My appointment date:______ & Time:_______

____

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Vital Information

Name ______________________________Soc. #(for insurance use only)_______-________-_______
Address___________________________________City___________________Zip____________
Email Address_____________________________________ **Date of Birth**___________________
Home Ph ___________________Business Ph ___________________Cell Ph___________________
(Please circle the best phone number to contact you.)

Would you like to apply your insurance benefits? Yes / No (Supply insurance card, if yes)
Insurance Carrier:______________________________

Marital Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Widowed ☐ Divorced
Name of Spouse/Partner ____
Children living at home? ☐ Y ☐ N Number of Children_________
Names and Ages of Children ____

Place of Work ____
City______________________State______________________Zip__________________________

- What type of work do you do? ____
- Rank your satisfaction with work. (Low 1 2 3 4 5 6 7 8 9 10 High)
- Whom may we thank for referring you to our office? _____________________________________
- Reason for seeking services?(please be detailed)______________________________________
  ____
  ____
  - How Long have you felt this?____
  - Have you felt this before? Y or N If Yes When?_________________________________
  - Have you seen another Doctor? Y or N If Yes Who?______________________________
  - What did they do? ____
  - Are your injuries due to an accident? Yes / No If Yes, please explain: ________________
    ____
  - Is this due to an (Please check one): ☐ auto accident(date)_______, ☐ workers-comp, ☐ Neither

∴ Are there any other health concerns we can help you with? ________________________________
____
____

- Is there anything about your Spine or Nervous System that we should know?
(I.e. Any previous surgeries) ____
____
____

- Primary Care Physician Information (For the best results, we may need to coordinate care with your Primary Care Physician)
  - Name?____
  - Address?____
  - Phone Number?____
  - How long have you been under his/her care?____________________________

Symptoms/Conditions

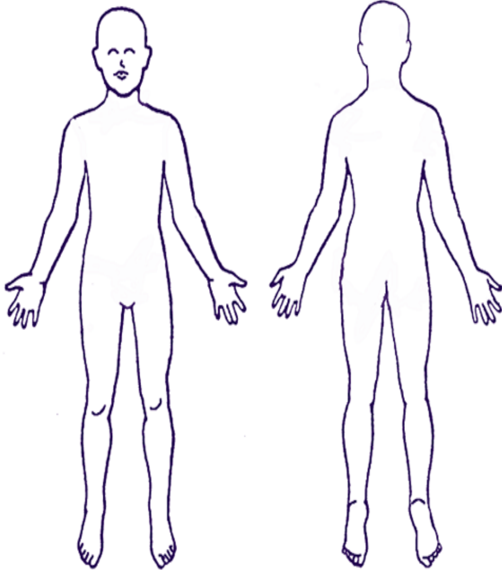
CHECK ANY SYMPTOMS THAT YOU HAVE EXPERIENCED IN THE LAST YEAR:

___ Lack of Energy/ Fatigue
___ Get upset, Irritated/Short Temper
___ Lack ability to Concentrate
___ Emotional Imbalance
___ Hormonal Imbalance
___ Cancer
___ Weak Immune Function
___ Difficulty falling asleep
___ Runny Nose (not during a cold)
___ Anxiety
___ Suffer from Headaches
___ HIV/AIDS

___ Allergies
___ Asthma
___ Chronic Chest Condition
___ Painful Swelling in Joints
___ Tension across Shoulders
___ Pain in Legs or Arms
___ Muscular Pain – Anywhere
Where? ________________
___ Neck Pain
___ Lower Back Pain
___ Numbness /Tingling in body
Where? ________________

___ Chest Pain
___ High Blood Pressure
___ Low Blood Pressure
___ Digestive Problems/Pain
___ Poor appetite
___ Indigestion
___ Heartburn
___ Pain in the Lower Abdomen
___ Poor Bowel Movements
___ PMS
___ Diminished or Frequent Urination
___ Constipated

Please mark are of pain/complaint:



- **Please list symptoms other than above:**
  ____
  ____
  ____
- Any previous bone fracture/ surgeries?
  ____
  ____
- Any other health related concerns/issues?
  ____
  ____
- Any other diagnosis?
  ____
  ____

Important: Fill out the following section completely and honestly.

- **Do you use marijuana for any reason (recreational or medicinal)? Y / N**
  How often?____________________
- **List off ALL prescribed & over the counter medications (include recreational drugs).**

∴ TYPE: ________________ Reason: ______________________________ How Long? ___________
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∴ TYPE: ________________ Reason: ______________________________ How Long? ___________
∴ TYPE: ________________ Reason: ______________________________ How Long? ___________

Please attach a list of any others

Life Style History

- Rate your nutrition: Poor Fair Good Very Good Excellent
- Rate your consistency in eating regular "balanced" meals: (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- What is your average daily fluid intake? (Measurement by Glasses)

  Coffee___/Day Alcohol___/Day Water___/Day Soda___/Day
- What is your average sleep and rest per day?

  Hours per night: ___/hrs Daytime naps: Y N Do you wake up refreshed? Y N
- Do you exercise? What do you do and how often? ______________________________

____
- Rate your average quality of sleep. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- Rate your weekly activity (exercise) level. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- Rate your daily ENERGY level. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- Rate your ability to stay perfectly healthy this year. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- Rate your body's ability to repair from workouts, injury, stress, etc. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)
- What are your play and relaxation activities? ______________________________
- How do your symptoms affect your daily activities, work? Play? Enjoyment in life?

