

Date: _____



Healthy Family Chiropractic, LLC

7853 E. Arapahoe Ct., Suite 2200
Centennial, CO 80112

◆ Patient Information ◆

Name: _____ SSN: _____ - _____ - _____
Last First Middle Initial

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____ E-mail: _____

Date of Birth: ____ / ____ / ____ Age: ____ Employer: _____ Work Location: _____

Gender: Female • Male Marital Status: Single • Married • Divorced • Widowed • Other

Spouse's Name: _____ Cell Phone: (____) _____ - _____

Spouse's Employer: _____ Work Phone: (____) _____ - _____

Emergency Contact: _____ Relationship to you: _____ Phone: (____) _____ - _____

Who referred you to us? (Please list specific provider, friend, family member, etc.) _____

We are glad that you have chosen our clinic! We will do our best to help restore & to help you maintain your optimal health.

Primary Health Care

Provider: _____ Location (city): _____ Phone: (____) _____ - _____

Please list other providers that you have seen for the symptoms that you are currently experiencing: _____

Note: You will need to sign a Patient Authorization to Release Information form. This will allow us to request records from other providers that have participated in your care, so that we may have access to information concerning your current and past health.

When did your symptoms start? _____

Describe your symptoms, and how they began. _____

As concerns your current symptoms, what tests have you previously had, if any, & when were they performed?

X-rays date: _____ MRI/CT date: _____
 EMG date: _____ Other _____

Date: _____

Patient Name: _____

In order to help you in the best way possible, please complete the following *Patient Health Questionnaire*

Current Medication: Please list the name and dosage. (Include prescription drugs, vitamins, herbal supplements, over-the-counter medications, birth control pills & hormone replacement therapy)

- 1. _____ 5. _____ 9. _____
- 2. _____ 6. _____ 10. _____
- 3. _____ 7. _____ 11. _____
- 4. _____ 8. _____ 12. _____

Allergies (environmental, medication, food, latex, other substance): Please list the type of allergies & the reaction(s) you have:

Hospitalizations	Description	Year	Description	Year
(Please list past surgeries &/or illnesses.)	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

Have you ever been in a car accident? Yes No If yes, please provide details.

Women Only

Menstrual Periods: Age Onset _____ Regular periods? Yes No Date Last Period Began ____/____/____

Painful Periods? Yes No Elaborate: _____

Pap Smear (if applicable): Date of last Pap: ____/____/____ Have you ever had an abnormal Pap Smear? Yes No

Pregnancy: # of Children: Born Alive ____ • Cesarean ____ • Premature ____ • Stillborn ____ • Miscarriages ____ • Abortions ____

Describe any complications (if applicable): _____

Is there a chance that you could be pregnant? Yes No Infertility issues in the past or present? Yes No

Menopause (if applicable): Approx. Age Onset: _____ Treatment required for symptoms? Yes No

Bone Density (if applicable): Date last exam: ____/____/____ What were the results? _____

Military Service Only

Branch of service: _____ Length of enlistment: From _____ to _____

Location(s) served: _____

Did you sustain any injuries? Yes No If yes, please provide details. _____

Date: _____

Patient Name: _____

Personal Habits – Please answer honestly. This information is needed to ensure the best possible treatment. All information is *completely* CONFIDENTIAL. Please rate your answer on a scale from 1 to 5, with 1 = No/Never and 5 = Yes/Often.

	No/Never → Yes/Often					Elaborate
	1	2	3	4	5	
Exercise regularly (3-4 x week)						
Sleep well						
Eat 3 meals per day						
Eat refined sugar / baked goods / breads, etc.						
Drink at least 2 liters (64 oz.) of water daily						
Drink soda (pop)						<input type="checkbox"/> Diet <input type="checkbox"/> Regular
Drink coffee						<input type="checkbox"/> Regular <input type="checkbox"/> Decaffeinated <input type="checkbox"/> Other
Drink alcohol						<input type="checkbox"/> Wine <input type="checkbox"/> Beer <input type="checkbox"/> Other
Drink tea						<input type="checkbox"/> Black <input type="checkbox"/> Herbal <input type="checkbox"/> Iced <input type="checkbox"/> Hot <input type="checkbox"/> Other
Chew tobacco						
Smoke						
Use recreational drugs						
Experience Stress						

Please mark if you have had the following conditions in the past and/or present:

- Drug Addiction
 Alcoholism
 Eating Disorder
 Anxiety/Depression
 Attention deficit/Autism

Are there any environmental risks involved in your job or home environments? Yes No

If yes, please provide details. _____
 (Examples: chemical fumes, radiation exposure, mold, lead paint, etc.)

