DENVER CENTRAL CHIROPRACTIC
PEOPLE | PETS

CONFIDENTIAL
HEALTH INFORMATION

Please complete this information fully and accurately - this information can affect the overall course of care.
We comply with all federal privacy standards.
Please print clearly.

Dr. Erin Moran
2105 E Virginia Avenue Denver, CO 80209
720.350.4353
denvercentralchiro@gmail.com
www.denvercentralchiro.com

Patient Number (*office use only*)

Today's Date (MM/DD/YYYY) | First Name | Middle Name (or initial) | Last Name

Address | City | State | Zip

Sex ◯ M ◯ F

Birth Date (MM/DD/YYYY) | Marital Status | Number of Children

Home Phone | Cell Phone | Work Phone

May We Contact You At Work? ◯ Yes ◯ No

Email | Employer | Occupation

Preferred Method of Contact? ◯ Home Phone ◯ Cell Phone ◯ Work Phone ◯ Email

Emergency Contact | Emergency Contact's Relation | Emergency Contact's Phone

How did you hear about us?

Who is your primary care physician?

Date and reason for your last doctor visit

Have you previously seen a chiropractor? ◯ Yes ◯ No

Chiropractor's Name and Office | Date of Last Visit

Were you satisfied with your care? ◯ Yes ◯ No

Why?

Do you wear any of the following? ◯ Heel Lifts ◯ Innersoles ◯ Arch Supports ◯ Orthotics

Other | For how long?

Were they prescribed by a doctor? ◯ Yes ◯ No

CURRENT MEDICATION(S): List ANY/ALL Medications you are CURRENTLY taking. Be Specific.

Medication	Dosage	For What Condition	How Long Have You Been Taking This

List medications you are allergic to

CURRENT Vitamins, Herbs, Supplements, etc.: List ANY/ALL non-prescription items you are CURRENTLY taking. Be Specific.

Vitamins, Minerals, Herbs	Dosage	For What Condition	How Long Have You Been Taking This

CURRENT HEALTH CONDITIONS

Primary Complaint (The primary symptom that prompted you to seek care today)

Have you received care for this problem before?
○ Yes ○ No

If Yes, Please Explain

How did the problem start?
○ Suddenly ○ Gradually ○ Post-Injury ○ Work Accident ○ Auto Accident

Onset (When did you first notice your current symptoms?)

Is this condition:
○ Getting Worse ○ Improving ○ Intermittent ○ Constant ○ Unsure

What have you done to relieve the symptoms?

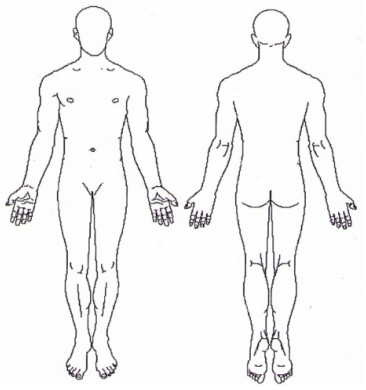
What makes the problem better?

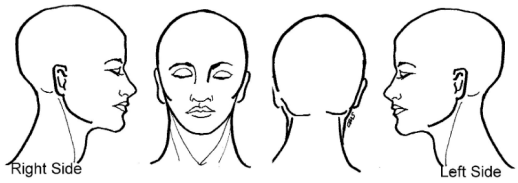
What makes the problem worse?

What else should Dr. Erin know about your current condition?

Do you have any additional health concerns that you would like to address?

Please mark the areas on your body where you feel the pain or dysfunction.
Use the space below to decribe, in your own words, what it feels like (aching, burning, numbness, pins and needles, stabbing, throbbing, etc.).





REVIEW OF SYSTEMS Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check any condition that you've HAD or currently HAVE.

HAD	HAVE	*Constitutional*
○	○	Chills
○	○	Daytime Drowsiness
○	○	Fatigue
○	○	Fever
○	○	Night Sweats
○	○	Weight Gain
○	○	Weight Loss

HAD	HAVE	*Eye / Vision*
○	○	Blindness
○	○	Blurred Vision
○	○	Cataracts
○	○	Change in Vision
○	○	Double Vision
○	○	Eye Pain
○	○	Field Cuts
○	○	Glaucoma
○	○	Itching
○	○	Photophobia (sensitivity to light)
○	○	Tearing
○	○	Wear Glasses / Contacts

HAD	HAVE	*Ears, Nose and Throat*
○	○	Bleeding
○	○	Dentures
○	○	Difficulty Swallowing
○	○	Discharge
○	○	Dizziness
○	○	Ear Drainage
○	○	Ear Pain
○	○	Fainting
○	○	Frequent Sore Throats
○	○	Headaches
○	○	Hearing Loss
○	○	History of Head Injury
○	○	Hoarseness
○	○	Loss of Sense of Smell
○	○	Nasal Congestion
○	○	Nosebleeds
○	○	Postnasal Drip
○	○	Rhinorrhea (runny nose)
○	○	Sinus Infections
○	○	Snoring
○	○	Sore Throat
○	○	Tinnitus (ringing in ears)
○	○	TMJ Problems

