Coor Wellness

2140 N 12th St, Grand Junction, CO 81501

Phone: 970-712-6059

Patient Information:

Date		SSN		Birthday	
First Name		Middle Name		Last Name	
Sex	◯ Male ◯ Female	Height		Weight	
Married/Civil Union:		Spouse Name		# of Children	
Home #		Cell #		Work #	
Address					
City		State		Zip	
Emergency Contact		Emergency Relation		Emergency Phone	
Email					

Patient Social

Alcohol:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Caffeine:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Diet Food Products:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Drugs:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
OTC Stimulants:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Exercise:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Homemade Food:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Processed:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Soft Drinks:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never	Tobacco:	◯ Daily ◯ Weekly ◯ Occasionaly	◯ Never
Water:	◯ Daily	◯ Weekly	◯ Occasionaly	◯ Never			

Referral Information:

Referring Physician:		Referred Patient:		Referred by	
Advertisement:	◯ Yes ◯ No	Advertisement:			
Referred Directory:	◯ Yes ◯ No	Referred Directory:			

Chiropractic Experience:

Who referred you to our office: _____

Where did you hear about us? ☐ Newspaper ☐ Sign ☐ Yellow Pages ☐ Mailing ☐ Community Event ☐ Other _____

Have you been adjusted by a chiropractor before? ◯ Yes ◯ No If yes, Why? _____

Doctor's Name: _____ Approximate Date of Visit _____

Employer Information:

Employed:		Employer Name			
Employer Address:					
Employer City:		Employer State:		Employer Zip:	
Occupation:		Work Supervisor:		Supervisor #:	
Work Duties:					

Reason for this Visit:

Describe the reason for this visit?

When did this concern begin? _____ Has this concern: ○ Gotten Worse ○ Stayed Constant ○ Come and Gone

Does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Other Activities

Briefly Explain: _____

Has this concern occurred before? ○ Yes ○ No

Briefly Explain: _____

Have you seen other doctor's for this concern? ○ Yes ○ No Doctor's name: _____

Type of Treatment: _____

Complaint Information:

Injury Occurred: ○ Work ○ Automobile ○ Third-Party ○ Other Injury Date: _____

Injury Origin: _____

Desc Discomfort: _____

Interfere w/ Activities: ○ Yes ○ No Affected Sleep: ○ Yes ○ No Frequency: _____

Missed Work: ○ Yes ○ No Unable to Work from: _____ Unable to Work Until: _____

Affected Appetite: ○ Yes ○ No Explain: _____

Reduced Work: ○ Yes ○ No Explain: _____

Does it Worsen: ○ Yes ○ No Explain: _____

Weather Affects it: ○ Yes ○ No Explain: _____

Aggravates Condition: _____

Improves Condition: _____

Received Treatment: ○ Yes ○ No Explain: _____

X-rays Taken: ○ Yes ○ No Explain: _____

Pain level Rating - Scale 1 to 10: At its best: ____ At its Worst: ____ Current Level: ____

Same Condition Before: ○ Yes ○ No Date: _____ Practitioner: _____

Insurance Information:

Payment Name _____ Primary Phone # _____ Primary ID/Policy _____

Payment Address _____

Payment City _____ Payment State _____ Payment Zip _____

Primary Group # _____ Primary Name _____ Primary DOB _____

Secondary Name _____ Secondary Phone # _____ Secondary ID/Policy _____

Secondary Address _____

Secondary City _____ Secondary State _____ Secondary Zip _____

Secondary Group # _____ Secondary Name _____ Secondary DOB _____

Claim # _____ Claim Contact _____ Claim # _____

Attorney Name _____ Attorney Phone # _____

Goals for Your Care

People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ I want the Doctor to select the type of care appropriate for my condition

☐ Relief care: Symptomatic relief of pain or discomfort.

☐ Corrective care: Correcting and relieving the cause of the problem as well as the symptom

☐ Comprehensive care: Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic Care

Personal Health History

Last Physical Exam: _____ Primary Phys: _____ Phys Phone #: _____

Phys City: _____ Phys State: _____ Phys Zip: _____

Health Conditions: _____

Previous Chiro Care: ◯ Yes ◯ No Date: _____ Condition(s) treated: _____

Chance Pregnant: ◯ Yes ◯ No Planning: ◯ Yes ◯ No

Medications: _____

Supplements: _____

Personal Incident History:

Broken Bones: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Sprains/Strains: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Hospitalized: ◯ Yes ◯ No Explain: _____

Surgery: ◯ Yes ◯ No Explain: _____

Auto Accident: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Struck Unconscious: ◯ Yes ◯ No Treatment: ◯ Yes ◯ No Explain _____

Eating Disorder: ◯ Yes ◯ No Explain: _____

Stroke: ◯ Yes ◯ No Explain: _____

Health Checklist:

