



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: Single Married Divorced 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?

Constant 100% Frequent 75% Intermittent 50% Occasional 25% Rare 10%

Are symptoms: Improving Progressively Worse Same

Describe any recent related accident or fall _____

What makes symptoms increase? _____

What makes symptoms decrease? _____

Type of pain:

Sharp Dull Aching Burning

Throb Numbness 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

