COLORADO
CHIROPRACTIC

865 Englewood Parkway
Englewood, CO 80110
303.795.3668

Welcome to our clinic!

Our Mission at the Colorado Chiropractic Clinic is to provide the members of our community with high quality, affordable health care in a comfortable and caring environment. We seek to provide this by offering high-quality chiropractic care as well as educating patients on how to build & maintain a higher level of health.

The purpose of today's office visit is to allow the prospective new patient the opportunity to discuss his/her conditions with the Doctor, to determine the cause of the problem, and to take the first steps towards recovery.

To ensure your first visit with us is a pleasant one, here are the procedures you can expect during the next 45 - 60 minutes with us. Please feel free to ask questions if you need assistance.

Health History	A complete understanding of your current health issues is essential to help the Doctor provide the most appropriate treatment and recommendations.
Consultation	You will meet the Doctor who will review your health history with you and determine if yours is a chiropractic case.
Examination	Standard physical, orthopedic, neurological, and chiropractic tests will be performed to determine the cause and appropriate treatment of your condition.
Treatment	This office is unique in that the first adjustment is usually given on the same day, at the discretion of the Doctor. If you would like to be treated today, your appointment may take additional time as we analyze your case. patient

CONFIDENTIAL HISTORY

Today's Date: _____ Birthdate: _____ Age: _____

First: _____ Last: _____ M.I. _____ SSN: _____

Address: _____ Home Phone #: _____

City: _____ ZIP: _____ Work Phone #: _____

E-mail: _____ Cell Phone #: _____

Check if you are: □ Married □ Single □ Widowed □ Divorced □ Separated

Occupation: _____ Employer: _____

How did you find us?: □ Google □ Yelp □ Insurance □ Already knew us □ Referred by: _____

Dates of Worked Missed due to Injury: _____

NATURE OF MVA

Date & Time of Motor Vehicle Collision: _____ Road conditions: □ Dry □ Wet □ Icy

Was a police report made? □ Yes □ No Do you have a copy of the report? □ Yes □ No

Did you go to the hospital? □ Yes □ No _____ How did you get there? _____

How long did you stay? _____ What parts have been x-rayed? _____

What was your diagnosis? _____

What treatments were given? _____

Please describe the Motor Vehicle Collision to the best of your knowledge.

_____

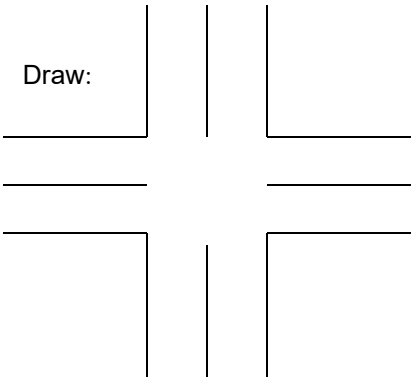
_____

_____

_____

_____

Draw:



Which seat were you sitting in? _____ How many people in vehicle? ____

Were you aware of the pending collision? □ Yes □ No Did you tense up? □ Yes □ No

Were you in a (car) (truck) (other)? Year _____ Make _____ Model _____

Where was your vehicle damaged? _____ What was the estimated damage cost? $_____

Did you receive any injury, bruise, or pain from the seat belt? □ Yes □ No □ Not Buckled

What direction were you looking? _____ Was your foot on the brake? □ Yes □ No

CURRENT CONDITIONS

Did you have pain immediately? □ Yes □ No

Please describe when your first experienced pain: _____

_____

List & Describe Present Complaints / Conditions in order of Importance (please be specific):

Example: Pain in lower back on right side that goes down the back of right leg to the knee. Worse when bending.

