www.denver-chiropractor.com

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.)

Workman's Compensation Insurance Carrier:__________________________
Workman's Compensation Phone Number:__________________
Workman's Compensation Claim #:________________

Marital Status: ☐ Married ☐ Domestic Partner ☐ Single ☐ Widowed ☐ Divorced
Name of Spouse/Partner ______________________________________
Children living at home? ☐ Y ☐ N Number 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)
- What was the date of your injury?____________ Do you have an open claim? YES / NO
- How many hours do you work on average in a week?___________
- How were you injured and what is your injury/injuries?____________________
____
____
____
- What activities do you have problems performing since your injury?______________
____
____
    - 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? ____
- What are your typical duties at work?__________________________________
____
- Have you received treatment for this injury yet? YES / NO
- If yes, what treatments have you had?__________________________________
____
- Is there anything about your Health, Spine, Extremities or Nervous System that we should know?

(I.e. Any previous surgeries) ____
____
- Workman's Compensation Physician Information (For the best results, we may need to coordinate care with your Physician)
    - Name?____
    - Address?____
    - Phone Number?_______________________________________

Symptoms/Conditions

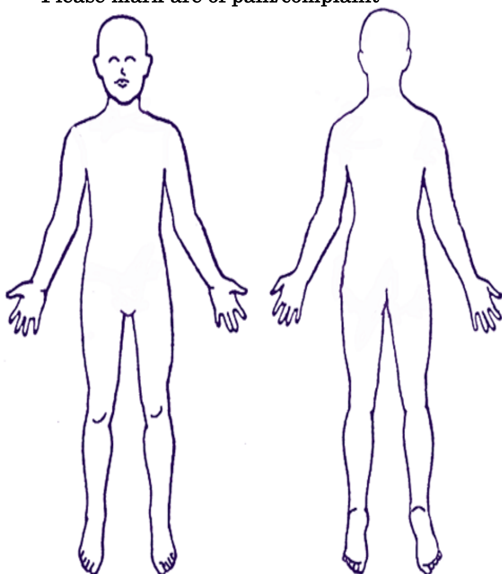
CHECK ANY SYMPTOMS THAT YOU HAVE EXPERIENCED S INCE YOUR INJURY:

___ 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.

- 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 hobbies?_______________________ ____
- 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:

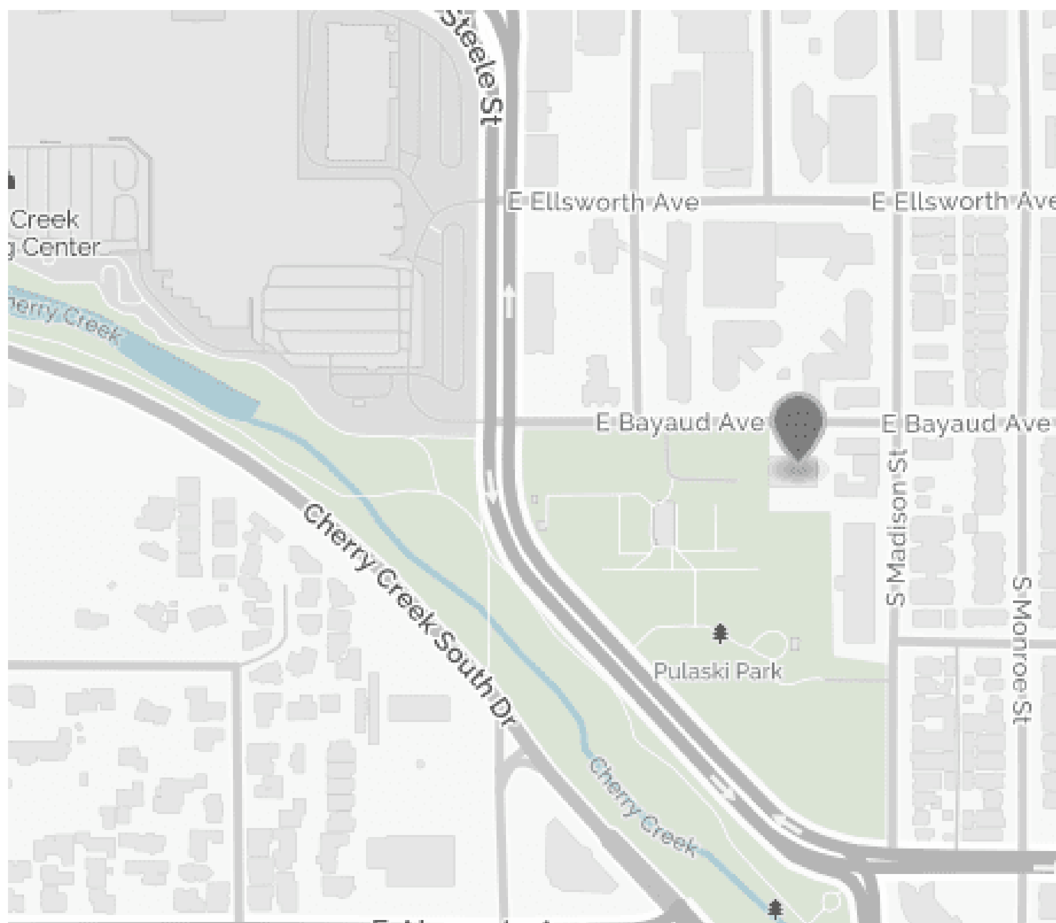
Signature: ________________________________ Date: ______________

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.