

My appointment date: _____ & Time: _____



Vital Information

Date: ___ / ___ / ___

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)

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? _____

➤ Are your injuries due to an accident? Yes / No If Yes, please explain: _____

➤ 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? _____
- 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) _____

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

➤ Rate your average quality of sleep. (poor) 1 2 3 4 5 6 7 8 9 10 (excellent)

➤ Do you exercise? What do you do and how often? _____

➤ 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? _____

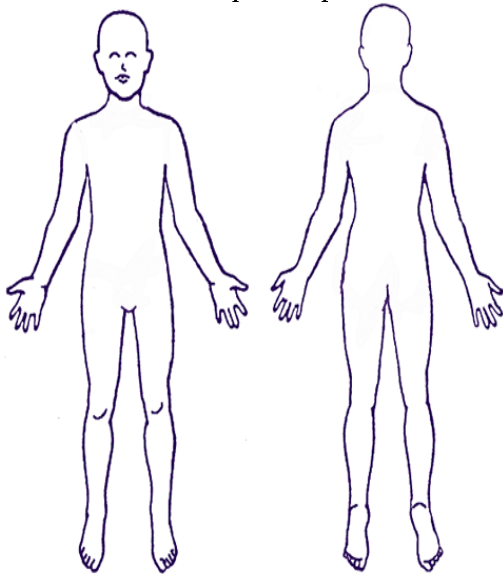
➤ Family relationship (i.e. Good, stressful, none) Why? _____

Symptoms/Conditions

PLEASE CHECK THE CONDITIONS OR SYMPTOMS THAT YOU EXPERIENCE:

- | | | |
|---|--|--|
| <input type="checkbox"/> Lack of Energy/ Fatigue
<input type="checkbox"/> Get upset, Irritated/Short Temper
<input type="checkbox"/> Lack ability to Concentrate
<input type="checkbox"/> Emotional Imbalance
<input type="checkbox"/> Hormonal Imbalance
<input type="checkbox"/> Cancer
<input type="checkbox"/> Weak Immune Function
<input type="checkbox"/> Difficulty falling asleep
<input type="checkbox"/> Runny Nose (not during a cold)
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Suffer from Headaches
<input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Allergies
<input type="checkbox"/> Asthma
<input type="checkbox"/> Chronic Chest Condition
<input type="checkbox"/> Painful Swelling in Joints
<input type="checkbox"/> Tension across Shoulders
<input type="checkbox"/> Pain in Legs or Arms
<input type="checkbox"/> Muscular Pain – Anywhere
Where? _____
<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Lower Back Pain
<input type="checkbox"/> Numbness /Tingling in body
Where? _____ | <input type="checkbox"/> Chest Pain
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Low Blood Pressure
<input type="checkbox"/> Digestive Problems/Pain
<input type="checkbox"/> Poor appetite
<input type="checkbox"/> Indigestion
<input type="checkbox"/> Heartburn
<input type="checkbox"/> Pain in the Lower Abdomen
<input type="checkbox"/> Poor Bowel Movements
<input type="checkbox"/> PMS
<input type="checkbox"/> Diminished or Frequent Urination
<input type="checkbox"/> 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?

➤ **Do you use prescription, over the counter and/or recreational drugs/medications?**

If yes, please list:

- ∴ TYPE: _____ Reason: _____ How Long? _____
- ∴ TYPE: _____ Reason: _____ How Long? _____
- ∴ TYPE: _____ Reason: _____ How Long? _____
- ∴ TYPE: _____ Reason: _____ How Long? _____
- ∴ TYPE: _____ Reason: _____ How Long? _____

Please attach a list of any others

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: _____

TERMS OF ACCEPTANCE

When one seeks chiropractic health care and is accepted for such care, it is essential for both doctor and patient to be working towards the same objective.

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it.

Adjustment: An adjustment is a procedure to facilitate the body's correction of vertebral subluxation. The chiropractic method of correction is by specific adjustments of the spine.

Health: A state of optimal physical, mental, and spiritual well being, not merely the absence of disease or infirmity.

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which produces pain and disease by interfering with normal nerve impulses traveling between the brain and body.

Chiropractors do not offer to diagnose or treat any disease or condition other than vertebral subluxation, nor do chiropractors offer advice regarding treatment prescribed by others.

By eliminating spinal subluxations, chiropractic improves the health of your spine and nervous systems. This restores your body's natural resistance to stress and disease. Many patients claim that they have more energy and less illness as a result of regular chiropractic care.

