



Patient Health History Information

Office Use:
Acct # : _____
Last Adj: _____

Falcon: 11605 Meridian Market View #142, Falcon, CO 80831

(719) 799-6565

Date: _____

First Name: _____ Last Name: _____ (Nickname Preferred): _____

Cell # (____) ____-____ Home # (____) ____-____ Work # (____) ____-____ ext. _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

E-mail address: _____ Age: _____ Birth Date: _____

Appointment Reminder Preference: Text Reminders: (____) ____-____ Phone Call: (____) ____-____

Occupation: _____ Employer: _____

Emergency Contact (Name): _____ (Relation) _____ Phone # (____) ____-____

Marital Status: M S W D Name of Spouse: _____

Names/Ages Children: _____

How were you **referred** to our office? _____

Family Medical Doctor: _____ Currently without a regular medical doctor

Address: _____

Phone: _____

When doctors work together, it benefits you. May we have your permission to update your medical doctor regarding your care at this office? Yes No

Please check all insurance/coverage options that may be applicable to your case: Major Medical Medicare

Auto Accident Worker's Compensation Medical Savings Account & Flex Plans CareCredit No Coverage VA

Name of Primary Insurance Company: _____

Name of Secondary Insurance Company (if applicable): _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to Rock Solid Chiropractic, PLLC. I authorize the doctor to release all information necessary to communicate with personal physicians and other healthcare providers and payors and to secure the payment of benefits. I understand that I am responsible for all costs of chiropractic care, regardless of insurance coverage. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be immediately due and payable.

*The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the **HIPAA NOTICE** that is available to you at the front desk before signing this consent.*

Initial applicable boxes indicating your preference(s) to receive messages regarding personal information:

Cell Home Work Email No messages may be left regarding personal information.

The following person(s) have my permission to receive my personal health information:

Patient's Signature: _____ Date: _____

Guardian's Signature Authorizing Care: _____ Date: _____

HISTORY OF PRESENT ILLNESS

Chief Complaint(s) or Purpose of this appointment: _____

Date symptoms appeared or accident occurred: _____

Have you ever had the same or a similar condition(s)? No Yes

Describe conditions, if applicable: _____

How did it originally occur? _____

Has it become worse recently? Yes No Same Better Gradually Worse

If yes, when and how? _____

How frequent is the condition? Constant Daily Intermittent Night Only Morning _____

How long does it last? All Day ___ Hours / ___ Minutes

Describe the pain: Sharp Dull Numbness Tingling Aching Burning Stabbing
 Other _____

What relieves the problem? _____

What aggravates the problem? _____

If you did not have pain, what activities would you be enjoying? _____

Days lost from work: _____ Work Duties: _____

Are there any other conditions or symptoms that may be related to your major symptom? Yes No Unsure

If yes, describe: _____

NO SYMPTOMS

EXTREME SYMPTOMS

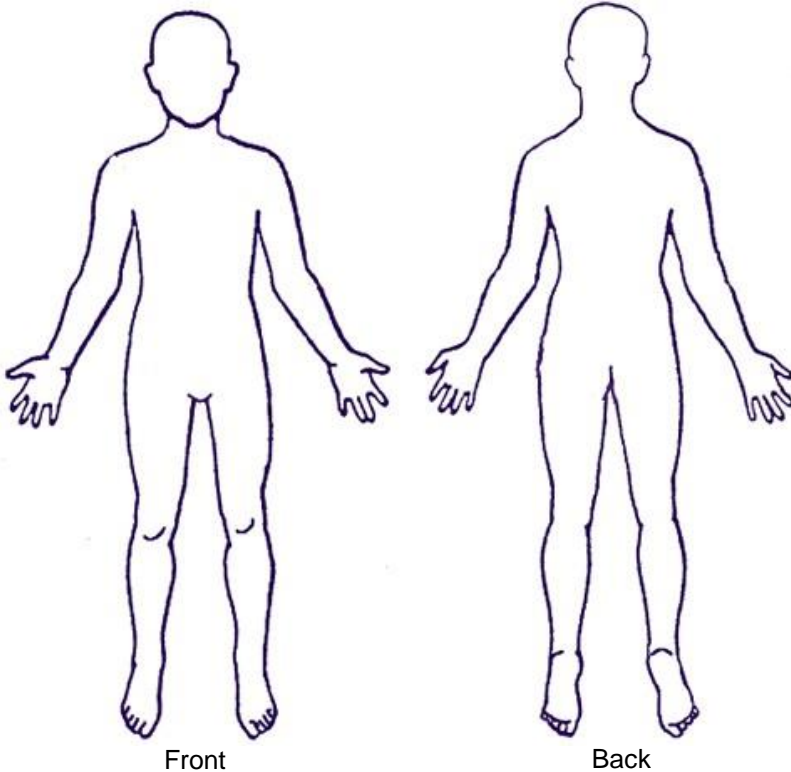
_____ Please place an "X" on the line above to indicate level of problem.

