

Inspired Chiropractic and Wellness

13550 Northgate Estates Drive, Suite 210 Colorado Springs, CO 80921
(719) 447-9848 office (719) 599-0958 fax

General Information

Name *First* *Middle* *Last*

Preferred Name

Date of Birth

Age

Gender Male Female

Genetic Background African Caucasian European Native American

Asian Hispanic Middle Eastern _____

Highest Education Level High School Graduate Post-Graduate

Job Title

Nature of Business

Primary Address *Number, Street* *Apt. No.*

City *State* *Zip*

Alternate Address *Number, Street* *Apt. No.*

City *State* *Zip*

Home Phone 1

Home Phone 2

Work Phone

Cell Phone

Fax

Email

Emergency Contact *Name* *Phone Number*

Address *Apt. No.*

City *State* *Zip*

Physician *Name* *Phone Number*

Fax

Referred by

Doctor referral Website Friend or Family Member Other _____

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CREDIT CARD INFORMATION

Patient _____ Date _____

DOB _____

Preferred Method of Payment (*please circle one*): Cash / Check / Credit Card

Credit Card Type (*please circle one*): VISA MASTERCARD DISCOVER

**Note: If Discover is your primary card, please provide another card (i.e., MC or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process.*

Primary Card

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

Secondary Card

Name on Card _____

Card Type Visa MasterCard Discover

Account Number _____

Expiration Date (mm/yy) _____

CVV# _____

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Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? _____

If you had a magic wand and could erase three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger your change in health? _____

What makes you feel worse? _____

What makes you feel better? _____

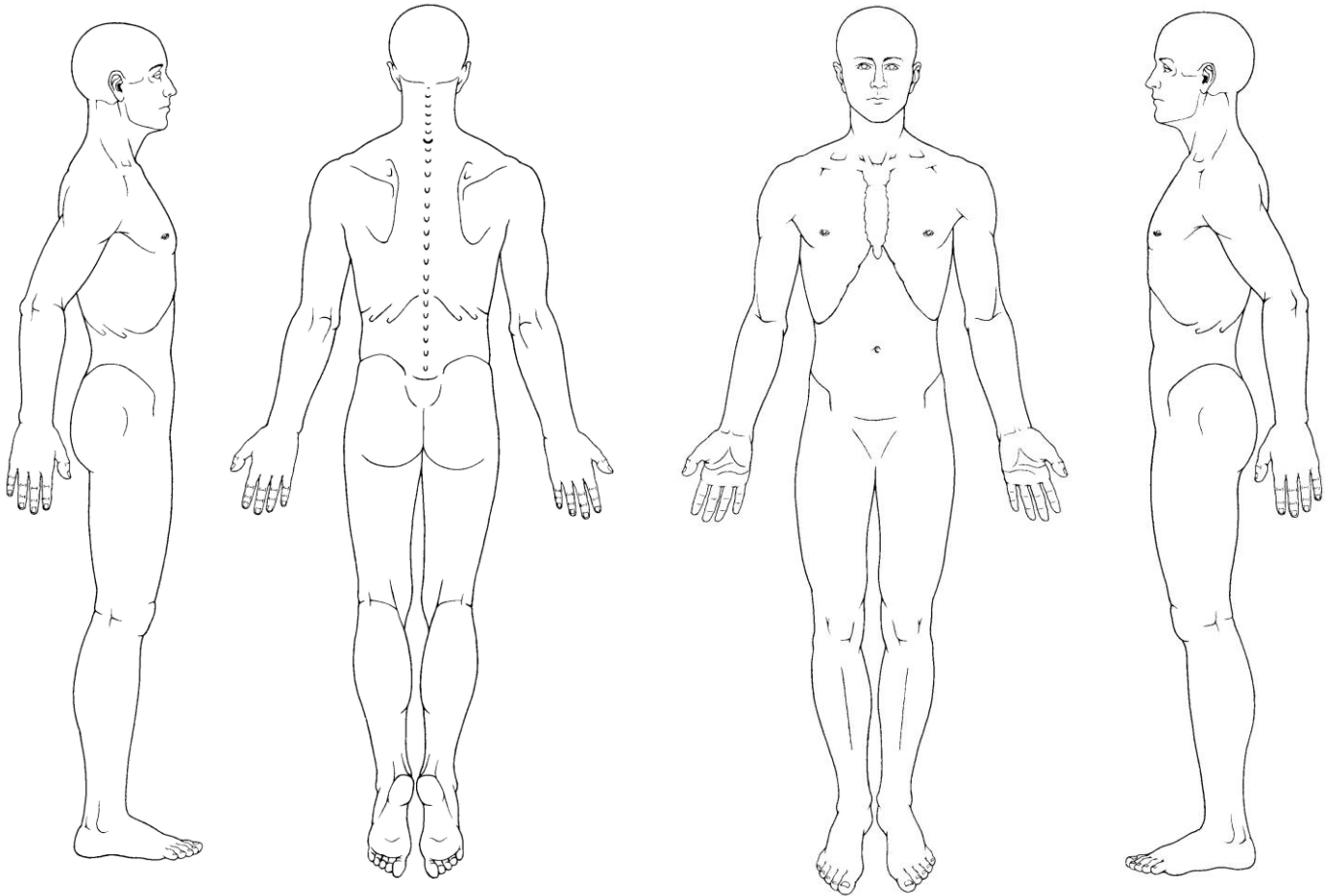
Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success		
					Excellent	Good	Fair
<i>Example: Post Nasal Drip</i>		X		<i>Elimination Diet</i>	X		

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Pain Diagram



Please mark off the areas of your complaint on the diagram above.
Please use the following symbols on the pain diagram to accurately describe your condition.

