

# **CONFIDENTIAL PATIENT CASE HISTORY**

**Please complete this questionnaire. This confidential history will be part of your permanent records. THANK YOU.**

**Canyon Ridge Chiropractic 7280 Lagae Rd. Castle Pines, CO 80108**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex: M F

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

Marital Status: S M D W Spouse's Name \_\_\_\_\_ Children, Ages \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Who referred you to us? \_\_\_\_\_ How else did you hear about us? \_\_\_\_\_

What is your major complaint? \_\_\_\_\_

How long have you had this condition? \_\_\_\_\_

Have you had this or similar conditions in the past? \_\_\_\_\_

Do any positions make it feel worse? \_\_\_\_\_

Do any positions make it feel better? \_\_\_\_\_

Is this condition:  Improved  Unchanged  Getting Worse

Is this condition interfering with your:  Work  Sleep  Daily Routine  Other: \_\_\_\_\_

List any other doctors seen for this: \_\_\_\_\_

Are you currently taking medication? \_\_\_ Yes \_\_\_ No. List medications: \_\_\_\_\_

\_\_\_\_\_

List the approximate dates of any surgery or treated conditions: \_\_\_\_\_

\_\_\_\_\_

Have you been in an auto accident or had any other personal injury?

\_\_\_ Yes \_\_\_ No. Please describe \_\_\_\_\_

## **Family History**

Please list any health conditions as well as ages of family members.

Father: \_\_\_\_\_

**Mother:** \_\_\_\_\_

Brother/s and Sister/s: \_\_\_\_\_

**Please complete the following pages. Thank You.**

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# HEALTH REPORT

Reason for seeking care: \_\_\_\_\_

List any type of treatment received for this condition:  
\_\_\_\_\_

Have you had similar accidents or injuries before? \_\_\_ Yes \_\_\_ No If yes, explain:  
\_\_\_\_\_

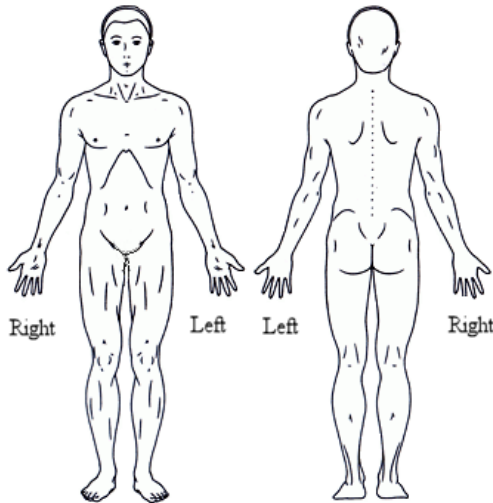
Do you have any relatives with a similar condition Y/N relation: \_\_\_\_\_

Have you received chiropractic treatment previously? \_\_\_ Yes \_\_\_ No  
If yes, explain: \_\_\_\_\_

Have you been treated for any health condition by a physician in the last year? \_\_\_ Yes \_\_\_ No  
If yes, explain: \_\_\_\_\_

Do you smoke Y/N \_\_\_ Alcohol Y/N \_\_\_ Daily \_\_\_ Weekly \_\_\_ Social \_\_\_ Occasional  
Caffeinated drinks per day \_\_\_\_\_

Do you take Vitamins/Supplements Y/N \_\_\_ If yes, list types and how often  
\_\_\_\_\_



Please circle degree of pain, 0 none, 10 severe pain.

0 1 2 3 4 5 6 7 8 9 10

Using the symbols below, mark on the pictures where you feel pain.

- Numbness        = = =
- Dull Ache        O O O
- Burning         X X X
- Sharp/Stabbing // /
- Pins, Needles   + + +
- Other            ^ ^ ^

Is this condition worse during certain times of the day? Y/N

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Please mark each item below for each sign or symptom you presently have or previously had:

**GENERAL SYMPTOMS**

- Convulsions
- Dizziness
- Fainting
- Headache
- Nervousness
- Numbness
- Wheezing

**MUSCLES & JOINTS**

- Low Back Problems
- Pain between Shoulders
- Neck Problems
- Arm Problems
- Leg Problems
- Swollen Joints
- Painful Joints
- Stiff Joints
- Sore Muscles
- Weak Muscles
- Walking Problems
- Sprains/Strains
- Broken Bones

