Denver Chiropractic

Date: ____/____/______ **Personal Information**

First Name:_________________________________ Middle Initial_____ Last Name:____________________________

Preferred Nickname :___________________ Email(confidential):____

Driver's Lic # __________________________ State________ SS# ____

Address: __________________________________City:_________________________State:____ Zip:_____________

Home Phone: ( )___________________________ Cell Phone: ( )_______________________________

Birth Date:____/____/_____ Age:_____ Childr.Names/Ages:____

Employer: ____________________________________ Occupation/Title: __________________________________

Work Phone: ( )___________________________Is it OK to contact you @ work? Y N Emergency only

Work Address_____________________________City__________________State:______Zip_____________

Occasionally, the Doctor may need to contact you about your care…best time to contact you? _________________

Best Weekdays / Time frames for appointments w/ us? ____

Marital Status: Single Married Divorced Separated Widowed Cohabitating Other:_____________________

Spouse Name:_________________ Spouse's D.O.B.____________ Spouse's Emplr:___________________________

Primary Physician Information:

Doctor's Name: ______________________________ Office Name ____

Addr: ____ Appox. date of last visit______________________

Phone ____________________________Fax __________________________Website:____________________________

Emergency Contact (Name/Phone): ____

How did you hear about our office? (**if yellow pgs, specify book**)____

When did you **LAST** receive chiropractic care **(NEVER)** ? _________________________For?_____________________

Have <u>all</u> your Chiropractic experiences been: N/A Good Not So Good Other:___________________________

Have you ever received Chiropractic care for 2 months or more, consistently? _______________________________

Do you have any plans to be out of town or travel within the next 30 days? **Y N** *For how long? ____________

<u>*Valued Patients:</u> To keep the cost of your health care at an affordable fee, Family Chiropractic remains a <u>zero balance</u> facility. This means we do not bill our patients or send monthly statements unless necessary. Co-pays, Co-insurances, Deductibles, or Self-Pay payments are expected at each visit, unless Pre-paid.
<u>Scheduling Appointments</u>**: Family Chiropractic understands that circumstances/emergencies can prevent our patients from keeping their scheduled appointments. **Therefore, if you cannot keep your scheduled appointment PLEASE CALL OUR OFFICE ASAP to notify us that you are on your way or to Reschedule. Thank You**
WE RESERVE THE RIGHT TO CHARGE YOU FOR "NO-SHOW" APPOINTMENTS. I agree and initial here:_________

Denver Chiropractic

Confidential Case History

O – Occasional F – Frequent C – Constant

Name:________________________ **Date:**____________________

Using the Key above, check those symptoms you do have or have had in the past year. **Leave it blank** if you haven't had it. Also, CIRCLE THE CONDITION if you are being/have been treated for it.

	O	F	C
Allergies			
Chills			
Convulsions			
Dizziness			
Fainting			
Fatigue			
Fever			
Headache			
Loss of Sleep			
Weight Loss			
Nervousness			
Depression			
Neuralgia			
Numbness			
Abnorm Sweats			
Tremors			

	O	F	C
Arthritis			
Bursitis			
Foot Trouble			
Hernia			
Pain In:			
Low Back			
Neck			
Upper/Mid Back			
Shoulders			
Elbows			
Hands/Wrists			
Hips/Buttocks			
Fingers/Toes			
Knees			
Ankles/Feet			
Tailbone			
Poor Posture			
Sciatica			
Scoliosis			
Swollen Joints			
TMJ/Jaw Probs.			
Groin			
Loss of Taste			
Loss of Smell			

	O	F	C
Burps /Gas			
Colitis / I.B.S.			
Sm.Intest/Colon			
Constipation			
Diarrhea			
Digestive Issues			
Abdmnl Cramps			
Celiac Disease			
Gall Bladder			
Hemorrhoids			
Abn Eatng/Hungr			
Jaundice			
Liver Trouble			
Nausea/Vomitg			
Stomach Probs			
Poor Appetite			
Dry Mouth			
Vomitting Blood			

	O	F	C
Asthma			
Colds			
Double Vision			
Hearing Loss			
Dental Decay			
Earache			
Ear Discharge			
Ear Noises			
Gland Issues			
Thyroid Probs.			
Eye Pain/Weak			
Blurry Vision			
Far Sighted			
Gum Trouble			
Hay Fever			
Hoarseness			
Nasal Blockage			
Near Sighted			
Nosebleeds			
Sinus Infection			
Sore Throat			
Tonsillitis			

	O	F	C
Loss of Balance			
High Blood Pres			
Low Blood Pres			
Blood Clot Prob.			
Circultion Prob			
Fast/Slow Heart			
Swollen Ankles			
Varicose Veins			

	O	F	C
Chest Pain			
Chronic Cough			
Breathing Probs			
Spittin up Blood			
SpittinUpPhlegm			
Wheezing			

	O	F	C
Boils / Blisters			
Bruise Easily			
Dryness/Cracks			
Sting Sensitivity			
Itching			
Skin Rashes			
Warts			

	O	F	C
Bed Wetting			
Blood in Urine			
Freq. Urination			
Kidney Infect.			
Kidney Stones			
Urination Pain			
Prostate Probs.			

