Denver Upper Cervical Chiropractic - Patient Health History

Patient Section

Patient Name:	Date:	DOB:	Patient #:
Cell #:	Work #:	Email:	
Street Address:	City:	State:	Zip:
Marital Status: Married Widowed Seperated/Divorced Single	Spouse Name:	# Of Children:	
How did you hear about us?			
Diagnosed conditions (autoimmune, disease/infection/other):			
Medications:			
Surgeries or Hospitilizations (date, type, reason):			
Advanced Imaging Studies (x-ray, MRI, CT, etc - date, body region, findings):			
Allergies:			
Broken Bones (date, bone, side of body):			

Family History of... and who; example Mother's Father "MF" or Father "F"				Heart Disease	
Stroke		Autoimmune		Genetic Disorder	
Diabetes		Blood Disorders		Lung Disease	
Arthritis		Gastrointestinal		Neurological	
Cancer		Other			

Specialists seen for current condition

Type	Clinicians Name	Phone Number	Practice Name
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Please check the box to the left of your preference below to help us know how to best communicate with you: *We want you to know; email is not considered secure or HIPPA complaint. Hence we need explicit permission to communicate with you via email.

Do we have your permission to email you about your appointments?	☐	No	☐	Yes at the email listed above
Do we have your permission to email you about our x-ray findings?	☐	No	☐	Yes at the email listed above
Do we have your permission to email you about all other clinical findings?	☐	No	☐	Yes at the email listed above
Do we have your permission to email you copies of your x-rays if requested?	☐	No	☐	Yes at the email listed above
Do we have your permission to send you text messages about appointments?	☐	No	☐	Yes at the cell phone listed above
Do we have your permission to call and leave you a voicemail messages?	☐	No	☐	Yes at the cell phone listed above

Name: _____ Signature: _____ Date: _____

Please mark below where appropriate if you're currently experiencing, have experienced in the past, or have never experienced a problem with the listed symptom, system, or function. These will be discussed in greater detail with the doctor.

Cognition + Behavior	Past	Current	Never	Date
Brain Fog	___	___	___	_____
Memory Issues	___	___	___	_____
Moodiness	___	___	___	_____
Anger	___	___	___	_____
Irritability	___	___	___	_____

Balance	Past	Current	Never	Date
Vertigo	___	___	___	_____
Dizziness	___	___	___	_____
Poor Balance	___	___	___	_____

Sensory	Past	Current	Never	Date
Hearing Loss	___	___	___	_____
Sensitivity to Sound	___	___	___	_____
Abnormal Taste	___	___	___	_____
Abnormal Smell	___	___	___	_____
Ringing in your ears	___	___	___	_____
Pins and Needles	___	___	___	_____
Unexplained Hot/Cold	___	___	___	_____

Mental Health	Past	Current	Never	Date
Anxiety	___	___	___	_____
Depression	___	___	___	_____
Stress	___	___	___	_____
Other	___	___	___	_____

Circulatory	Past	Current	Never	Date
Palpitations	___	___	___	_____
Murmurs	___	___	___	_____
Arrhythmia	___	___	___	_____

Respiratory	Past	Current	Never	Date
Shortness of Breath	___	___	___	_____
Asthma	___	___	___	_____

Neurological	Past	Current	Never	Date
Migraines	___	___	___	_____
Headaches	___	___	___	_____
Seuzures	___	___	___	_____
Tremors	___	___	___	_____
Chronic Fatigue	___	___	___	_____
Low Energy	___	___	___	_____
Difficulty reading/writing/speech	___	___	___	_____

Sleep	Past	Current	Never	Date
Poor Sleep Quality	___	___	___	_____
Trouble Falling Asleep	___	___	___	_____
Trouble Staying Asleep	___	___	___	_____
Poor Sleep Comfort	___	___	___	_____

Organ Dysfunction	Past	Current	Never	Date
Kidney	___	___	___	_____
Liver	___	___	___	_____
Spleen	___	___	___	_____
Gallbladder	___	___	___	_____
Bladder	___	___	___	_____
Pancreas	___	___	___	_____
Appendix	___	___	___	_____

Digestive Function	Past	Current	Never	Date
Vomiting	___	___	___	_____
Acid Reflux	___	___	___	_____
Ulcer	___	___	___	_____
Indigestion	___	___	___	_____
Constipation	___	___	___	_____
Diarrhea	___	___	___	_____
Nausea	___	___	___	_____

