____ Work Address _____

Insurance Company _____ ID # _____

Primary Insured's Name _____ Relationship to Patient _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Date of Birth _____

Primary Insured's ID # _____ Primary Insured's SS _____ - _____ - _____

Our policy requires payment in-full for all services rendered at the time of your visit, unless other arrangements have been made with our office manager. Your signature below shows that you understand and agree to our financial policy and that you authorize our staff to perform any necessary services needed during diagnosis and treatment.

Signature _____ Date _____

Health History

Previous Chiropractor _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Please describe the symptoms or injuries your previous chiropractor was treating _____

Were x-ray films taken? Yes [Date _____] No Were MRI films taken? Yes [Date _____] No

Primary Care Physician _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip Code _____

Were x-ray films taken? Yes [Date _____] No Were MRI films taken? Yes [Date _____] No

We would like to remain in contact with your primary care physician and specialists, as required, during your course of treatment with our clinic to help improve the continuity and quality of your care. This contact will include phone calls and the delivery of reports or films to your PCP as needed. This release can be canceled or limited at any time in writing. Your signature below shows that you understand and agree with our request.

Signature _____ Date _____

Are you currently seeing any specialists in addition to your PCP? No Yes (Please list names & addresses below)

Physician's Name Specialty Address

Current Medications/Supplements Reason for Taking Prescribing Doctor Dosage

Health History Continued

Previous Surgeries	Reason	Surgeon	Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all known allergies (include food allergies): _____

Previous Serious Accidents and Injuries (auto, work-related, falls, etc.): _____

Height _____ Weight _____ Left or Right Handed? _____

Have you or an immediate family member ever experienced any of the following diseases or medical conditions?

C – current medical condition **P** – past medical condition **F** – immediate family member

Respiratory and Cardiovascular

_____ Difficulty Breathing	_____ Asthma	_____ Emphysema	_____ Tuberculosis
_____ Heart Attack	_____ Chest Pain	_____ High/Low Blood Pressure	_____ Mitral Valve Prolapse
_____ Artificial Valves	_____ Congenital Heart Defect	_____ Heart Surg./Pacemaker	_____ Heart Murmur
_____ Sinus Problems	_____ Anemia	_____ Stroke	_____ _____

Musculoskeletal

_____ Severe/Freq. Headaches	_____ Knee/Hip Replacement	_____ Joint Pain/Soreness	_____ Broken Bones
_____ Frequent Neck Pain	_____ TMJ Syndrome	_____ Muscle Sprain/Strain	_____ Artificial Bones/Joints
_____ Lower Back Problems	_____ Spinal Fusion	_____ Laminectomy	_____ Spondylolisthesis
_____ Herniated Disc	_____ Osteoporosis	_____ Spina Bifida	_____ Muscle Spasms

Gastrointestinal

_____ Ulcers	_____ Nausea	_____ Diarrhea/Constipation	_____ Bloody Stools
_____ Intestinal Ulcers/Colitis	_____ Gall Bladder Disorders	_____ Difficult Bowel Mvmt	_____ Diverticulosis

Genitourinary

_____ Incontinence	_____ Difficult Urination	_____ Kidney Stones	_____ Kidney Disorders
_____ Prostate Pain/Disorders	_____ Venereal Disease	_____ Syphilis	_____ _____

For Women Only

_____ Hysterectomy	_____ Uterine Fibroids	_____ Ovarian Cysts	_____ Severe Menstrual Cramping
_____ Number of Pregnancies	_____ Number of Deliveries	_____ Number of Abortions/Miscarriages	

Ears, Nose and Throat

_____ Loss of Hearing	_____ Ringing in the Ears	_____ Glaucoma	_____ Loss of Sight
_____ Blurred Vision	_____ Visual Disturbances	_____ Epiglottitis	_____ Tonsillectomy

Neurological

_____ Epilepsy	_____ Dizziness	_____ Fainting Spells	_____ Migraines
_____ Loss of Memory	_____ Seizures	_____ Psychiatric Disorders	_____ Multiple Sclerosis

General Health History

_____ Diabetes	_____ Cancer	_____ Chemotherapy	_____ Gout
_____ General Fatigue	_____ Rheumatoid Fever	_____ Allergies [food/medicine]	_____ Sudden Weight Loss
_____ Shingles	_____ Skin Grafts	_____ Hepatitis	_____ HIV+/AIDS
_____ Alcohol/Drug Abuse	_____ Insomnia	_____ Arthritis	_____ _____

Lifestyle – Please Mark All That Apply To You

_____ Alcohol	_____ Tobacco	_____ Recreational Drugs	_____ Caffeine
_____ Exercise Regularly	_____ Sleep 8+ hrs per night	_____ Wear Orthotics	_____ Wear Lifts

Current Complaint

Please describe the quality and location of the pain that has brought you to our office today _____

What do you believe has caused this pain?

- Fall Lifting/Bending Automobile Accident Accident/Injury at Work Position During Sleep
 Other: _____

Please rate your overall pain on a scale from 1 [little to no pain] to 10 [worst pain you have experienced] _____

How have your symptoms affected your daily life?



– decreased my ability to perform this task

X – prevented me from performing this task

Daily Activities Affected by Symptoms

- | | | | |
|-----------------------|-----------------|-----------------------|--------------------|
| ____ Sleeping | ____ Eating | ____ Bathing | ____ Dressing |
| ____ Grooming | ____ Sitting | ____ Standing | ____ Bending |
| ____ Lifting/Carrying | ____ Running | ____ Sexual Relations | ____ Driving Car |
| ____ Moving | ____ Reading | ____ Writing | ____ Shopping |
| ____ Traveling | ____ Child Care | ____ Dining Out | ____ Social Events |

Activities Within The Home Affected by Symptoms

- | | | | |
|---------------------|----------------|---------------------|------------------------|
| ____ Cooking | ____ Ironing | ____ House Cleaning | ____ Laundry |
| ____ Washing Dishes | ____ Vacuuming | ____ Dusting | ____ Interior Painting |

Activities Outside The Home Affected by Symptoms

- | | | | |
|------------------------|----------------------|------------------------|----------------------|
| ____ Yard Work | ____ Gardening | ____ Mowing Lawn | ____ Car Washing |
| ____ House Maintenance | ____ Farm Activities | ____ Pet Care/Exercise | ____ Watering Plants |

Work Activities Affected by Symptoms

- | | | | |
|------------------------|--------------------|------------------------|-------------------------|
| ____ Concentration | ____ Computer Work | ____ Typing | ____ Writing |
| ____ Lifting/Carrying | ____ Machine Work | ____ Using Telephone | ____ Standing Long-Term |
| ____ Sitting Long-Term | ____ Traveling | ____ Level of Patience | _____ |

Sports and Hobbies Affected by Symptoms

____ Please list the sports you are unable to participate in: _____

____ Please list the hobbies or activities you are unable to participate in: _____

Chiropractic Care Goals

- Achieve and Maintain Full Body Health Increase Range of Motion Improve My Performance
 Treat Specific Condition or Injury Improve Nutrition Reduce Pain Only

Signature _____

Date _____
