



Alternative Chiropractic Center, P.C.

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Confidential Patient Health Record

Name _____	Date _____	
Address _____		
City _____	State _____	Zip _____
Phone Numbers: Home _____	Work _____	Cell _____
Email _____	Date of Birth _____	S.S.# _____
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
Number of Children and Ages _____		
Employer Name _____		
Employer Address _____		
How did you hear about us? _____		
Whom may we thank for referring you? _____		

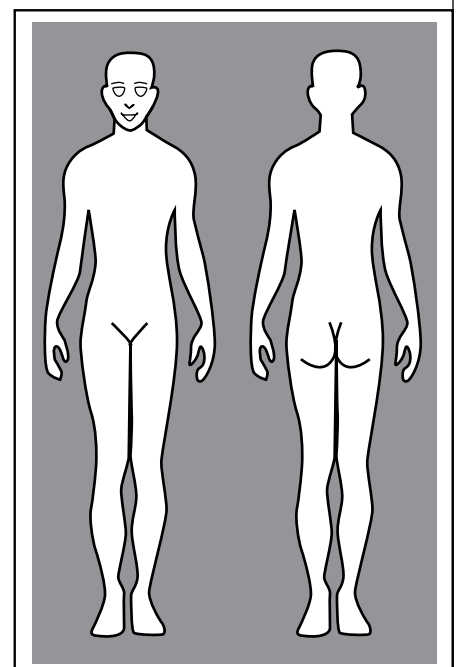
Emergency Contact

Name _____	Relationship _____
Home Phone # _____	Work Phone _____

Patient Condition

Primary Reason for Care _____
Secondary Reason for Care _____
Date symptoms started _____
What are your main treatment goals? _____
How often do you experience the symptoms? <input type="checkbox"/> Constant 100% <input type="checkbox"/> Frequent 75% <input type="checkbox"/> Intermittent 50% <input type="checkbox"/> Occasional 25% <input type="checkbox"/> Rare 10%
Are symptoms: <input type="checkbox"/> Improving <input type="checkbox"/> Progressively Worse <input type="checkbox"/> Same
Describe any recent related accident or fall _____
What makes symptoms increase? _____
What makes symptoms decrease? _____
Type of pain: <input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Throb <input type="checkbox"/> Numbness <input type="checkbox"/> Other _____
Where does the pain radiate to? _____
How bad is your pain (indicate 0 no pain to 10 unbearable) 0-----5-----10

Please mark your areas of pain on the figure below



Health History

What treatment have you already received for your condition?

Medication

Surgery

Physical Therapy

Acupuncture

Chiropractic

None

Other _____

If so, Name and Address of doctor(s) who have treated you for your condition _____

Please mark **C** if a current condition, **P** if a past condition and leave blank if not applicable.

___ ADD/ADHD

___ Depression

___ Kidney Stone

___ Psychiatric Care

___ AIDS/HIV

___ Diabetes

___ Knee Pain

___ Rheumatic Fever

___ Anemia

___ Dizziness

___ Leg Pain

___ Scarlet Fever

___ Anorexia

___ Epilepsy

___ Liver Disease

___ Sciatica

___ Anxiety

___ Fainting

___ Low Back Pain

___ Seizures

___ Appendicitis

___ Fibromyalgia

___ Mid Back Pain

___ Shingles

___ Arm Pain

___ Gall Stones

___ Migraine Headaches

___ Shoulder Pain

___ Arthritis

___ Goiter

___ Miscarriage

___ Sinus Congestion

___ Asthma

___ Gout

___ Mononucleosis

___ STDs

___ Bronchitis

___ Headaches

___ Multiple Sclerosis

___ Stroke

___ Bulimia

___ Heart Disease

___ Mumps

___ Thyroid Problems

___ Cancer

___ Hepatitis

___ Neck Pain

___ Tonsillitis

___ Carpal Tunnel

___ Hernia

___ Night Sweats

___ Tuberculosis

___ Celiac Disease

___ Herniated Disc

___ Numbness or Tingling

___ Tumors/Growths

___ Chest Pain

___ Herpes

___ Osteoporosis

___ Ulcerative Colitis

___ Chicken Pox

___ High Cholesterol

___ Pacemaker

___ Ulcers

___ Chronic Fatigue

___ Hypertension

___ Parkinson's Disease

___ Upper Back

___ Cold Sores

___ Irritable Bowel Disease

___ Pinched Nerve

___ Urinary Tract Infection

___ Concussions

___ Infertility

___ Pneumonia

___ Vaginal Infection

___ Cough

___ Jaw pain

___ Polio

___ Whooping Cough

___ Crohn's Disease

___ Kidney Infections

___ Prostrate Problems

Others not listed above _____

Allergies:

