Rock Chiropractic

Where miracles can happen

Parker, Co 303-840-2092

Patient Application Pg1

Confidential Health Information

Date:

1 PATIENT CONTACT

Last Name:	First Name:	Middle Initial:
Preferred to be Called:	Occupation:	
Address:	Who can we thank for referring you?	
City: / State:	Zip:	
Home Phone:	Cell Phone:	
Work Phone:	E-mail:	
	Insurance:	

2 PATIENT PERSONAL

Age:	Date of Birth:	Social Security #:	Gender: M / F

Marital Status: Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced ☐

Name of Spouse:	Names and Ages of Children:

3 EMERGENCY CONTACT

Name:	Home Phone:
Relationship:	Cell Phone:

4 GENERAL HEALTH

Have you ever had Chiropractic Care? ☐ Yes ☐ No		Frequency of past adjustments?	How long ago?
The goal of todays appointment?		Do you have any allergies? (specify)	
How often do you drink alcoholic beverages?		Any drug related allergies? (specify)	
Do you exercise? ☐ Yes ☐ No	Type?	Frequency?	Do you Smoke? ☐ Yes ☐ No How Much?

Have you ever suffered from or been diagnosed as having any of the following, write P to the side for past conditions:

Yes	No		Yes	No		Yes	No	
☐	☐	*Head Aches/Problems	☐	☐	Ear Infections	☐	☐	Ruptures
☐	☐	Neck problems	☐	☐	Frequent colds	☐	☐	Coughing Blood
☐	☐	Shoulder Problems	☐	☐	Asthma	☐	☐	Digestive Problems
☐	☐	Arm Problems	☐	☐	Menstrual Cramps	☐	☐	Alcoholism
☐	☐	Numb - Arms / Hands	☐	☐	Tiredness / Fatigue	☐	☐	Drug Addiction
☐	☐	Pain b/w Shoulders	☐	☐	*Broken or Fractured Bones	☐	☐	HIV Positive
☐	☐	Low Back Problems	☐	☐	Circulatory Problems	☐	☐	Gall Bladder
☐	☐	Leg Problems	☐	☐	*Rheumatoid Arthritis	☐	☐	Depression
☐	☐	Numb - Legs / Feet	☐	☐	Seizures/Convulsions	☐	☐	Tumors
☐	☐	Painful/Stiff Joints	☐	☐	A Congenital Disease	☐	☐	Epilespy
☐	☐	Sinus Problems	☐	☐	Excessive Bleeding	☐	☐	Pacemaker
☐	☐	Sore Muscles	☐	☐	High/Low Blood Pressure	☐	☐	Strokes
☐	☐	Dizziness	☐	☐	*Diabetes	☐	☐	*Cancer
☐	☐	Fainting	☐	☐	*Osteoarthritis	☐	☐	Ulcers

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Patient Application Pg 2

5 Medication List

Please use other page if necessary

Names of all Medications	Names of Vitamins	Non-Rx / Rx	Date Started/Stopped	Who Prescribed Dr. / Self
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐
		☐ ☐		☐ ☐

Miscellaneous Notes:

6 Systems Review

Please check the box C if you currently have this symtom, P if you have had it in the past and NA if neither apply. Please do not leave any blanks.

C	P	NA		C	P	NA	
☐	☐	☐	High / Low Blood Pressure	☐	☐	☐	Diarrhea
☐	☐	☐	Dizziness/Fainting	☐	☐	☐	Nausea
☐	☐	☐	Insomnia	☐	☐	☐	Female Problems
☐	☐	☐	Low Resistance: Chronic Colds/Flu	☐	☐	☐	Prostate Problems
☐	☐	☐	Tension	☐	☐	☐	Hands/Feet Cold
☐	☐	☐	Confusion	☐	☐	☐	Hand Tremors
☐	☐	☐	Tiredness / Fatigue	☐	☐	☐	Loss of Memory
☐	☐	☐	Ulcers	☐	☐	☐	Nervousness
☐	☐	☐	Eye/Vision Problems	☐	☐	☐	Sweaty Palms
☐	☐	☐	Difficulty Breathing	☐	☐	☐	Speech Difficulty
☐	☐	☐	Heart problems	☐	☐	☐	Anxiety
☐	☐	☐	Loss of Bladder Control	☐	☐	☐	Depression
☐	☐	☐	Constipation				

Doctors Use Only

Please identify all facilities/providers you have seen for these conditions and those you are currently seeing, if any, for your presenting problem(s).

Dr. Name/Facility	Problem	Type of Treatment Received	Dates of Care

Doctors Notes Only:_____

7 Main Complaint

What is your primary complaint?

On the scale below, please rate the severity of your **primary** complaint (At it's worst):

0. No pain	1. Slight Discomfort	2. Slight pain	3.	4.	5.	6.	7.	8.	9. Pain keeps me bed ridden	10. Pain that causes thoughts of suicide
			Moderate Pain				Severe Pain			

On the scale below please rate the percentage of time you experience your **primary** complaint:

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%

How long have you suffered with this problem?