Please use

P - Where you experience Pain **N** - Where you experience Numbness **T** - Where you experience Tingling
B - Where you experience Burning **C** - Where you experience Cramping

Activities that are painful to perform

Sitting Standing Walking Bending Lying Down Lifting Resting Looking Down Other _____

Type of pain:

Sharp Dull Throbbing Numbness Aching Shooting Burning Tingling Cramps Stiffness Swelling Other _____

Is your condition getting Better Worse Same?

How bad is your pain now?

0 1 2 3 4 5 6 7 8 9 10

No Pain _____ Unbearable Pain

How often do you have pain? 0--10--20--30--40--50--60--70--80--90--100 (%of day)

Patient Signature _____

Date _____

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Medication and Supplements

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____ Have

you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

Have you had prolonged or regular use of Acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.) Yes No

Frequent antibiotics > 3 times/year Yes No Long term antibiotics Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past Yes No

Use of oral contraceptives Yes No

Food allergies

Do you have known adverse food reactions or sensitivities? Yes No If yes, describe symptoms _____

Do you have any food allergies or sensitivities? Yes List all: _____ No

Do you have an adverse reaction to caffeine? Yes No If Yes, do you feel: Irritable or Wired Aches & Pains

Sleep/rest

Average number of hours you sleep per night: >10 8-10 6-8 < 6

Do you have trouble falling asleep? Yes No Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No Do you snore? Yes No

Do you use sleeping aids? Yes No Explain: _____

Gynecologic History *(for women only)*

Women's Menstrual and Obstetric History *Check box if yes and provide number of*

Age at first period: _____ Menses Frequency: _____ Length: _____ Last Menstrual Period: _____

Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring How long? _____

Do you use contraception? Yes No Condom Diaphragm IUD Partner vasectomy

Pregnancies _____ Caesarean _____ Vaginal deliveries _____ Miscarriage _____ Abortion _____

Living Children: _____ Ages and gender: _____

Post Partum Depression Toxemia Gestational Diabetes Baby over 8 pounds

Breast Feeding For how long? _____

Women's Disorders / Hormonal imbalances

Fibrocystic Breasts Endometriosis Fibroids Infertility Painful Periods Heavy periods PMS

Last Mammogram: _____ Breast Biopsy/Date _____ Last PAP test: _____ Normal Abnormal

Date of Last Bone Density Results: High Low Within Normal Range

Are you in menopause? Yes No Age at Menopause _____ Perimenopausal? Yes No

Hot Flashes Mood Swings Concentration/Memory Problems Vaginal Dryness Decreased Libido

Heavy Bleeding Joint Pains Headaches Weight Gain Loss of Control of Urine Palpitations

Use of hormone replacement therapy. How long? _____

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PERSONAL MEDICAL HISTORY

= Past Condition = Ongoing Condition

Diseases/Diagnosis/Conditions Check appropriate box and provide date of onset

Musculoskeletal/pain

- Osteoarthritis _____
- Fibromyalgia _____
- Chronic Pain _____
- Other _____

Neurologic / Mood

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Autism _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other Neurological Problems _____

- Other _____

Metabolic / Endocrine

- Type 1 Diabetes _____
- Type 2 Diabetes _____
- Hypoglycemia _____
- Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes)
- Hypothyroidism (low thyroid) _____
- Hyperthyroidism (overactive thyroid) _____
- Endocrine Problems _____
- Polycystic Ovarian Syndrome (PCOS) _____
- Infertility _____
- Weight Gain _____
- Weight Loss _____
- Frequent Weight Fluctuations _____
- Bulimia _____
- Anorexia _____
- Binge Eating Disorder _____
- Other _____

Inflammatory / Autoimmune

- Chronic Fatigue Syndrome _____
- Autoimmune Disease _____
- Rheumatoid Arthritis _____
- Lupus SLE _____
- Immune Deficiency Disease _____
- Herpes-Genital _____
- Severe Infectious Disease _____
- Poor Immune Function _____
(frequent infections) _____
- Food Allergies _____
- Environmental Allergies _____
- Multiple Chemical Sensitivities _____
- Latex Allergy _____
- Other _____

Skin Diseases

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____

Cardiovascular

- Heart Attack _____
- Other Heart Disease _____
- Stroke _____
- Elevated Cholesterol _____
- Arrhythmia (irregular heart rate) _____
- Hypertension (high blood pressure) _____
- Other _____

Gastrointestinal

- Irritable Bowel Syndrome _____
- Crohn's _____
- Gastritis or Peptic Ulcer Disease _____
- GERD (reflux) _____
- Celiac Disease _____
- Other _____

Skin Diseases

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

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Respiratory Diseases

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Sleep Apnea _____
- Other _____

Genital and Urinary Systems

- Kidney Stones _____
- Gout _____
- Interstitial Cystitis _____
- Frequent Urinary Tract Infections _____
- Frequent Yeast Infections _____
- Erectile Dysfunction / Sexual Dysfunction _____
- Other _____

Cancer

- Type or location _____

Injuries

Check box if yes

- Back injury Head Injury
- Neck Injury Broken Bones
- Other

Surgeries

Check box if yes and provide date of surgery

- Appendectomy _____
- Hysterectomy +/- Ovaries _____
- Gall Bladder _____
- Hernia _____
- Tonsillectomy _____
- Dental Surgery _____
- Joint Replacement—Knee/Hip _____
- Heart Surgery—Bypass Valve _____
- Angioplasty or Stent _____
- Pacemaker _____
- Other _____
- None _____

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Family History

Check family members that apply

	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Spondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												