- _____
- _____
- _____
- _____

How are your current symptoms different from what you've had in the past? _____

PERSONAL MEDICAL HISTORY

Have you been treated for any health condition by a Physician in the last year? □ Yes □ No

If so, what Doctor, and why? _____

List the approximate dates of any surgeries, serious illnesses, accidents, or unusual diseases you have had:

_____

Joint Replacement(s) / Date(s): _____

List all medication(s) that you have used recently (i.e., aspirin, sleeping pills, anti-depressants): _____

_____

Has medication been helpful with your pain? □ Yes □ No

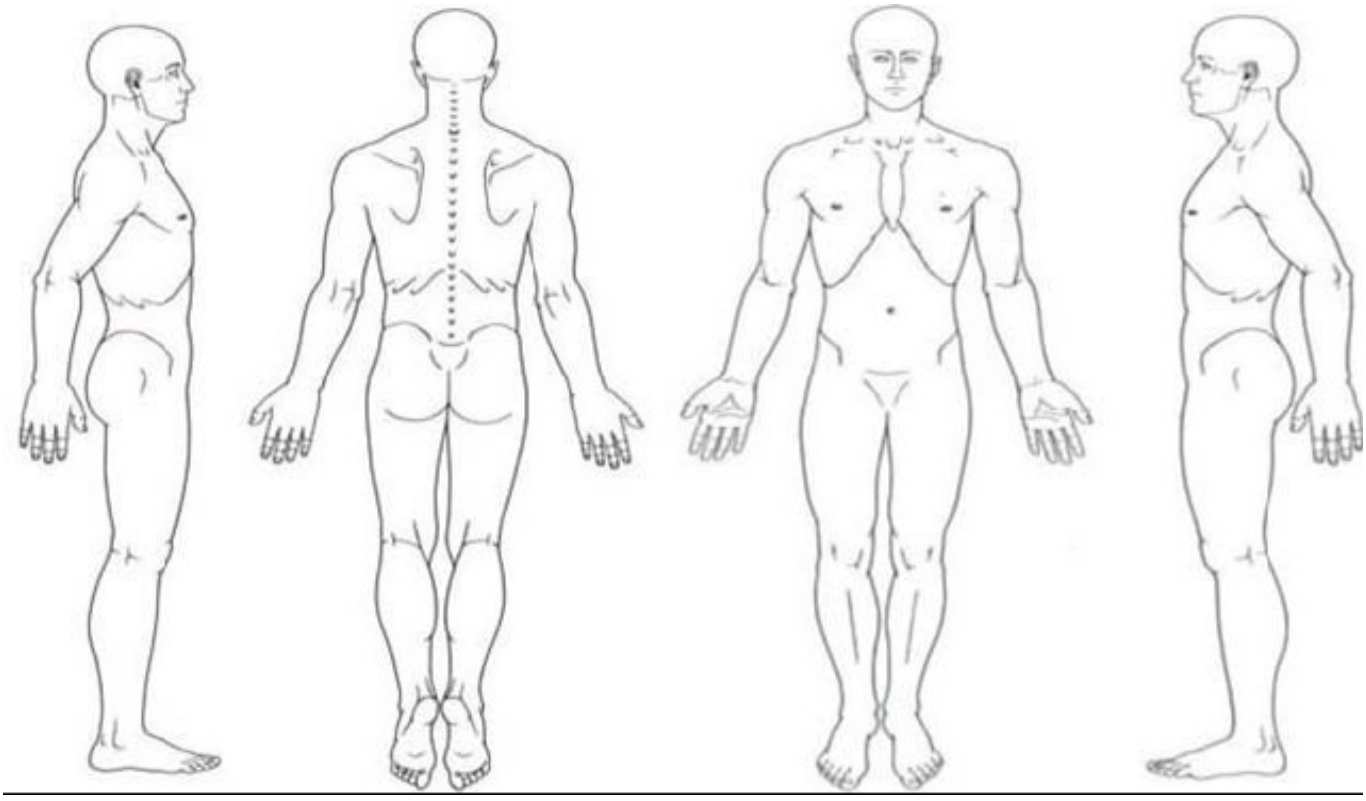
Date of last: Spinal X-ray: _____ Physical Exam: _____ Blood / Urine Test: _____