Women:	O	F	C
Breast Pain			
Menstr. Cramps			
Heavy Flow			
Hot Flashes			
Irregular Cycle			
Menopausal			
Irreg. Discharge			
Yeast Infections			

Name:_____________________________ **Date:__________________**

Please CIRCLE the follow conditions you have or have had:

Cancer	Cold Sores	Goiter	Measles	Rheumatic Fever	Whooping Cough
Anemia	Diabetes	Fever Blisters	Miscarriage	Scarlet Fever	Venereal Disease
Appendicitis	Pneumonia	Heart Disease	Mult.Sclerosis	Stroke	Epilepsy
Eczema	HIV/AIDS	Mumps	Tuberculosis	Polio	Arthritis:___________________
Emphysema	Influenza	Pleurisy	Ulcers	Breast Lumps	Arteriosclerosis
Crohn's	Pacemaker	Aneurysm	Alcoholism	Gout	Other(s):___________________

Have you been treated for any conditions in the last year? No Yes

If yes, please describe ____

Date of last physical exam ___________ Is there a chance that you are PREGNANT? No Yes # of Wks:___

Have you recently had XR, MRI, or CT taken? No Yes *If yes, where? ______________________________

MEDICATIONS you now take: (Please list for what condition, dosage, and frequency, etc) ________________

____

____

Vitamins, Minerals, Herbs, Supplements you now take: (Please list for what condition, dosage, frequency)

____

____

Have you ever:	No	Yes	Briefly Explain
Had broken bones?			____
Been hospitalized?			____
Had any auto accidents?			____
Had Sprains/Strains?			____
Been struck unconscious?			____
Had surgery?			____

Family History

Family Member	Past & Present Health conditions(Example: heart disease, cancer, diabetes, arthritis, etc.)

Habits:	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
Soft Drinks				
Water				
Salty Foods				
Sugary Foods				
Artifcl Swtnrs				

	Yes	No
Do you experience daily pain?		
Does pain wake you up at night?		
Do weather changes affect your symptoms?		
Do you wear orthotics?		
Are your symptoms worse at certain times of the day?		
Does anything prevent you from getting rid of these problems?		

Denver Chiropractic/P.O. Box 1375 /Denver, NC 28037 (704) 489.2273/F704.489.2274

NEUROLOGICAL AND VASCULAR QUESTIONNAIRE

NAME ____ **DATE** _______________

****For any YES answer PLEASE *CIRCLE ANYTHING "IN" THE QUESTION THAT APPLIES*…and then on the line below *DESCRIBE the Specifics*…such as which SIDE of the body, which fingers/toes, etc:**

1. Do you suffer from neck pain with pain in your shoulder, arms or hands? NO YES
   Specifics: ____

2. Do you have weakness, numbness or burning in your shoulder, arms or hands? NO YES
   Specifics: ____

3. Do your hands or arms fall asleep regularly? NO YES
   Specifics: ____

4. Do you have reduced feeling (sensation) or swelling in your hands or arms? NO YES
   Specifics: ____

5. Do you suffer from a loss of hand grip strength? NO YES
   Specifics: ____

6. Do you suffer from back pain with pain in your buttocks, legs or feet? NO YES
   Specifics: ____

7. Do you have weakness, numbness or burning in your buttocks, legs or feet? NO YES
   Specifics: ____

8. Do our legs or feet fall asleep regularly? NO YES
   Specifics: ____

9. Do you have reduced feeling (sensation) or swelling in your legs, feet? NO YES
   Specifics: ____

10. Do you suffer from cold hands or feet? NO YES
    Specifics: ____

11. Do you suffer from headaches, dizziness or memory loss? NO YES
    Specifics: ____

12. Do you have difficulty maintaining your balance? NO YES
    Specifics: ____

13. Do you suffer from vertigo or blurred vision? NO YES
    Specifics: ____

14. Do you suffer from a reduced hearing capacity? NO YES
    Specifics: ____

15. Do you suffer from ringing in your ears? NO YES
    Specifics: ____

16. Do you have bladder or bowel control problems on a regular basis? NO YES
    Specifics: ____