Denver Headache & Spine Center

Confidential Patient Information Date: ____________________

Name: ____ Soc. Sec. No. __________________________

Address: ____ City: _________________________________

State: ________________ Zip: _________________ Birth Date: ______________ Age: ________

Marital Status (circle one): M S D W How many children and ages? ______________________________

Home Number: _________________ Work Number: ________________ Cell Phone:___________________

E-mail: __________________ Occupation: _____________________ Employer: ______________________

Name of Insurance Company: _____________________________ Ins. Phone: _________________________

Address: ______________________________ Ins. ID#: ______________________ Group #_____________

Insured's name if patient is dependent: ____________________________ SSN: _____________________

Insured's employer: ______________________________________ Insured's Birth date: ______________

Name of Husband/Wife: _____________________________ Occupation & Employer: ___________________

Referred by: _______________________________ Best times for appointments for you (circle one): AM PM

Have you ever been under Chiropractic Care? ( ) Yes ( ) No Year: ________ Doctor: __________________

Payment is expected at time of visit!

Name of person responsible for payment:

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It is our office policy to have your initial examination; consultation and x-rays paid for at the time these services are rendered. For your convenience we have listed several options below from which to choose. Please check the one you will be using for today's visit.

CASH CHECK VISA MASTERCARD DISCOVER AMERICAN EXPRESS OTHER

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Denver Headache & Spine Center P.C. will prepare any necessary reports and forms assisting me in making collections from the insurance company and that any amount authorized to be paid directly to this office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment any fees for professional services rendered me will be immediately due and payable.

Signature: ____ Date: _________________________

Guardian or Spouses Authorizing Care: ____

List your complaints in order of severity:

1) ______________________________ For how long? ______________

2) ______________________________ For how long? ______________

3) ______________________________ For how long? ______________

What activities aggravate your condition? ______________________________

Is this condition getting progressively worse? ( ) Yes ( ) No ( ) Constant ( ) Comes and goes

Is this condition interfering with your: ( ) Work ( ) Sleep ( ) Daily Routine ( ) Other ______________

Does the pain radiate to any part of your body? ( ) Yes ( ) No Where? ______________

How did your condition start? ______________________________

Have you had a similar condition before? ( ) Yes ( ) No If yes, where & what were results? ______________

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Is condition due to injury or sickness that is work related? ( ) Yes ( ) No Reported to employer? ( ) Yes ( ) No

Is your condition due to an automobile accident? ( ) Yes ( ) No Date accident happened: ______________

Have you lost any days from work? ( ) Yes ( ) No ______________________________

Date of last physical exam? ______________________ **Females:** Are you pregnant? ( ) Yes ( ) No

What surgeries have you had? ______________________________

Serious illnesses: ( ) Measles ( ) Mumps ( ) Chicken Pox ( ) Other ______________________

What medications are you currently taking? ______________________________

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Have you ever suffered from: (Check all that apply)

( ) Allergy	( ) Neck Pain	( ) Ear noises	( ) Poor Circulation	( ) Kidney inf./stones
( ) Dizziness	( ) Neck Stiffness	( ) Ear Infections	( ) Rapid heart beat	( ) Prostate trouble
( ) Lightheaded	( ) Poor Posture	( ) Enlarged Thyroid	( ) Slow heart beat	( ) Cramps/backache
( ) Fatigue	( ) Sciatica	( ) Eye pain	( ) Anemia	( ) Excessive menstrual flow
( ) Headache	( ) Swollen joints	( ) Failing Vision	( ) Stroke	( ) Irregular cycle
( ) Sleep problems	( ) Colon trouble	( ) Venereal Disease	( ) Chest Pain	( ) Lumps in breast
( ) Ulcers	( ) Diarrhea	( ) Bruising easily	( ) Difficult breathing	( ) Hot flashes
( ) Nervousness	( ) Difficult digestion	( ) Hay fever	( ) Pleurisy	( ) Alcoholism
( ) Depression	( ) Hemorrhoids	( ) Nosebleeds	( ) Shortness/breath	( ) Swelling of ankles
( ) Arthritis	( ) Nausea	( ) Sinus Infections	( ) Itching	( ) Diabetes
( ) Bursitis	( ) Asthma	( ) High blood pressure	( ) Varicose veins	( ) Cancer
( ) Foot Trouble	( ) Colds	( ) Low blood pressure	( ) Bed wetting	( ) Irritability
( ) Low back pain	( ) Deafness	( ) Pain over heart	( ) Frequent urination	

Family History: (Check all that apply)

	Diabetes	Heart Disease	Cancer	Back Pain	Headache
Mother	( )	( )	( )	( )	( )
Father	( )	( )	( )	( )	( )
Brother	( )	( )	( )	( )	( )
Sister	( )	( )	( )	( )	( )
Grandparents	( )	( )	( )	( )	( )

Habits:

	Heavy	**Moderate**	**Light**	**None**	**Explain:**
Alcohol	( )	( )	( )	( )	
Coffee	( )	( )	( )	( )	
Tobacco	( )	( )	( )	( )	
Drugs	( )	( )	( )	( )	
Exercise	( )	( )	( )	( )	
Sleep	( )	( )	( )	( )	
Appetite	( )	( )	( )	( )	

Tingling or numbness in: (check all that apply)

( ) Shoulders ( ) Hand ( ) Knees
( ) Arms ( ) Hips ( ) Feet
( ) Elbows ( ) Legs ( ) Fingers

If yes, explain: ____

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Do you take vitamins or minerals? ( ) Yes ( ) No

Are you wearing: ( ) Heel lifts ( ) Sole lifts ( ) Inner Soles ( ) Arch supports

Comments: ____

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