List all nutritional and/or vitamin supplements taken regularly: □ Multivitamin □ Fish Oil □ Probiotic □ VitaminD □ Others: _____

Do you exercise? □ Yes □ No What Activities? _____ How often? _____

Please mark **ALL areas** of pain or numbness/tingling on the figures below:

Include: □ Head □ Neck □ Chest □ Back □ Arms □ Hands □ Legs



Type of Pain: □ Local □ Traveling □ Tingling □ Numb
□ Achy □ "Electric" □ Sharp □ Dull

***NECK**: What is your TYPICAL or AVERAGE pain?*

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

***NECK**: What is your level of pain AT ITS WORST?*

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

***BACK**: What is your TYPICAL or AVERAGE pain?*

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

***BACK**: What is your level of pain AT ITS WORST?*

No pain _____ worst possible pain

0 1 2 3 4 5 6 7 8 9 10

How often do you experience your symptoms?

- □ Constantly (76-100% of the day)
- □ Frequently (51-75% of the day)
- □ Occasionally (26-50% of the day)
- □ Intermittently (0-25% of the day)

How are your symptoms changing?

- □ Getting Better
- □ Not Changing
- □ Getting Worse
- □ In Bed

When do you notice them most?

- □ Morning
- □ Afternoon
- □ Evening

Which of the following cause pain or are difficult?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	O	O	O	O
Stand from Chair	O	O	O	O
Standing	O	O	O	O
Walking	O	O	O	O
Lying Down	O	O	O	O
Bending Over	O	O	O	O
Climbing Stairs	O	O	O	O
Computer Use	O	O	O	O
Driving a Car	O	O	O	O

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Household Chores	O	O	O	O
Lifting Objects	O	O	O	O
Reaching Overhead	O	O	O	O
Dressing Myself	O	O	O	O
Getting to Sleep	O	O	O	O
Staying Asleep	O	O	O	O
Concentrating	O	O	O	O
Exercising	O	O	O	O
Yard Work	O	O	O	O
Other:_____	O	O	O	O

For each of the conditions listed below, place a check in the past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the present column.

Past	*Present*	
○	○	Headaches
○	○	Neck Pain
○	○	Upper Back Pain
○	○	Mid Back Pain
○	○	Low Back Pain
○	○	Shoulder Pain
○	○	Elbow/Upper Arm Pain
○	○	Wrist Pain
○	○	Hand Pain
○	○	Hip/Upper Leg Pain
○	○	Knee/Lower Leg Pain
○	○	Ankle/Foot Pain
○	○	Jaw Pain
○	○	Joint Swelling/Stiffness
○	○	Arthritis
○	○	Rheumatoid Arthritis
○	○	General Fatigue
○	○	Muscular Incoordination
○	○	Visual Disturbance
○	○	Dizziness

Past	*Present*	
○	○	High Blood Pressure
○	○	Heart Attack
○	○	Chest Pains
○	○	Stroke
○	○	Angina
○	○	Kidney Stones
○	○	Kidney Disorders
○	○	Bladder Infection
○	○	Painful Urination
○	○	Loss of Bladder Control
○	○	Prostate Problems
○	○	Abnormal Weight Gain/Loss
○	○	Loss of Appetite
○	○	Abdominal Pain
○	○	Ulcer
○	○	Hepatitis
○	○	Liver/Gall Bladder Disorder
○	○	Cancer
○	○	Tumor
○	○	Asthma
○	○	Chronic Sinusitis

Past	*Present*	
○	○	Diabetes
○	○	Excessive Thirst
○	○	Frequent Urination
○	○	Smoking/Tobacco Prod.
○	○	Drug/Alcohol Dependency
○	○	Allergies
○	○	Depression
○	○	Systemic Lupus
○	○	Epilepsy
○	○	Dermatitis/Eczema/Rash
○	○	HIV/AIDS

Females Only

○	○	Birth Control Pills
○	○	Hormonal Replacement
○	○	Pregnancy

Other Health Problems/Issues

○	○	_____
○	○	_____
○	○	_____