

File# \_\_\_\_\_



2584 Patterson Road Suite D, Grand Junction, CO, 81505; Phone: 970.243.8896

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

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Ph: \_\_\_\_\_ Work Ph: \_\_\_\_\_ Cell Ph: \_\_\_\_\_

Best Number to contact you: Home Work Cell Social Security #: \_\_\_\_\_

Email Address: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F circle one: single married widowed divorced separated

Occupation: \_\_\_\_\_ Spouse's occupation: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Name and Ages of Children: \_\_\_\_\_

**Whom may we thank for referring you or how did you hear about us? (Circle all that apply)**

- |              |                           |             |
|--------------|---------------------------|-------------|
| TV           | Google                    | Website     |
| Radio        | Massage Day at work       | Facebook    |
| Person _____ | Print advertisement _____ | Other _____ |

Would you like us to check your insurance benefits to see if they will contribute to your care? \_\_\_Yes \_\_\_No

Main reason for consulting our office today: \_\_\_\_\_

Anything about your Nerve System and Spine we should know about? \_\_\_\_\_

What is your level of commitment to yourself, your life and well-being? \_\_\_High \_\_\_Medium \_\_\_Low

Have you ever sought the services for this or any other health concern from the following:

- |                      |                   |               |                |                       |
|----------------------|-------------------|---------------|----------------|-----------------------|
| ___Massage therapist | ___Acupuncturist  | ___Naturopath | ___Yoga Studio | ___Physical Therapist |
| ___Personal Trainer  | ___Nutritionalist | ___Rolfer     | ___Pilates     | ___Other _____        |

Who is your primary care doctor? \_\_\_\_\_ Phone # \_\_\_\_\_

Have you been adjusted by a chiropractor before? \_\_\_Yes \_\_\_No

Who: \_\_\_\_\_ Date of last Adjustment: \_\_\_\_\_

Frequency of visits: \_\_\_\_\_ times a week/month Duration of care: \_\_\_\_\_ weeks/months/years

- What is your daily fluid intake: Coffee \_\_\_/day Alcohol \_\_\_/day Water \_\_\_/day Soda \_\_\_/day
- Sleep/Rest Habits: Daytime naps: Y N Hours a night: \_\_\_/hrs Do you wake up refreshed? Y N
- Exercise Habits: (please describe what you do and how often) \_\_\_\_\_
- What type of work do you do? \_\_\_\_\_ Satisfied/Enjoy your work? Y N
- Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list)
- What are your current play and relaxation activities \_\_\_\_\_

Check any of the symptoms or conditions below that you experience?

File# \_\_\_\_\_

- |  |  |                                     |  |
|--|--|-------------------------------------|--|
| <input type="checkbox"/> Headaches         | <input type="checkbox"/> Carpal Tunnel       | <input type="checkbox"/> Asthma     | <input type="checkbox"/> Digestive Problems              |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Problem Sleeping    | <input type="checkbox"/> Vertigo    | <input type="checkbox"/> Pain Between Shoulder Blades    |
| <input type="checkbox"/> Mid-Back Pain     | <input type="checkbox"/> Ringing in Ears     | <input type="checkbox"/> Anxiety    | <input type="checkbox"/> Shortness of Breath             |
| <input type="checkbox"/> Low-Back Pain     | <input type="checkbox"/> Loss of Balance     | <input type="checkbox"/> Cancer     | <input type="checkbox"/> Tension across Top of Shoulders |
| <input type="checkbox"/> Sciatic Pain      | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Allergies  | <input type="checkbox"/> Numbness in Arms/Legs           |
| <input type="checkbox"/> Leg or Hip Pain   | <input type="checkbox"/> Weight Trouble      | <input type="checkbox"/> Dizziness  | <input type="checkbox"/> Menstrual Pain                  |
| <input type="checkbox"/> Shoulder/Arm Pain | <input type="checkbox"/> Low Energy/Fatigued | <input type="checkbox"/> Depression | <input type="checkbox"/> Other _____                     |

If Female, are you pregnant or any chance of being pregnant?  Yes  No

Which one of the above symptoms is worst? \_\_\_\_\_ How long have you had it? \_\_\_\_\_

When it is at its worst, how does it feel? \_\_\_\_\_

The following 3 areas can contribute to nerve interference and diminished quality of life.

Circle the areas that apply to you and when.

