Life Enhancing Chiropractic

6189 Lehman Drive Suite 100
Colorado Springs, CO 80918 719-290-1441

NAME: ____AGE: _______DOB: ____/____/______ DATE:____________________

ADDRESS: CITY: STATE: ZIP: ____

PHONE NUMBER FOR TEXT MESSAGE IF AVAILABLE: ____

EMAIL ADDRESS: ____

MALE:_____ FEMALE:_________ HEIGHT: ___________WEIGHT:__________ BLOOD PRESSURE:______________________________

OCCUPATION: EMPLOYER'S NAME AND PHONE #: ____

SINGLE: _______MARRIED: _____SPOUSE'S NAME:_______________________________ DIVORCED:______ WIDOWED: _____

NO. OF CHILDREN: AGE, GENDER:____

Addressing what brought you to this office:

Please briefly describe your chief concern, including the effect it has had on your life.
____

____

Condition	Severity	Started?	First episode	Related to an injury?	Constant or ermittent mptoms
1					
2					
3					

Please list other Doctors you have seen for this condition: Chiropractor Medical Dr. NUCCA Dr. Other: _____________________

1. Name/Address____

Date: _____________________ What was the diagnosis:____

2. Name/Address____

Date: _____________________ What was the diagnosis:____

GENERAL HISTORY:

Please check (√) all symptoms you have ever had, even if they do not seem related to your current problem:

	Headaches		Ringing in Ears		Sleep Problems		Urinary Problems
	Pins & Needles In legs		Nervousness		Stiff Neck		Heartburn
	Fainting		Numb fingers		Cold Hands		Menstrual Pain
	Pins & Needles in arms		Loss of taste		Cold Feet		Menstrual Irregularity
	Loss of Smell (sense)		Stomach Upset		Constipation		Ulcers
	Back Pain		Fatigue		Fever		Loss of Balance
	Depression		Hot Flashes		Dizziness		Irritability
	Cold Sweats		Buzzing I Ears		Tension		Light sensitivity in Eyes

Other conditions/diseases you would like the doctor to be informed of:____

List any medications you are taking and why: (Prescription and non-prescription) ____
____

Have you had any surgery? (please include all surgical procedures)

1. Type-- Date --Doctor
____

2 Type-- Date --Doctor
____

3. Type-- Date --Doctor
____

4 Type-- Date --Doctor
____

Accidents and/or injuries: auto, work-related or other (especially those related to your present problems.)

1. Type-- Date --Doctor
____

2. Type-- Date --Doctor
____

3. Type-- Date --Doctor
____

Have you ever had x-rays taken? (if yes) When: ____________________ Where:__________________ Area of body:____________________
____

Do you wear orthotics or heel lifts in your shoes? No Yes What size?_________________ For how long?_________________________

If you’ve come to the office due to an auto accident or personal injury, please write a paragraph about what happened:

Anything else you would like the Doctor to know:

<u>This form does not need to be signed until you have met with the doctor at your consultation.</u>

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature:____ Date:____________________________