|For Office Use Only| Patient File # _____

Confidential Patient Information

GOLD Chiropractic & Rehab
1111 Washington Ave., Suite 117
Golden, CO 80401

phone: (720) 924- 6535
fax: (303) 273-0867
www.goldchiroandrehab.com

Date: _____/_____/_____

Patient's Full Name _____

Mailing Address:_____ City:_____ State:_____ Zip:_____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____ E-Mail: _____

☐ Male ☐ Female Date of Birth:_____/____/_____ ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Spouse's Name:_____ Number of Children/Ages_____

How Did You Find Us?

☐ Existing Patient
Who?_____
☐ Physician
Who?_____
☐ Friend
Who?_____

☐ Local Ad_____
☐ Google:_____
☐ Social Media (i.e. Facebook, Twitter, etc._____
_____

☐ Office Websit ☐ FAKTR Website ☐ Other:_____
☐ ART Website ☐ MPI Website
☐ ACA Website
☐ Other Website:_____

Primary Family Physician:_____

Adress: _____

City: _____ State: _____

Phone #: _____

Social Security # _____ - _____ - _____(last four used for file #)

Status: ☐ Employed ☐ Full Time Student ☐ Part Time Student ☐ Retired ☐ Unemployed Occupation:_____

Employer:_____ Employer Address:_____ Business Phone_____

Emergency Contact:_____ Relationship:_____ Phone: _____-_____-_____

Previous Chiropractic Care: ☐ **Yes** ☐ **No** **If Yes, for what Problem:** _____

Chiropractic Dr.'s Name _____ **City:** _____ **State:** _____

Is Today's Visit Due To A Work Related Injury: ☐ Yes ☐ No **Is Today's Visit Due To An Auto Accident:** ☐ Yes ☐ No
(If yes to either questions above, please check with receptionist, additional information is needed)

Date of Injury:_____

Authorization and Assignment

In consideration of your undertaking to care for me, the patient, I agree to the following:

1. You are authorized to release **any information** you deem appropriate concerning my physical or emotional condition, health history, or billing and payment history to any insurance company, attorney, or adjuster for the purpose of any claim for reimbursement of charges incurred by me.
2. I authorize my attorney and/or any insurance company to make **direct payment to you** of settlement proceeds.
3. I hereby assign and transfer to GOLD C &R the cause of action that exists in my favor against any insurance company obligated by contractual agreement to make payment to me or to GOLD C & R for the charges made for service. I authorize GOLD C & R to prosecute said action either in my name. I further authorize GOLD C & R to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts GOLD C & R does not collect from insurance companies, whether it be all or part of what was due, **I personally owe to GOLD C & R**.
4. I further agree that this Authorization and Assignment is irrevocable until all moneys owed to you (GOLD Chiropractic & Rehab) are **paid in full**.

Patient Signature:_____ **Date:**_____/_____/_____

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Dear Patient, Please complete this form and questionnaire. If you need assistance, please ask. Your answers will help us determine if Chiropractic care can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. Thank You.

Present complaint(s):_____

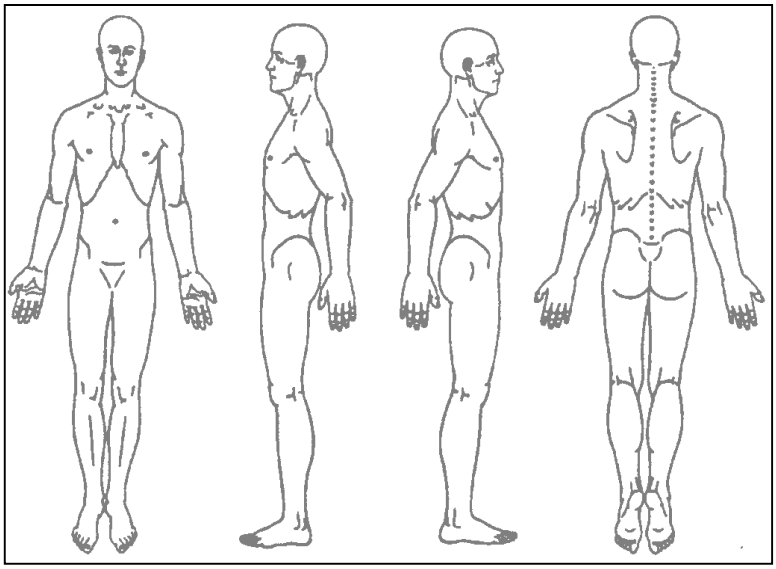
When did your symptoms begin? (Specific date if possible)_____

How did your symptoms begin? (i.e. Lifting, bending, ect.)_____

In the past have you had anything similar to this? ☐ Yes ☐ No Please explain_____

PAIN CHART

Please Mark the Areas of Pain *On The Diagram* Below, then Describe Your Pain(s) seperately in each box.