What have you done to try to correct this problem?

Subluxations can cause irritation to different fibers within nerves. What do you suffer from: ☐ Sharp ☐ Dull ☐ Aching ☐ Burning ☐ Cramping ☐ Shooting ☐ Stabbing ☐ Tingling ☐ Throbbing ☐ Numbness

When severe enough subluxations will cause radiating ☐ Pain ☐ Tingling ☐ Numbness down to the ☐ Arms ☐ Hands ☐ Legs or ☐ Feet

CA / Dr. Notes Only:

When do you notice the pain most? ☐ Worse AM ☐ Worse PM ☐ Worse w/Activity ☐ Constant / Daily

Have your ever had this in the past ☐ Yes ☐ No

How long does the pain last? Minutes Hours

How many times in the past have you had this?

What makes it feel better?

What makes it feel worse?

Have you missed work because of your primary complaint? ☐ Yes ☐ No

Dates missed?

Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (i.e. falls, sports injuries, repetitive motion) Yes ☐ No ☐

If yes, please explain.

Are you pregnant?

Number of pregnancies?

Miscarriages?

Date of last menstrual cycle?

8 Other Health Complaints

Please list other health complaints on the following lines:

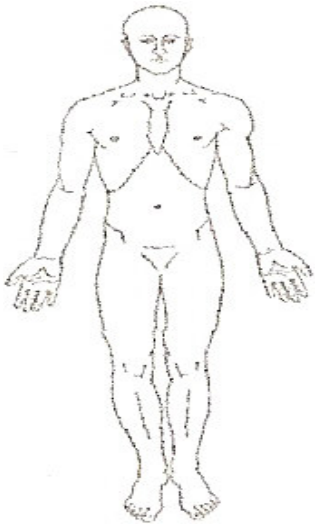
Complaint:	2	3	4
When did it 1st occur?			
What makes it better?			
What makes it worse?			
What type of pain?			
Where does it radiate?			
Location of complaint?			
Timing/Frequency of complaint?			

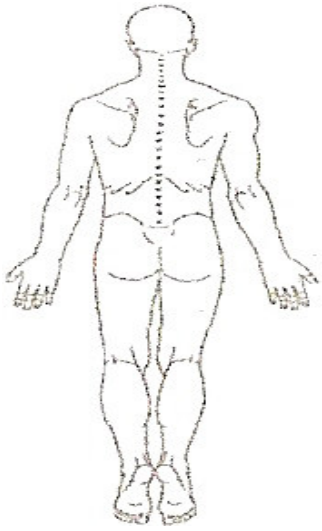
Doctor's Notes Only: _____

8 Continued

Please mark ALL the areas of all of your complaints on the diagrams below using the following letters:

A= Aching
B = Burning
C= Cramping
D= Dull
N= Numbness
S= Sharp
T= Tingling
SH= Shooting
ST= Stabbing
TH= Throbbing





9 Daily Activities

Please indicate how the following activities are effected by your complaints:

Carrying Groceries	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sit to Stand	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Climbing Stairs	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Pet Care	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Driving	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Extended Computer Use	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Household Chores	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Lifting Children	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Reading	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Concentrating	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Bathing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Dressing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Shaving	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sexual Activities	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Sleep	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Static Sitting	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Static Standing	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Yard work / Snow Shoveling	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Walking	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Reaching	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Kneeling	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Bending	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
Recreational Activities				
*Please list your own				
1_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
2_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
3_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐
4_____	No Effect ☐	Painful (Can Do) ☐	Painful (Limits) ☐	Unable to Perform ☐

On a scale of 1 to 10, ten being the highest, rate your commitment to making lifestyle changes to get rid of this problem:

Please specify your concerns that could interfere with your commitment (time, transportation, etc):

10 Injuries

From birth traumas and chronic poor posture to traumas and injuries throughout our lives, subluxations can occur, damaging our nervous systems.

Please list any **auto collisions** that you were involved in, either as the driver or passenger. Begin with the most recent.

Front, Back or Side Collision	Type of Treatment Received	Speed of Collision	Date of Collision
1			
2			
3			

Please list any **job injuries and/or repetitive movement** you have experienced. Begin with the most recent.

Type of Job Injury	Type of Treatment Received	Missed Worked Days	Date of Job Injury
1			
2			
3			

Please list any **sports injuries/traumas** you have now or have had in the past that may have caused subluxations.

Type of Injury	Type of Treatment Received	Type of Sport Playing	Date of Sports Injury
1			
2			
3			

Please list any **other injuries** caused during recreational activities, falls or impacts. Begin with the most recent.

Type of Injury	Type of Treatment Received	Activity Participating In	Date of Injury
1			
2			
3			