Dust

Mold

Trees

Weeds

Grass

Animal

Perfume

Smoke

Foods (list on next page)

Others _____

Descriptions & Dates on the following:

Hospitalizations/Surgeries you have had _____

Recent Infections (Cold, Flu etc) _____

Falls/Injuries _____

Fracture/Dislocations _____

Medications _____

Vitamins/Supplements _____

Please list family history of any diseases or conditions _____

Social and Occupational History

Diet: Food Cravings: Sweets Salt Sour Bitter Spicy
 Alcohol (type/drinks per week) _____
 Sugar (type/amount per day) _____
 Caffeine (type/drinks per day) _____
 Tobacco (type/amount per day) _____

Typical Breakfast: _____

Mid morning snack: _____

Typical Lunch: _____

Afternoon snack: _____

Typical Dinner: _____

Typical Beverages: _____

Favorite Foods: _____

Food Allergies: No Yes (list please) _____

FEMALE ONLY: Total Length of cycle _____ Length of Menses _____ Menses: Heavy Moderate Light
PMS Mood Swings Cramping Breast Tenderness Pregnant Post Menopausal

Gastrointestinal: Excess Hunger Poor appetite Nausea Hemorrhoids Diarrhea Constipation Heartburn Gas
 Bloating Strong Smell # of Bowel Movements/Day _____

Sleep: Hours per night _____ Quality: Poor Fair Good Trouble Falling Asleep Staying Asleep Insomnia
At what time do you wake up _____ How many times do you wake up? _____
Do you sleep on your: Back Side Stomach All Night Urination: How many times? _____

Urination: Excess urination Frequent urination Painful urination

Job activities include: _____

Physical activity at work Sedentary Light manual labor Moderate manual labor Heavy manual labor

How long do you speak on the telephone each day _____ Traditional receiver Headset

Do any of your work activities aggravate your present main complaints? Please Describe: _____

Stress Level: Mild Medium Severe

Reason _____

How do you handle stress? Exercise Sleep Eat Other _____

Energy Level: 0 1 2 3 4 5 6 7 8 9 10 Time of Lows _____

Exercise: 1.Type _____ Frequency _____

2.Type _____ Frequency _____

3.Type _____ Frequency _____

Consent for Care, Financial Policy Agreement,
and Privacy Practices Acknowledgement for
Alternative Chiropractic Center

Consent for Care: I, the undersigned, in consideration of Alternative Chiropractic Center's services, agree to the following terms:

I hereby grant permission to Alternative Chiropractic Center and its clinicians to perform examinations and therapeutic treatments as are considered necessary or advised for my diagnosis and treatment plan. Clinicians who treat me include, but are not limited to: medical doctors, acupuncturists, massage therapists, herbalists, nutritionists, physical therapists, rolfers, and/or chiropractors. My signature on this document serves as my consent for treatment.

Authorization to Release Information for Insurance clients: I authorize Alternative Chiropractic Center to release any information required to process a claim to any insurance company or attorney. I also authorize any insurance company or medical provider to release my medical records to Alternative Chiropractic Center for the purpose of processing my claim for benefits due. I hereby agree that a photocopy of this document is as valid and effective as the original copy.

Personal Responsibility for My Charges: I understand that I remain personally responsible for my charges, and that at any time, I can request a copy of my total charges from the office. I agree to pay the full amount of my charges to the office upon its demand. Any partial payments toward my charges shall be not acceptance of any installment payment plan, and shall not constitute a waiver of Alternative Chiropractic's right to receive payment in full upon demand. In the event that any payer denies payment or claim by an insurance company or second party, I agree that I am personally, fully, and immediately responsible for the portion of my charges denied or likely to be denied. In no event shall I hold Alternative Chiropractic Center liable in any of the above named instances.

HIPAA Notice of Private Practices: I understand I have access to the Notice of Privacy Practices and am able to review it and obtain a copy of it at my request.

Liability Agreement: I have read, understood and agree to the terms of this agreement.

Cancellation Policy: I agree to give 24 hours notice of cancellation and will be charged \$30.00 for services allotted if I do not show for an appointment or have a late cancellation.

Patient Signature _____ Date: _____

Patient Name (print) _____

Name of Custodial Parent/Legal Guardian _____

Parent/Guardian Signature _____ Date: _____