CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. Please print clearly.

Integrated Health Center

Dr. Ken Szarka

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Centennial, CO 80112
(303) 220-7319
www.coloradohealthcenter.com

Today's Date (MM/D/YYYY)

Have you ever consulted/been to a chiropractor in the past? ◯ **No** ◯ **Yes If so, When?** _____

Patient ID Number (office use only)

Age: _____ **Gender** ◯ **Female** ◯ **Male** **Marital Status:** ◯ **Married** ◯ **Single** ◯ **Divorced** ◯ **Widow**

Birth Date: (MM/DD/YYYY)

Social Security Number | **Last Name** | **First Name** | **Middle Initial**

Street Address | **City** | **State** | **Zip**

◯ **Primary** ◯ **Secondary** ◯ **Work** ◯ **Email**

Primary Phone Number | **Secondary Phone Number** | **Work Phone Number** | **Which number do you prefer to be contacted?**

Email Address | **Emergency Contact Name** | **Emergency Contact Phone Number**

Your Occupation | **Spouse's/Partner's Name**

Your Employer | **Spouse's/Partner's Contact Number**

Street Address | **City** | **State** | **Zip**

Insurance/Billing Information: **What is your preferred method of payment?** ◯ **Insurance** ◯ **Self Pay (cash/check/credit card)**

General Health Insurance Carrier | **Policy/ID Number** | ◯ **Self** ◯ **Spouse** ◯ **Parent** **Who Carries this Policy?**

Insured's Last Name | **Insured's First Name** | **MI** | **Birth Date(MM/DD/YYYY)**

Insured's Employer | **Telephone Number**

Insured's Address | **City** | **State** | **Zip**

Is this a Personal Injury/Auto Accident Claim? ◯ **Yes** ◯ **No** **Is this a Worker's Compensation Claim?** ◯ **Yes** ◯ **No**

Auto Insurance/Worker's Comp Insurance Carrier | **Claim Number** | **Date of Accident/Injury**

Claim Adjustor's Name | **Telephone Number** | **Attorney's Name** | **Telephone Number**

Patient Name:_____Date:_____

Primary Complaint: What is the reason for your visit today?

_____

_____

_____

◯ Intermittent ◯ Occasional
◯ Frequent ◯ Constant
Was the cause? ◯ **Accident/Injury**
◯ **Work** ◯ **Auto** ◯ **Other**

When did it Start?_____
Describe the Nature : ◯ Achy ◯ Sharp
◯ Numb/Tingling ◯ Stiff/Tight ◯ Spasm
◯ Radiating/Shooting ◯ Weak ◯ Burning

Other:_____

◯ **Recurrence of a long term condition**

What have you tried for treatment?
◯ Prescription medication ◯ Medical
◯ Over the counter drugs ◯ Ice
◯ Homeopathic remedy ◯ Heat
◯ Physical Therapy ◯ Massage
◯ Chiropractic Care ◯ Surgery
◯ Other:

_____

_____

Secondary Complaint: Is there another area of complaint today?

_____

_____

_____

◯ Intermittent ◯ Occasional
◯ Frequent ◯ Constant
Was the cause? ◯ **Accident/Injury**
◯ **Work** ◯ **Auto** ◯ **Other**

When did it Start?_____
Describe the Nature : ◯ Achy ◯ Sharp
◯ Numb/Tingling ◯ Stiff/Tight ◯ Spasm
◯ Radiating/Shooting ◯ Weak ◯ Burning

Other:_____

◯ **Recurrence of a long term condition**

What have you tried for treatment?
◯ Prescription medication ◯ Medical
◯ Over the counter drugs ◯ Ice
◯ Homeopathic remedy ◯ Heat
◯ Physical Therapy ◯ Massage
◯ Chiropractic Care ◯ Surgery
◯ Other:

_____

_____

Additional Complaints

_____

_____

_____

◯ Intermittent ◯ Occasional
◯ Frequent ◯ Constant
Was the cause? ◯ **Accident/Injury**
◯ **Work** ◯ **Auto** ◯ **Other**

When did it Start?_____
Describe the Nature : ◯ Achy ◯ Sharp
◯ Numb/Tingling ◯ Stiff/Tight ◯ Spasm
◯ Radiating/Shooting ◯ Weak ◯ Burning

Other:_____

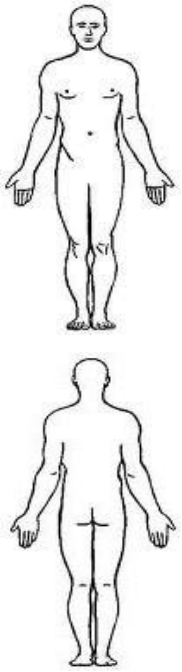
◯ **Recurrence of a long term condition**