Visual	Past	Current	Never	Date
Tracking across	___	___	___	_____
Trouble Converging	___	___	___	_____
Double Vision	___	___	___	_____
Tunnel Vision	___	___	___	_____
Poor Night Vision	___	___	___	_____
Blurred Vision	___	___	___	_____
Sensitivity to Light	___	___	___	_____
Visual Floaters	___	___	___	_____

Men	Past	Current	Never	Date
Erectile Dysfunction	___	___	___	_____

Women	Past	Current	Never	Date
Menstrual Irregularities	___	___	___	_____
Bad Menstrual Cramps	___	___	___	_____
Pregnancy Complications	___	___	___	_____
Birth Complications	___	___	___	_____
Pre-Menopause		___	___	_____
Peri-Menopause		___	___	_____
Post-Menopause		___	___	_____

Healthy Habits and Lifestyle Information

Please answer the following questions as well as you're able to. We understand you may not be certain of some answers, and others may be variable. When appropriate, think more about what you've averaged over the last 1-3 months

How many oz of water do you consume daily? (A nalgene bottle is 32 oz) _____

How many hours of sleep do you get per night? _____

How many days per week do you currently exercise? _____

If your condition has changed your exercise habits, how many days per week would you normally have exercised? _____

What do you do when you exercise? Sports | Pilates | Liftng | Stretching | Yoga | Walk | Cardio | Outdoor Activities | TaiChi

Feel free to elaborate here if you'd like: _____

Are you confident lifting weights? Y N It Depends

Are you physically comfortable lifting weights? Y N It Depends

Did you play sports growing up? If so, what sports? Y N _____

On average, how many hours do you spend sitting a day? _____

Do you wake up at a consistent time? Y N It Depends

If yes, what time do you usualy wake up? _____

Do you get daily sun exposure? Y N It Depends

If yes, on average how many hours are you outside weekly? _____

Do you have a morning routine? Y N It Depends

Do you have an evening routine? Y N It Depends

Do you have a bowel movement daily? Y N

If yes, how many daily, on average? _____

If no, how many weekly? _____

Do you have any dietary or nutritional considerations or protocols you follow? (ex; Keto, gluten free, vegan, paleo, dairy free, etc)

_____

Do you eat breakfast Y N It Depends

Daily Caffiene Y N It Depends

Do you get vegetables daily? Y N It Depends

Roughly what percetage of your meals is someone preparing (yourself, a parent, a spouse) vs eating out? _____

How many alcoholic drinks per week do you have? _____

Do you use cannabis? Y N It Depends

Do you use tobacco or nicotne? Y N It Depends

Does ^it help with your condition? Y N It Depends

Please select the number best correlating with your stress levels in the following arenas (0 = no stress, 10 = very high stress)

Stress: Work 0 1 2 3 4 5 6 7 8 9 10

Family/At Home 0 1 2 3 4 5 6 7 8 9 10

About Condition 0 1 2 3 4 5 6 7 8 9 10

Other 0 1 2 3 4 5 6 7 8 9 10

Please select the number best correlating with how fulfilled you feel in the following areans (0 = not fulfilled, 10 = very fulfilled)

Work 0 1 2 3 4 5 6 7 8 9 10

Family/At Home 0 1 2 3 4 5 6 7 8 9 10

Social 0 1 2 3 4 5 6 7 8 9 10

Emotionally 0 1 2 3 4 5 6 7 8 9 10

Do you feel like you have family support? Y N It Depends

Do you feel like you have social support? Y N It Depends

How committed are you to getting this fixed?

0 1 2 3 4 5 6 7 8 9 10

How committed are you to good health?

0 1 2 3 4 5 6 7 8 9 10

Do you have hobbies? Y N

If yes, please list some favorites: _____

Do you have any stress management or mindfulness practices? Y N

Please circle any you do and list any not mentioned:

Prayer | Meditation | Mindful Breathing | Journaling | Time outside | Counseling | Exercise | Music | Socializing | Other

_____

Do you have a daily gratitude practice? Y N It Depends

Do you feel in control of your life situation? Y N It Depends

Do you believe you can heal? Y N

I think so (but based on my experience, I'm starting to question it)

Anything else you'd like us to know? _____

_____

_____