HAD	HAVE	*Respiration*
○	○	Asthma
○	○	Cough
○	○	Coughing Up Blood
○	○	Shortness of Breath
○	○	Sputum Production
○	○	Wheezing

HAD	HAVE	*Cardiovascular*
○	○	Angina (chest pain)
○	○	Leg Pain / Ache
○	○	Heart Murmur
○	○	Heart Problems
○	○	High Blood Pressure
○	○	Low Blood Pressure
○	○	Orthopnea (difficulty breathing laying down)
○	○	Palpitations
○	○	Waking at night with shortness of breath
○	○	Shortness of breath with exertion or exercise
○	○	Swelling of Legs
○	○	Ulcers
○	○	Varicose Veins

HAD	HAVE	*Gastrointestinal*
○	○	Abdominal Pain
○	○	Belching
○	○	Black-Tarry Stools
○	○	Constipation
○	○	Diarrhea
○	○	Difficulty Swallowing
○	○	Heartburn
○	○	Hemorrhoids
○	○	Indigestion
○	○	Jaundice
○	○	Nausea
○	○	Rectal Bleeding
○	○	Abnormal Stool Color
○	○	Abnormal Stool Consistency
○	○	Vomiting
○	○	Vomiting Blood

REVIEW OF SYSTEMS (CONTINUED) Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please check any condition that you've HAD or currently HAVE.

HAD	HAVE	*Female*
○	○	Birth Control
○	○	Breast Lumps / Pain
○	○	Burning Urination
○	○	Cramps
○	○	Frequent Urination
○	○	Hormone Therapy
○	○	Irregular Menstruation
○	○	Pregnancy
○	○	Urine Retention
○	○	Vaginal Bleeding
○	○	Vaginal Discharge

I currently: ○ have menses ○ don't have menses

I am: ○ currently pregnant ○ NOT currently pregnant

Date of Last Menses: _____

HAD	HAVE	*Male*
○	○	Burning Urination
○	○	Erectile Dysfunction
○	○	Frequent Urination
○	○	Hesitancy / Dribbling
○	○	Prostate Problems
○	○	Urine Retention

HAD	HAVE	*Endocrine*
○	○	Cold Intolerance
○	○	Diabetes
○	○	Excessive Appetite
○	○	Excessive Hunger
○	○	Excessive Thirst
○	○	Abnormal Frequency of Urination
○	○	Goiter
○	○	Hair Loss
○	○	Heat Intolerance
○	○	Unusual Hair Growth
○	○	Voice Changes

HAD	HAVE	*Skin*
○	○	Changes in Nail Texture
○	○	Changes in Skin Color
○	○	Hair Growth
○	○	Hair Loss
○	○	Hives
○	○	History of Skin Disorders
○	○	Itching
○	○	Paresthesias
○	○	Rash
○	○	Skin Lesions / Ulcers
○	○	Varicosities

HAD	HAVE	*Nervous System*
○	○	Dizziness
○	○	Facial Weakness
○	○	Headache
○	○	Limb Weakness
○	○	Loss of Consciousness
○	○	Loss of Memory
○	○	Numbness
○	○	Seizures
○	○	Sleep Disturbance
○	○	Slurred Speech
○	○	Stress
○	○	Strokes
○	○	Tremor
○	○	Unsteadiness of Gait / Loss of Balance

HAD	HAVE	*Psychological*
○	○	Anxiety
○	○	Depression
○	○	Loss/Change in Appetite
○	○	Behavioral Change
○	○	Bi-polar Disorder
○	○	Insomnia
○	○	Convulsions
○	○	Confusion
○	○	Memory Loss
○	○	Mood Change

HAD	HAVE	*Allergy*
○	○	Anaphalaxis
○	○	Food Intolerance
○	○	Itching
○	○	Acute Nasal Congestion
○	○	Chronic Nasal Congestion
○	○	Rash
○	○	Sneezing
○	○	Adhesive Tape
○	○	Animals
○	○	Latex
○	○	Perfumes

HAD	HAVE	*Hematologic*
○	○	Anemia
○	○	Bleeding
○	○	Blood Clotting
○	○	Blood Transfusion
○	○	Bruising Easily
○	○	Fatigue
○	○	Lymph Node Swelling