Family History: Check (✓) any diseases that your relatives have had (if known).

Relatives	Arthritis	Cancer	Diabetes	Heart Disease, Stroke	Kidney Disease	Multiple Sclerosis, Parkinson's, Alzheimer's	Thyroid Disease
Father							
Mother							
Brothers							
Sisters							
Grandparents							

Other: _____

Date: _____

Patient Name: _____

For each of the symptoms/conditions listed below, place a check (✓) in the PAST column if you have had the symptom/conditions in the past. If you presently have a symptom and/or condition listed below, place a check (✓) in the PRESENT column.

Past	Present		Past	Present		Past	Present	
		<u>General</u>			<u>Neuromusculoskeletal</u>			<u>Respiratory</u>
<input type="checkbox"/>	<input type="checkbox"/>	Appetite change (↑/↓)	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Attention difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Joint aches/pains	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Poor balance/clumsiness	<input type="checkbox"/>	<input type="checkbox"/>	Spitting up blood/phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Dyslexia	<input type="checkbox"/>	<input type="checkbox"/>	Poor posture			<u>Kidney/Ureter/Bladder</u>
<input type="checkbox"/>	<input type="checkbox"/>	Fainting			<u>Pain in:</u>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Low back	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control bladder/urine
<input type="checkbox"/>	<input type="checkbox"/>	Fever/chills	<input type="checkbox"/>	<input type="checkbox"/>	Mid-back	<input type="checkbox"/>	<input type="checkbox"/>	Kidney infection or stones
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>	Painful urination
<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Shoulders/chest	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Face			<u>Females Only</u>
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Jaw	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycle
<input type="checkbox"/>	<input type="checkbox"/>	Skin condition	<input type="checkbox"/>	<input type="checkbox"/>	Arms	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Sleep loss	<input type="checkbox"/>	<input type="checkbox"/>	Elbows	<input type="checkbox"/>	<input type="checkbox"/>	Lumps in breasts
<input type="checkbox"/>	<input type="checkbox"/>	Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Hands/wrists/fingers	<input type="checkbox"/>	<input type="checkbox"/>	Painful menstruation
<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Hips	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract/bladder infections
<input type="checkbox"/>	<input type="checkbox"/>	Weight gain/loss	<input type="checkbox"/>	<input type="checkbox"/>	Legs	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge
		<u>Ears, Eyes, Nose, Throat</u>	<input type="checkbox"/>	<input type="checkbox"/>	Knees	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal dryness
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Feet/ankles/toes	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Tailbone/sits-bone			<u>Males Only</u>
<input type="checkbox"/>	<input type="checkbox"/>	Dental work (root canals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis/spinal curvature	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<u>Other Health Problems/Issues</u>
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds/flu			<u>Gastrointestinal</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness/laryngitis	<input type="checkbox"/>	<input type="checkbox"/>	Acid reflux/heartburn	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Celiac/Crohn's disease	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Strep throat	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Vision change (ie, blur, double)	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty digesting foods	<input type="checkbox"/>	<input type="checkbox"/>	
		<u>Cardiovascular</u>	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems			
<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Gas/bloating			
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel syndrome			
<input type="checkbox"/>	<input type="checkbox"/>	Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems			
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Mucus in stool			
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Nausea/vomiting			
<input type="checkbox"/>	<input type="checkbox"/>	Rapid/slow heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Pain in abdomen			
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	Ulcerative colitis			

Please give any other insights and/or information that you feel might be helpful in your care and/or health maintenance:

_____/_____/200____
Please print name of person completing form. Relationship (if other than patient) Date

_____/_____/200____