**CARDIO-VASCULAR**

- High Blood Pressure
- Heart Attack
- Pain over Heart
- Poor Circulation
- Heart Trouble
- Rapid Heart
- Slow Heart
- Strokes
- Swelling Ankles
- Varicose Veins

**EAR/NOSE/THROAT**

- Earache
- Ear Noises
- Enlarged Thyroid
- Frequent Colds
- Hay Fever
- Nasal Blockage
- Nose Bleeds
- Pain Behind Eyes
- Poor Vision
- Sinusitis
- Sore Throats
- Tonsillitis

**GASTRO-INTESTINAL**

- Belching/Gas
- Colon Problems
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gall Bladder Trouble
- Hemorrhoids
- Liver/Gallbladder
- Nausea
- Abdominal Pain
- Ulcer
- Poor Appetite
- Poor Digestion
- Vomiting
- Vomiting Blood
- Black Stool
- Bloody Stool
- Weight Loss/Gain

**RESPIRATORY**

- Asthma
- Chronic Cough
- Difficulty Breathing
- Spitting Blood
- Spitting Phlegm

**GENITO-URINARY**

- Blood in Urine
- Frequent Urination
- Kidney Infection
- Painful Urination
- Prostate Problems
- Loss of Bladder Control

**SKIN OR ALLERGIES**

- Boils
- Bruising Easily
- Dryness
- Eczema/Rash/Dermatitis
- Hives
- Itching
- Sensitive Skin
- Allergy \_\_\_\_\_

**FOR WOMEN ONLY**

- Birth Control \_\_\_\_\_
- Hormone Replacement
- Cramps/Backaches
- Excessive Flow
- Hot Flashes
- Irregular Cycle
- Miscarriage
- Painful Periods
- Vaginal Discharge
- Breast Pain

Pregnant at this Time Y/N

I hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health.  
I agree to allow this office to examine me for further evaluation.

Patient

Signature \_\_\_\_\_ Date \_\_\_\_\_

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## **INFORMED CONSENT FOR EXAMINATION AND TREATMENT**

I hereby consent to the performance of examination and treatment on me or on \_\_\_\_\_, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have had an opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand the neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications. An undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather, I wish to rely on the doctor to choose and recommend a best course of treatment based upon facts known that is in my best interest.

I further understand that there are certain degrees of risk associated with chiropractic healthcare and physical therapy, which includes, rarely, but not limited to; fractures, disc injuries, strokes, and strain/sprains and am therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or have been explained of the above information regarding consent. I have had an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend for this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female Patients: By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor pregnancy suspected or confirmed at this particular time.

Date of last menstrual period: \_\_\_\_\_

Patient's Name (Print): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship if not signed by parent: \_\_\_\_\_

How your health information may be used:

- To provide treatment: We will use your health information within our office to provide you with the best health care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between physician and staff. In addition, we may share your health information with referring physicians, clinical and pathology laboratories, pharmacies or other healthcare personnel providing you treatment.
- **To obtain payment:** We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent in electronically. We will be sure to only work with companies with a similar commitment to the security of your health information.
- **To conduct healthcare operations:** Your health information may be used during performance evaluation of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care at our office. As a result, health information may be included in training programs for students, interns, associates, business and clinical employees. It is also possible that health information will be disclosed during audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine processes of certification, licensing or credentialing activities,
- **In patient reminders:** Because we believe regular care is very important to your general health, we remind you of a scheduled appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.
- **Abuse or Neglect:** We will not notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically required or authorized by law or with the patient's agreement.
- **Public Health and National Security:** We may be required to disclose to federal officials or military authorities health information necessary to complete an investigation related to public health or national security.
- **For law enforcement:** As permitted or required by state or federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes.
- **Family, Friends, and Caregivers:** We may share your health information with those you tell us will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want, we will use our very best judgment when sharing your health information only when it will be important to those participating in your care.
- **To Coroners, Funeral Directors, and Medical Examiners:** We may be required by law to provide information to coroners, funeral directors, and medical examiners for the purposes of determining a cause of death and preparing a funeral.

I have received the Notice of Privacy Practices and I have been provided with an opportunity to review it.

Name \_\_\_\_\_ DOB \_\_\_\_\_  
Signature \_\_\_\_\_ Date \_\_\_\_\_