What have you tried for treatment?
◯ Prescription medication ◯ Medical
◯ Over the counter drugs ◯ Ice
◯ Homeopathic remedy ◯ Heat
◯ Physical Therapy ◯ Massage
◯ Chiropractic Care ◯ Surgery
◯ Other:

_____

_____

Please show location of your complaints:
"O" – Current Complaints
"X" - Previous Complaints



Activities of Daily Life Affected: How do your conditions affect some basic daily functions.

	No Effect	Mild	Moderate	Severe
Sitting	◯	◯	◯	◯
Standing	◯	◯	◯	◯
Walking	◯	◯	◯	◯
Getting up from a chair	◯	◯	◯	◯
Lying Down	◯	◯	◯	◯
Bending over	◯	◯	◯	◯
Climbing Stairs	◯	◯	◯	◯
At the computer	◯	◯	◯	◯
Getting in/out of car	◯	◯	◯	◯
Driving	◯	◯	◯	◯
Caring for family	◯	◯	◯	◯
Looking over shoulder	◯	◯	◯	◯

	No Effect	Mild	Moderate	Severe
Exercising	◯	◯	◯	◯
Yard Work	◯	◯	◯	◯
Household Chores	◯	◯	◯	◯
Grocery Shopping	◯	◯	◯	◯
Lifting objects	◯	◯	◯	◯
Showering/Bathing	◯	◯	◯	◯
Getting Dressed	◯	◯	◯	◯
Getting to sleep	◯	◯	◯	◯
Staying asleep	◯	◯	◯	◯
Concentrating	◯	◯	◯	◯
Reaching Overhead	◯	◯	◯	◯
Sexual activity	◯	◯	◯	◯

Personal Health/Social History:

How many hours of sleep do you get each night? _____ Do you wake feeling rested? ◯ Y ◯ N Number of days/week do you exercise?_____

What types of exercise do you perform? ◯Running/Treadmill/Elliptical ◯Yoga/Pilates ◯Weight Training ◯Cross Fit ◯Cycling ◯Other

On a scale of 0-10, (10 being the highest) what is your current level of stress? _____ What is the nature? ◯ Mental/emotional ◯ Physical

Mark on the scale the quality of food you eat: Processed----------Natural/Whole Food Are you trying to lose weight? ◯ Y ◯ N

Do you skip any meals? ◯ Y ◯ N Which? ◯Breakfast ◯Lunch ◯Dinner Do you drink water daily? ◯Y ◯N How much?_____oz

Alcohol Use	◯ Daily ◯ Weekly How much? _____	Birth Control	◯ Yes ◯ No
Tobacco Use	◯ Daily ◯ Weekly How much? _____	Hormone Replacement	◯ Yes ◯ No
Marijuana Use	◯ Daily ◯ Weekly How much? _____	Recreational Drugs	◯ Yes ◯ No
Pain relievers	◯ Daily ◯ Weekly How much? _____	Were you Vaccinated?	◯ Yes ◯ No
Heartburn meds	◯ Daily ◯ Weekly How much? _____	Antidepressants	◯ Yes ◯ No
Soft Drinks Use	◯ Daily ◯ Weekly How much? _____	Cholesterol medications	◯ Yes ◯ No

Medical History: Personal and Family

Patient Name:_____Date:_____

Please provide your health history, accidents, injuries, illnesses and previous/current treatments. Please provide as much detail as possible.

Illnesses:
Check the appropriate box

Have	Had	
◯	◯	AIDS
◯	◯	Alcoholism
◯	◯	Allergies
◯	◯	Arteriosclerosis
◯	◯	Cancer
◯	◯	Chicken Pox
◯	◯	Diabetes
◯	◯	Epilepsy
◯	◯	Glaucoma
◯	◯	Goiter
◯	◯	Gout
◯	◯	Heart disease
◯	◯	Hepatitis
◯	◯	HIV Positive
◯	◯	Malaria
◯	◯	Measles
◯	◯	Multiple Sclerosis
◯	◯	Mumps
◯	◯	Polio
◯	◯	Rheumatic Fever
◯	◯	Scarlet Fever
◯	◯	STD's
◯	◯	Stroke
◯	◯	Tuberculosis
◯	◯	Ulcer