DESCRIBE YOUR PAIN

#1 Complaint _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #1 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#2 Complaint (if applicable)_____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #2 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

DESCRIBE YOUR PAIN

#3 Complaint (if applicable) _____

(Rate your level of Pain, Scale 0-10)

0 1 2 3 4 5 6 7 8 9 10
No pain Unbearable

Check all that apply to your #3 Complaint

☐ Sharp ☐ Ache ☐ Tingling
☐ Stabbing ☐ Soreness ☐ Numbness
☐ Burning ☐ Weakness ☐ Dull
☐ Shooting ☐ Throbbing ☐ Constricting

☐ Other_____

How often is this complaint present?
☐ Constant 100% of the time ☐ Frequently 75%
☐ Intermittent 50% ☐ Occasional 25%

* Check each following box that applies to your pain(s), and place the **Complaint #** next to its corresponding box :

Is your Pain:	**Was the Onset:**	**Pain is aggravated by:**	**Pain is improved by:**
☐ Increasing	☐ Gradual	☐ Walking ☐ Lifting	☐ Medication ☐ Chiropractic Adjustment
☐ Decreasing	☐ Sudden	☐ Sitting ☐ Bending	☐ Rest
☐ Not Changing		☐ Riding in a car ☐ Stretching	☐ Exercise ☐ Other_____
☐ Varies		☐ Standing ☐ Twisting	☐ Therapy _____
		☐ Other_____	

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Family Doctor / Primary Care Physician(PCP)?_____
We normally keep your family doctor and/or referring physician informed regarding your care at this office.

☐ Yes ☐ No Is it okay to inform your PCP?

☐ Yes ☐ No Is pain affecting your ability to work or be active? **If Yes** explain:_____

_____

☐ Yes ☐ No Any change in bowel or bladder (bathroom) function? **If Yes** explain:_____

☐ Yes ☐ No Any fever or chills? **If Yes** explain:_____

☐ Yes ☐ No Any dizziness associated with symptoms? **If Yes** explain:_____

☐ Yes ☐ No Have you experienced any unexplained weight loss, fatigue, or blood loss? **If Yes** explain:_____

_____

☐ Yes ☐ No Are your complaints affecting your sleep? **If Yes** explain:_____

☐ Yes ☐ No Have you had any tests for this complaint? (i.e. X-rays, MRI, CT) **If Yes** explain:_____

☐ Yes ☐ No Any past or recent falls / accidents / surgeries / broken bones?
If Yes explain:_____

☐ Yes ☐ No Have you seen any other physicians in the past 6 months? **If Yes** explain:_____

_____

☐ Yes ☐ No Have you had any prior treatment for this or a related complaint, including any physical therapy?
If Yes, who?_____

What treatment?_____

☐ Yes ☐ No Have you ever been in the hospital or had surgery for any reason? **If Yes** explain:_____

_____

☐ Yes ☐ No Have you ever been in an accident? **If Yes** explain:_____

☐ Yes ☐ No Do you smoke? **If Yes** how much?:_____

If you have quit smoking, when did you quit?_____

☐ Yes ☐ No Do you consume alcohol?

☐ Yes ☐ No Do you exercise? **If Yes** what is your routine?_____

What type of care are you interested in?

☐ Pain relief only ☐ Healing of current condition ☐ Optimizing your health ☐ All three

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What **non-prescription** medication are you currently taking?

☐ Tylenol ☐ Aspirin
☐ Ibuprofen ☐ None
☐ Other_____

How often?
☐Daily ☐Weekly ☐Other:_____

What **Prescription** medication are you taking?

☐ Anti-inflammatory ☐ Birth Control Pill ☐ Diet Pills
☐ Pain Killers ☐ Cholesterol Meds ☐ Nerve Pills
☐ Muscle Relaxers ☐ Insulin ☐ HRT
☐ Blood Pressure Meds ☐ Tranquilizers ☐ Sleeping Aid
☐ Blood Thinners
☐ Other_____ ☐ None

Specific names if possible:_____

FAMILY HISTORY AND HEALTH STATUS: List any diseases, disorders, or major illnesses. If deceased, from what?
(This information may help determine your familial susceptibilities to illness, disorders, etc, and help me better treat your condition.)

Mother:_____ Father:_____

Brother(s):_____ Sister(s):_____

Other:_____ Other:_____

Do you have any other health concerns or diseases? (eg: heart disease, hypothyroidism, asthma, alergies, etc.)_____

_____

Do you have any specific dietary guidelines you follow? ☐ Gluten Free ☐ Dairy Free ☐ Vegetarian / Vegan

☐ Other: _____

☐ **Yes** ☐ **No** **Do you consume artificial sweeteners? If so, please specifiy:** ☐Sweet N' Low/Sugar Twin/Sacchrine ☐Splenda/Sucralose ☐Equal/NutraSweet/Aspartame ☐Sweet One/Swiss Sweet/cesulfame-K ☐Other_____

☐ **Yes** ☐ **No** **Do you consume diet beverages such as soda, sports drinks, tea, or others?**
If so, please specify type(s): _____

☐ **Yes** ☐ **No** **Do you belong to a local gym, sports team/ league, etc.?**
If so, please specify: _____

☐ **Yes** ☐ **No** **Would you like more information on Nutrition and/or Supplement recommendations?**