I, (print name) _____ have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction.

I therefore accept chiropractic care on this basis.

Signature: _____

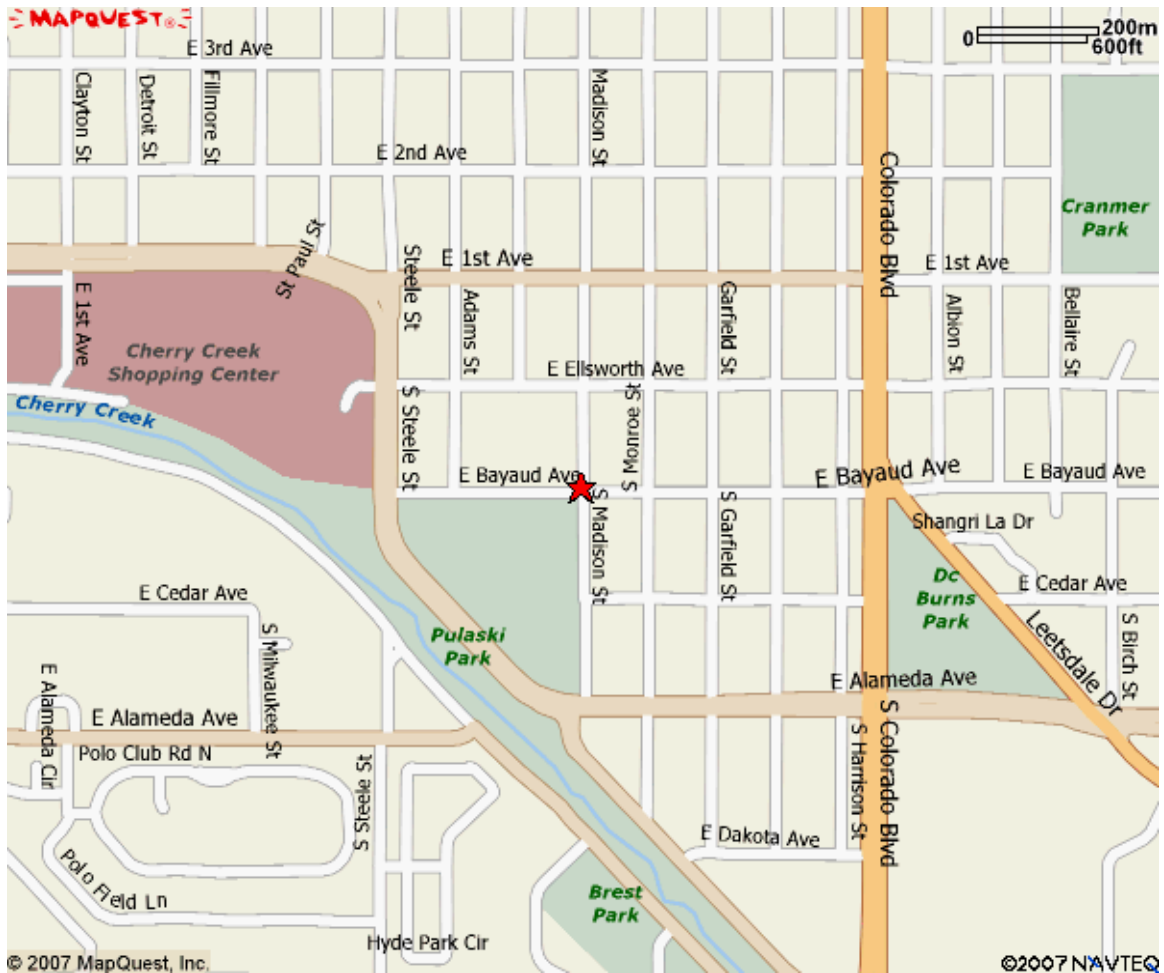
Date: _____

Directions to the Café of Life/Zone Healing Center in Cherry Creek

100 South Madison St Ste 1A

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 Madison St. We are at the intersection of Madison and Bayaud. Our building is on the left. The entrance and parking are behind the building. Our entrance is at the east end of the parking lot.

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. Turn left onto South Madison St. Our building is the first on the left. The entrance and parking are behind the building. Our entrance is at the east end of the parking lot.

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. Turn left on South Madison Street. Our building is the first on the left. The entrance and parking are behind the building. Our entrance is at the east end of the parking lot.