SUBJECTIVE PAIN ASSESSMENT

Indicate the location of your symptoms on the drawing using the following description:

- A=Ache
- B=Burning
- ST=Stabbing
- SP=Spasm
- N=Numbness
- P=Pins and Needles
- T=Throbbing
- ← =Shooting or traveling

Example: ST placed between the shoulder blades indicated stabbing pain in that location.





Patient Name _____ Date _____

HEALTH HISTORY

List **ALL** injuries, falls, auto-accidents, major illnesses or surgeries **over lifetime**. **Doctors determine relevance:**

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

What medications, drugs, or supplements are you taking? For medications, list what it is being used to treat, and how long you have been taking it. _____

Do you have any allergies of any kind? Yes No If **yes**, describe: _____

Do you have any Congenital Condition? Yes No If **yes**, describe: _____

For Women: Are you pregnant? _____ *If yes, when is your due date?* _____

Previous births vaginal or cesarean (include complications, if any) _____

Please indicate if you are or have experienced the conditions listed below as follows: "N"= NOW or "P"= PAST

Headaches _____
Frequency _____
Location _____
Neck Pain or Stiffness _____
Back Pain or Stiffness _____
Numbness/Tingling _____
Location _____
Loss of Strength _____
Location _____
Arthritis _____
Location _____
Type _____
Bones/Fractures _____
Location _____
Joint Pain/Swelling _____
Location _____
Muscle Spasms _____
Location _____

Frequent Colds _____
Type _____
Fever _____
Fatigue _____
Reason _____
Weight Loss or Gain (circle) _____
Amount _____
Timeframe _____
Diabetes _____
Osteopenia or Osteoporosis (circle) _____
Cancer _____
Type _____
Treatment _____
HIV Positive _____

Sleeping Problems _____
Due to: pain or busy mind (circle)
Nervousness _____
Cause _____
Tension _____
Cause _____
Irritability _____
Cause _____
Depression _____
Cause _____
Loss of Memory _____
Loss of Balance _____
Dizziness _____
Fainting _____
Seizures _____
Ears Ring or Buzz _____
Loss of Taste _____
Loss of Smell _____
Trouble with Eyes _____
Describe _____
Eating Disorder _____
Type _____
Drug Addiction _____
Alcoholism _____

Heart Disease _____
High Blood Pressure _____
Low Blood Pressure _____
Chest Pain/ Tightness _____
Shoulder/Arm/Neck pain _____
Circulation Problems _____
Hands/Feet Cold _____
Excessive Bleeding _____
Stroke _____
Pacemaker _____

Indigestion _____
Ruptures _____
Location _____
Gall Bladder Problems _____
Ulcers _____
Unusual Bowel Patterns _____
Frequency _____
Consistency _____

Doctor's Notes: _____ _____ _____	Primary Condition Authorized by VA : _____
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SOCIAL HISTORY

Please indicate beside each activity whether you engage in it:

OFTEN= "O" SOMETIMES= "S" NEVER= "N"

Vigorous Exercise _____	High Stress Activity _____
Moderate Exercise _____	Family Pressures _____
Type _____	Financial Pressures _____
Alcohol Use: _____	Other Mental Stress _____
Drug Use: _____	Other (specify) _____
Tobacco Use: _____	
Caffeine Use: _____	

FAMILY HISTORY

Please review the below-listed diseases and conditions and indicate those that are current health problems of the family member. Leave blank those spaces that do not apply. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

CONDITION	FATHER	MOTHER	SPOUSE	BROTHER(S)		SISTERS		CHILDREN	
	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []	Age []
Arthritis									
Asthma-Hay Fever									
Back Trouble									
Bursitis									
Cancer									
Constipation									
Diabetes									
Disc Problem									
Emphysema									
Epilepsy									
Headaches									
Heart Trouble									
High Blood Pressure									
Insomnia									
Kidney Trouble									
Liver Trouble									
Migraine									
Nervousness									
Neuritis									
Neuralgia									
Pinched Nerve									
Scoliosis									
Sinus Trouble									
Stomach Trouble									
Other:									
Age/cause of death:									

I certify the information provided is accurate to the best of my knowledge:

Signature of Patient/Legal Guardian _____ Date _____