Confidential Patient Information

Date ______________________

Name ______________________ Referred By ______________________

Address ______________________
STREET CITY STATE ZIP

Home Phone ______________________ Work Phone ______________________

Birth date ____________ Age ____ Marital M S D W Number of Children ___

Occupation ______________________ Employer ______________________

Social Security No. ______________________ Colo. Drivers License ______________________

Case History

Chief Complaint ______________________

Result of: ☐ Auto Accident ☐ Injury ☐ Work Related ☐ Other

Date of Accident/Injury ______________________ Last Day of Work ______________________

How and where this began ______________________

How long you have had this condition ______________________

Other doctors you have seen ______________________ When ______________________

Address ______________________

Had X-rays taken ____________ When ____________ Area X-rayed ______________________

Spouse's name ______________________ Occupation ______________________

Employer ______________________ Address ______________________

Nearest relative not living with you ______________________

Address ______________________ Phone ______________________

For females: Are you pregnant? ____________ How long? ______________________

For minors: Both parents ______________________

Address ______________________
STREET CITY STATE ZIP

Financial

How do you plan to handle your account: ☐ Cash ☐ Check ☐ Mastercard ☐ Visa

Insurance

Do you have personal, group health or accident insurance? ______________________

Company name ______________________ Address ______________________

Subscriber name ______________________ Group number ______________________

I have read the above information and certify it to be true and correct to the best of my knowledge and hereby authorize this office to do whatever is necessary, in accordance with the state statutes, for the care and management of this complaint. I also understand that I am responsible for all financial obligations arising from these services.

____
Patient Signature Date

Health Questionnaire

Please indicate for each of the questions below your experience by use of the following codes:

1 - never had, 2 - previously had, 3 - presently have, R - Right, L - Left

MUSCULO-SKELETAL

____Headache
____Neck Pain/Stiffness, R.L.
____Numbness/Tingling in arms,
____hands, fingers, R.L.
____Head seems too heavy
____Pain down arms
____Head/shoulders feel tired
____Pain between shoulders
____Shoulder pain, R.L.
____Muscle spasms or cramps
____Dizziness/loss of balance
____Ringing in ears, R.L.
____Fainting
____Blurred or double vision
____Hearing loss
____Mid back pain
____Low back pain
____Numbness/Tingling in legs,
feet, toes, R.L.
____Pain down legs, R.L.
____Hip pain, R.L.
____Foot trouble
____Broken bone
____Pain or clicking jaw
____arthritis
____Back curvature
____Swollen and stiff joints
____Difficulty in excessive
standing, walking, sitting,
riding, bending, lifting,
twisting
____Pain with cough or sneeze

CARDIO- RESPIRATORY

____Chest pain
____Difficulty breathing
____Allergies/asthma
____Sinus problems
____Difficult breathing
____Heart problems
____High or low blood pressure
____Varicose veins
____Irregular heartbeat
____Cold hands/feet
____Fatigue

GASTRO-INTESTINAL

____Poor appetite
____Nausea/vomiting
____Indigestion
____Heartburn
____Bloating/cramping
____Ulcers
____Diarrhea
____Constipation
____Liver/gall bladder
____Excessive gas
____Hemorrhoids
____Excessive thirst/hunger
____Difficult swallowing
____Weight control
____Crave sweets
____Trouble sleeping
____Under stress
____Light bothers eyes
____Muscle twitches
____Depressed
____Nervous
____Excessive sweating
____Trouble concentrating
____Learning disability
____Mood changes
____Memory loss
____Bladder problems
____Excessive urination
____Painful urination
____Prostate trouble
____Impotence
____Kidney stones
____Bed wetting

FEMALE

____Menstrual problems
____Cramps
____Breast lumps/soreness
____Irregular periods
____Discharge
____Yeast infections
____Infertility

HABITS

	NONE	LIGHT	MODERATE	HEAVY
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Sweets	☐	☐	☐	☐
Vitamins	☐	☐	☐	☐

What surgeries have you had?

____
____
____

What drugs are you taking?

____
____
____

Have you been in car accidents:

☐ Past year ☐ Past 5 years
☐ Over 5 years ☐ Never

____
____