  ____
- Family relationship (i.e. Good, stressful, none) Why? ______________________________

____

Life Stressors

Please circle if in your life you've experienced these:

Physical stress:			*Explain:*
Birth Trauma (as a mother or a child)	Y	N	______________
Slips/Falls	Y	N	______________
Car Accidents (please specify)	Y	N	*When?* ______________
______________			
Sports Injuries	Y	N	______________
Physical Abuse	Y	N	______________
Work Injuries	Y	N	______________
Poor posture	Y	N	______________
Sitting on your wallet for years	Y	N	______________
Extensive Computer Work	Y	N	______________
Carrying Heavy Purse/Book bag/Child	Y	N	______________
Repetitive Lifting /Bending	Y	N	______________
Driving for many hours	Y	N	______________
Continuous Hours Standing/Sitting	Y	N	______________
Emotional Stress:			
Relationships	Y	N	______________
Career	Y	N	______________
Children	Y	N	______________
Verbal Abuse	Y	N	______________
Sickness or Loss of Loved One	Y	N	______________
Chemical Stress:			
Environmental (i.e. Pollution)	Y	N	______________
Smoker (amount)	Y	N	______________
Second Hand smoke	Y	N	______________

What do you feel is your primary stress? ______________________________

The statements on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

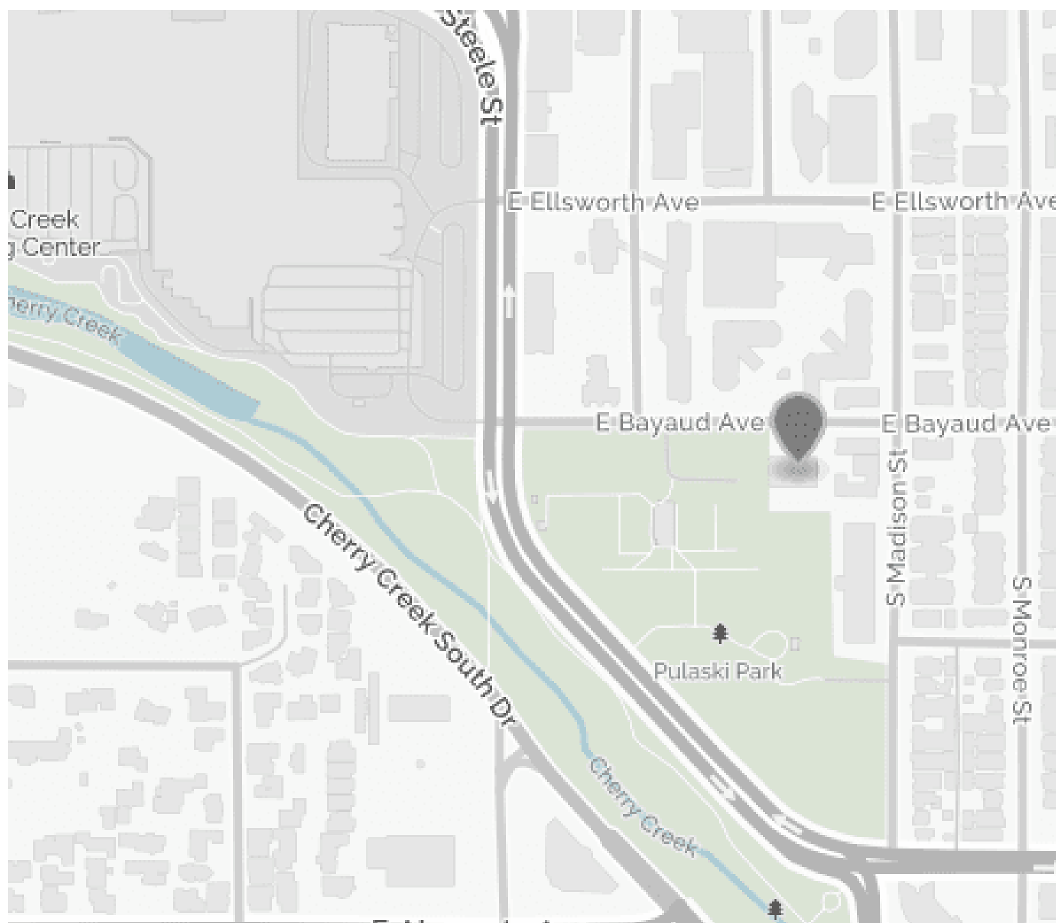
Signature: ______________________ Date: ____________

We are dedicated to igniting and assisting the healing process of as many people as possible. We provide an exceptional healing experience for people with chronic illnesses or imbalances to extremely healthy individuals who want exceptional health for themselves and their family. Many of whom are dissatisfied with standard health care; consisting of endless drugs, needless surgeries and sky rocketing health care bills. Unlike other health care providers we offer possibilities for true healing and not a temporary fix or patch.

To see real patient testimonials go to www.denver-chiropractor.com

Directions to Lifetime Wellness and Chiropractic in Cherry Creek

3400 E Bayaud Ave Ste. 290
Denver, CO 80209
(PH) (303) 399- 3569



Directions from Downtown: Take Speer Blvd East. Speer will become East 1st Ave. Continue on East 1st for approximately 1.5 miles. Turn right onto Steele St. and turn left onto East Bayaud Ave. Our office is on your right in about 200 feet.

Directions from DTC: Take I-25 North toward Denver. Take the Colorado Blvd exit and turn right onto South Colorado Blvd. Stay on Colorado for approximately 2 miles. Turn left onto East Bayaud Avenue. We are the second building on your left past Madison.

Directions from the Airport: Take I-70 West to the Colorado Blvd exit. Head south for approximately 4 miles. Turn right on East Bayaud Avenue. We are the second building on your left past Madison.