ILLNESSES

HAD	HAVE	
○	○	ADD
○	○	Allergies / Hay Fever
○	○	Anemia
○	○	Asthma
○	○	Alzheimer's
○	○	Arthirtis
○	○	Cerebral Palsy
○	○	Chicken Pox
○	○	Crohn's / Colitis
○	○	CRPS (RSD)
○	○	CVA (Stroke)
○	○	Cystic Kidney Disease
○	○	Depression
○	○	Diabetes (insulin dep)
○	○	Diabetes (non insulin)
○	○	Ear Infections
○	○	Eczema
○	○	Emphysema
○	○	Eye Problems
○	○	Fibromyalgia
○	○	Food Allergies
○	○	Heart Disease
○	○	Hypertension
○	○	Headaches
○	○	Hepatitis
○	○	HIV
○	○	Influenzal Pneumonia
○	○	Liver Disease
○	○	Lung Disease
○	○	Lupus Erythema (discoid)
○	○	Lupus Erythema (systemic)
○	○	Multiple Sclerosis
○	○	Measles
○	○	Mumps
○	○	Psoriasis
○	○	Parkinson's Disease
○	○	Unspecified Pleural Effusion
○	○	Pneumonia
○	○	Psychiatric Problems
○	○	Rash
○	○	Scoliosis
○	○	Seizures
○	○	Sickle Cell Anemia
○	○	Shingles
○	○	Spina Bifida
○	○	STD's (unspecified)
○	○	Suicide Attempt(s)
○	○	Thyroid Problem
○	○	Vertigo
○	○	Other: _____

Have any of your family members experienced any of these illnesses? If yes, please list illness and family member.

SURGERIES

HAD	HAVE	
○	○	Angioplasty
○	○	Appendectomy
○	○	Caesarian Section
○	○	Cardiac Catherterization
○	○	Carpal Tunnel Repair
○	○	Coronary Artery Bypass
○	○	Cosmetic
○	○	Dental
○	○	Gall Bladder
○	○	Hemorrhoidectomy
○	○	Hernia Repair
○	○	Hysterectomy
○	○	Joint Reconstruction
○	○	Joint Replacement
○	○	Knee Repair
○	○	Laminectomy
○	○	Mastectomy
○	○	Vasectomy
○	○	Pacemaker
○	○	Rotator Cuff
○	○	Spinal Fusion
○	○	Tonsilectomy
○	○	Other: _____

DATES: _____ Dates: _____ Dates: _____ Dates: _____

FAMILY HISTORY

Relative	Age (if living)	State of Health: Good	State of Health: Poor	Illness	Age at Death	Cause of Death: Natual	Cause of Death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

Are there any other hereditary health issues that you know about?

SOCIAL HISTORY

	Daily	Weekly	How Much?
Alcohol Use	○	○	
Coffee Use	○	○	
Tobacco Use	○	○	
Exercising	○	○	
Pain Relievers	○	○	
Soft Drinks	○	○	
Water Intake	○	○	

	Yes	No
Job Pressure / Stress?	○	○
Financial Peace?	○	○
Recreational Drugs?	○	○
Are you on a special diet?	○	○
Is your weight a concern?	○	○

My dietary intake consists mainly of the following: (mark all that apply)

○ vegetables ○ high salt ○ low salt
○ whole grains ○ high sugar ○ low sugar
○ high fiber ○ low calorie ○ low saturate fats
○ high protein ○ low carbohydrate

Decribe your typical eating habits:

○ skip breakfast ○ two meals a day
○ three meals a day ○ snacking in between meals

ACTIVITIES OF DAILY LIVING

How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Caring for family	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard Work	○	○	○	○

Decribe any other problems with activities of daily living that you are experiencing

How many hours per day do you typically spend sitting at a desk or on a conputer, tablet or phone?

How much sleep do you average per night? (hours)

How much do you exercise and what type?

How do you normally sleep?
○ Back ○ Side ○ Stomach

Do you wake up:
○ Refreshed and ready ○ Stiff and tired

What would be the most significant thing that you could do to improve your health?

In addition to the main reason for your visit today, what (3) additional health goals do you have?

1)

2)

3)

ACKNOWLEDGEMENT & CONSENT

To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

_____ *initial*
I instruct the chiropractor to deliver the care that, in her professional judgement, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxations. Chiropractic is a separate and distinct heath profession from medicine and does not proclaim to cure any named disease or entity.

_____ *initial*
I may request a copy of the Private Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

_____ *initial*
I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY): _____

_____ *initial*
I grant permission to be texted, called and/or emailed to confirm or reschedule an appointment and to be sent occassional cards, letters, emails or health information to me as an extension of my care in this office.

_____ *initial*
I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.

_____ *initial*
As a courtesy to our doctor and clients, all cancellations and reschedules should be made 24 hours in advance. Any cancellations or schedule changes on the day of an appointment are subject to a $25 late cancel fee. Any missed appointments are subject to the full service fee of that appointment. In the event of an emergency, this fee may be waived as we understand life happens.

_____ *initial*
To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.

Patient (or Guardian's) signature

Date (MM/DD/YYYY)