C=Child T=Teenager A=Adult N=Not at all (please circle)

**Physical Stress**

**Emotional Stress**

**Chemical Stress**

Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip/ fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Sports Injury	C T A N	Money	C T A N	Caffeine	C T A N
Physical Abuse	C T A N	Fast paced life	C T A N	Artificial Sweeteners	C T A N
Work Injury	C T A N	Hold in Feelings	C T A N	Prescription Drugs	C T A N
Poor Posture	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer work	C T A N	Loss of loved one	C T A N		
Repetitive lift/bending	C T A N				
Prolonged Driving	C T A N				
Prolonged Standing	C T A N				
Prolonged Sitting	C T A N				
Surgery/Broken bones	C T A N				
Lack of Physical Activity	C T A N				
Excess Physical Activity	C T A N				

- What do you feel is the primary stress in your life?
- Rate (circle) your combined overall level of stress from all sources listed above:  
No Stress—1—2—3—4—5—6—7—8—9—10--High Stress

**TERMS OF SERVICE**

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**ADJUSTMENT:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

**HEALTH:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

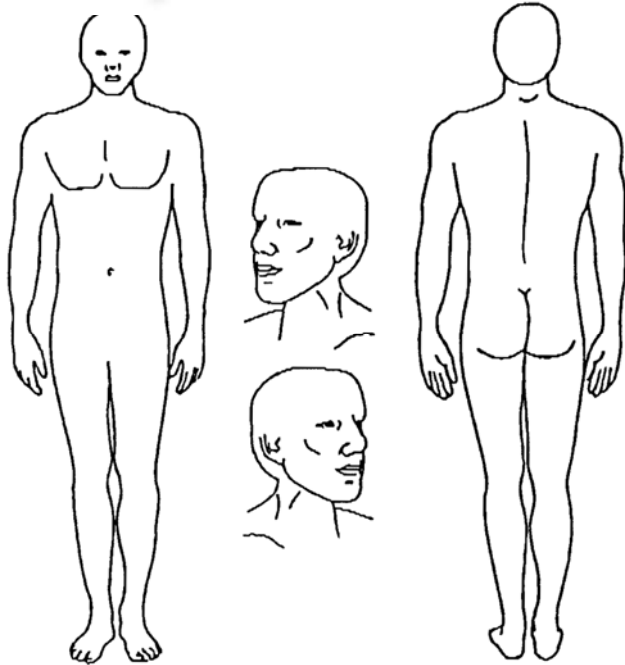
We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR ONLY PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I, (Printed name) \_\_\_\_\_ (Signature) \_\_\_\_\_ undertake chiropractic services on the understanding of and agreement with, the above explanation. \_\_\_\_\_ (Date).

Consent to evaluate and adjust a minor and/or child: I, \_\_\_\_\_ (Print name) being the parent or legal guardian of \_\_\_\_\_ (Print name) give permission for my child to receive chiropractic care.

# INITIAL/PROGRESS REPORT



PLEASE MARK YOUR AREAS OF PAIN ON THESE FIGURES, INDICATING WHICH TYPE OF PAIN YOU ARE EXPERIENCING.

- A = SHARP PAIN
- B = DULL PAIN
- C = BURNING PAIN
- D = NUMBNESS
- E = TINGLING

Please mark the intensity of pain you are experiencing on the pain scale.

<b>0</b>	1	2	3	4	5	6	7	8	9	<b>10</b>
No Pain	Mild		Discomforting		Distressing		Horrible		Excruciating	

**Daily Activities:** Effects of Current Condition on Performance

- |                              |                                    |  |  |  |
|------------------------------|------------------------------------|--|--|--|
| 1. Bending:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 2. Carrying Groceries:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 3. Change Posn-Sit-Stand:    | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 4. Climb Stairs:             | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 5. Driving:                  | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 6. Ext Computer Use:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 7. Household Chores:         | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 8. Kneeling:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 9. Lift Children:            | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 10. Lifting:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 11. Reading (Concentration): | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 12. Self Care-Bathing:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 13. Self Care-Dressing:      | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 14. Self Care-Shaving:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 15. Sexual Activities:       | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 16. Sleep:                   | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 17. Sitting:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 18. Standing:                | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 19. Walking:                 | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 20. Yard Work:               | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 21. Other _____              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |
| 22. Other _____              | <input type="checkbox"/> No Effect | <input type="checkbox"/> Mild Painful (Can do) | <input type="checkbox"/> Mod Painful (Limited) | <input type="checkbox"/> Sev Unable to Perform |

Date: \_\_\_\_\_ Name (Printed) \_\_\_\_\_ Signature \_\_\_\_\_

# Initial Health History

Name: \_\_\_\_\_ Date \_\_\_\_\_ File # \_\_\_\_\_

- What symptoms are causing you to seek care in our office and where is it located?
- Please list any health concerns in your Family History.
- Past Health History (general health, illness, injuries, hospitalizations, medications, surgeries).
- Mechanism of trauma/injury (how did you hurt yourself)? When was the onset of symptoms?
- How would you describe your symptom/problem? Does it radiate?
- Duration (how long), intensity (scale of 1-10 how bad), frequency (how often)
- What makes it better or worse?
- What prior interventions, treatments, or medications have you used for this problem?
- Is there any reason you should not be adjusted?