- [ ] Alcoholism
- [ ] Allergies
- [ ] Anemia
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Asthma
- [ ] Autoimmune Disease
- [ ] Back Pain
- [ ] Bleeding Disorders
- [ ] Breast Lump
- [ ] Bronchitis
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cataracts
- [ ] Chest Pain
- [ ] CHF
- [ ] Cold Extremities
- [ ] Constipation
- [ ] COPD/emphysema
- [ ] Cramps
- [ ] CVA (stroke/TIA)
- [ ] Dementia/Alzheimer's
- [ ] Depression
- [ ] Diabetes
- [ ] Diagnosed emotional/mental
- [ ] Digestion Problems
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Menstruation
- [ ] Eye Pain or Difficulties
- [ ] Fatigue
- [ ] Frequent Urination
- [ ] Gallbladder disease/stones
- [ ] Glaucoma
- [ ] Gout
- [ ] Headache
- [ ] Hemorrhoids
- [ ] High Blood Pressure
- [ ] Hot Flashes
- [ ] Irregular Heart Beat
- [ ] Irregular Menstrual Cycle
- [ ] Kidney Infection
- [ ] Kidney Stones
- [ ] Liver disease/cirrhosis
- [ ] Loss of Balance
- [ ] Loss of Memory
- [ ] Loss of Smell
- [ ] Loss of Taste
- [ ] Lung disease
- [ ] Macular Degeneration
- [ ] Migraines
- [ ] Nosebleeds
- [ ] Pacemaker
- [ ] Parkinson's
- [ ] Polio
- [ ] Poor Posture
- [ ] Prostate Trouble
- [ ] Retinal Disease
- [ ] Sciatica
- [ ] Seizures
- [ ] Shortness of Breath
- [ ] Sinus Infection
- [ ] Skin Sensitivity
- [ ] Sleep Problems/Insomnia
- [ ] Smoked
- [ ] Spinal Curvatures
- [ ] Stroke
- [ ] Swelling of Ankles
- [ ] Swollen Joints
- [ ] Thyroid Condition
- [ ] Tuberculosis
- [ ] Ulcers
- [ ] Varicose Veins
- [ ] Venereal Disease
- [ ] Other

_____

Have you had any of these Cardiovascular Diseases? Please select all that apply.

- [ ] Myocardial infarction
- [ ] Hypertension
- [ ] Hypercholesterolemia
- [ ] Bypass surgery
- [ ] Coronary artery disease

Do you have Diabetes? If so what type?

- ○ Type I
- ○ Type II
- ○ Juvenile

Do you have any stomach/digestive issues? Please select all that apply.

- [ ] Ulcers
- [ ] Reflux
- [ ] IBS

Family Health History:

Family Health History

EHR Information:

Pefered Language _____ Smoking Status _____ Smoking Start Date _____

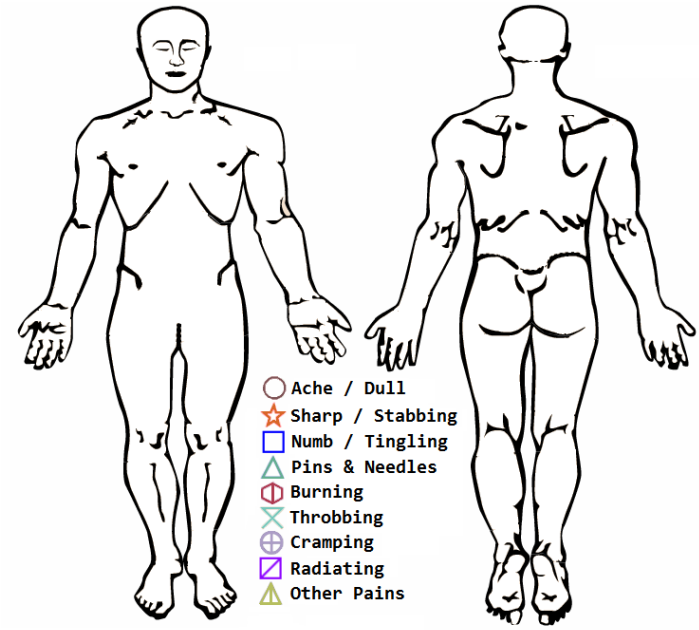
Ethinicty _____ Race _____

☐ I choose to decline receipt of my clinical summary after every visit

Current Medications And Dosage

Medication Allergies

Patient Symptoms:



Office PolicyWe do our best to keep a timely schedule and expect the same from our patients. A $25 fee is assessed for no-show appointments or for patients who do not call to cancel or reschedule at least 24 hours in advance. On average, for every appointment made on a specific day and time, 2 patients are turned down for that time slot. Please be respectful of CCMC's highly qualified professionals and their need to serve all patients. All bank services' fees associated with a "bounced check" are directly billed to the patient plus a $25 accounting fee. Consent to Office Policy, Treatment, Care and Treadmill Gait and Foot-Strike AnalysisI hereby agree to the Office Policy and I request and consent to the performance of medical services, examinations, chiropractic adjustments and other procedures (including various modes of physiotherapy, Active Release Techniques (A.R.T.) , massage, and diagnostic x-ray) on me (or the patient named below, for whom I am legally responsible for) by the doctors and staff of Colorado Chiropractic & Muscle Care, and/or other licensed clinic doctors or providers working at the clinic. I have had an opportunity to discuss with the doctor and/or with other office staff the nature and purpose of medical services and examinations, chiropractic adjustments, and other procedures. I authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I also understand my responsibility to inform this office of any changes in my medical status. I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of my treatment for my present condition and for any future condition(s) for which I seek treatment. I consent to treadmill gait and foot-strike analysis and assume all risks involved using a treadmill. I will ask for and accept instructions if I need help using the treadmill.

Signature _____ Date: _____