Treatments
Check the appropriate box

Past	Current	
◯	◯	Acupuncture
◯	◯	Antibiotics
◯	◯	Birth control
◯	◯	Blood Transfusion
◯	◯	Chemotherapy
◯	◯	Chiropractic
◯	◯	Dialysis
◯	◯	Herbal Remedies
◯	◯	Homeopathy
◯	◯	Hormone Therapy
◯	◯	Inhaler
◯	◯	Massage Therapy
◯	◯	Physical Therapy
◯	◯	Medications

Please list your current meds or supplements:

_____
_____
_____
_____
_____
_____
_____
_____

Injuries: Please indicate if you have:

◯ Broken or fractured a bone
_____
◯ Had a spine or nerve injury
_____
◯ Had a concussion
_____
◯ Whiplash (CAD auto injury)
Dates:_____
◯ Work accidents
Dates:_____
◯ Sprained an Ankle/Foot
◯ Rotator Cuff (shoulder)
◯ Other:
_____
_____
_____

Surgeries:

◯ Appendix ◯ Heart
◯ Cosmetic ◯ Cancer
◯ Eye ◯ Dental
◯ Tonsils ◯ Gynecological
◯ Spine ◯ Shoulder
◯ Joint ◯ Other
_____

Doctor's Notes:

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Family History: Some health issues are inherited, so please tell us about your immediate family

Relative	Age(if living)	Illnesses/Health Conditions	Age at Death	Cause of Death
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____

Review of Your Systems: Please indicate if you **Have** or **Had** any of the conditions in the following systems of your body.

1. Musculoskeletal

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck Pain	◯	◯	Back Problems	◯	◯	Hip Disorders
◯	◯	Knee Injuries	◯	◯	Foot Ankle Pain	◯	◯	Elbow/Wrist	◯	◯	TMJ Issues	◯	◯	Poor Posture	◯	◯	Shoulder Issues

2. Neurological

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headaches	◯	◯	Dizziness	◯	◯	Pins/Needles	◯	◯	Numbness

3. Cardiovascular

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	↑Blood Pressure	◯	◯	↓Blood Pressure	◯	◯	↑Cholesterol	◯	◯	Poor Circulation	◯	◯	Angina	◯	◯	↑Bruising

4. Respiratory

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Asthma	◯	◯	Apnea(sleep)	◯	◯	Emphysema	◯	◯	Hay Fever	◯	◯	Loss of Breath	◯	◯	Pneumonia

5. Digestive

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Eating Disorder	◯	◯	Ulcer	◯	◯	Food Sensitive	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

6. Sensory

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Blurred Vision	◯	◯	Ear Ringing	◯	◯	Hearing Loss	◯	◯	Ear Infections	◯	◯	Loss of Smell	◯	◯	Loss of Taste

7. Skin

Have	Had		Have	Had		Have	Had		Have	Had		Have	Had		Have	Had	
◯	◯	Skin Cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair Loss	◯	◯	Rashes/Hives

Review of Systems – continued Patient Name:_____Date:_____

8. Endocrine					
Have Had	**Have Had**	**Have Had**	**Have Had**	**Have Had**	**Have Had**
◯ ◯ Thyroid Issues	◯ ◯ Immune Issue	◯ ◯ Hypoglycemia	◯ ◯ Infections	◯ ◯ Swollen glands	◯ ◯ Low energy
9. Genitourinary					
Have Had	**Have Had**	**Have Had**	**Have Had**	**Have Had**	**Have Had**
◯ ◯ Kidney Stones	◯ ◯ Infertility	◯ ◯ Incontinence	◯ ◯ Prostate Issue	◯ ◯ Erectile Issue	◯ ◯ PMS symptoms
10. Constitutional					
Have Had	**Have Had**	**Have Had**	**Have Had**	**Have Had**	**Have Had**
◯ ◯ Fainting	◯ ◯ Low Sex Drive	◯ ◯ Poor Appetite	◯ ◯ Fatigue	◯ ◯ Weakness	◯ ◯ Weight Gain/Loss

Acknowledgements & Consent to Treatment

To set clear expectations, good communications and help you get the best results from your care, please read each statement and initial your agreement.

Initial_____ **I instruct the chiropractor to deliver the care that, in his best professional judgment, 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/joint subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initial_____ **I may request a copy of the Privacy 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. By initialing I consent to allow the disclosure of my protected health information for the sole purpose to carry out treatment, payment activities and healthcare operations.**

Initial_____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initial_____ **I acknowledge that any insurance I 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_____ **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 concerns.**

_____ _____

Patient (or Guardian's) Signature Date (MM/DD/YYYY)