ROCK SOLID CHIROPRACTIC

*Office Use:*
Acct # :_____
Last Adj: _____

# Patient Health History Information

☐ ***Falcon: 11605 Meridian Market View #142, Falcon, CO 80831***
☐ ***Citadel: 3510 Galley Rd. #102, Colorado Springs, CO 80909***
***(719) 799-6565***

Date:_____

Name:_____ Name Preferred: _____ Home Phone: _____ Cell: _____

Address:_____

City:_____ State:_____ Zip:_____

E-mail address:_____

Age:_____ Birth Date:_____ Marital: M S W D

***Patient Appointment Reminder Preference:***

☐*Text Reminder: Cell Provider:*_____

☐ *Phone Call:* _____

Occupation:_____ Name of Spouse:_____

Names/AgesChildren:_____

Emergency Contact:_____ Phone:_____

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

Family 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? _____

Please *circle* any and all insurance/coverage options that may be applicable to your case**:**

*Major Medical* *Worker's Compensation* *Medicare* *Auto Accident* *CareCredit* *Self- Pay* *Medical Savings Account & Flex Plans* *Other:*_____

Name of Primary Insurance Company:_____
Name of Secondary Insurance Company (if any):_____

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

_____

_____

Patient's Signature:_____ Date:_____

Guardian's Signature Authorizing Care:_____ Date:_____

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**Patient Name**_____ **Date**_____

## HISTORY OF PRESENT ILLNESS

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

Date symptoms appeared or accident happened: _____

Have you ever had the same or a similar condition(s)? _____ If yes, when and describe: _____

_____

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 _____ Few Hours _____ Minutes _____

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

Stabbing _____ Other _____

What relieves the problem? _____

What aggravates the problem? _____

*What does this prevent you from doing or enjoying?* __ _____

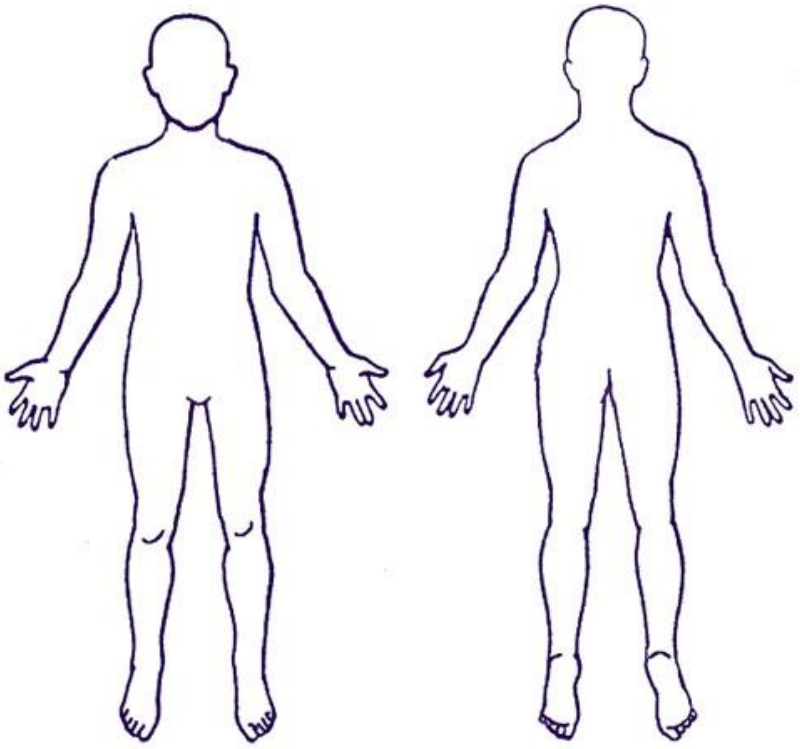
Days lost from work: _____ Work Duties: _____

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

If yes, describe: _____

**NO SYMPTOMS** — **EXTREME SYMPTOMS**

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



FRONT BACK

***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.*

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# HEALTH HISTORY

List ***ALL*** major **illnesses, injuries, falls, auto-accidents 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 _____
Women: Are you pregnant? _____ Previous childbirth vaginal or cesarean_____

_____

*Please indicate with the letter **N** if you have these conditions **now** or **P** if you have had these conditions previously.*
***"N" = Now*** ***"P" = Previously***

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_____

Heart Disease_____
High Blood Pressure_____
Low Blood Pressure_____
Chest Pain/ Tightness_____
Shoulder/Arm/Neck pain _____
Circulation Problems_____
Hands/Feet Cold_____
Excessive Bleeding_____
Stroke_____
Pacemaker_____

Frequent Colds_____
Type_____
Fever_____
Fatigue_____
Reason_____
Weight Loss or Gain (circle)
Amount_____
Timeframe_____
Diabetes_____
Osteopenia or Osteoporosis (circle)
Cancer_____
Type_____
Treatment_____
HIV Positive_____

Indigestion_____
Ruptures_____
Location_____
Gall Bladder Problems_____
Ulcers_____
Unusual Bowel Patterns_____
Frequency_____
Consistency_____

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_____

Doctor's Notes:

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**Patient Name**_____ **Date**_____

## 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 Age [ ] | MOTHER Age [ ] | SPOUSE Age [ ] | BROTHER(S) Age [ ] Age [ ] | SISTERS Age [ ] Age [ ] | CHILDREN 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_____