Chance Chiropractic Center
303-604-6164
chancechiropracticcenter.com

400 S. McCaslin Blvd. Suite 213 Louisville CO 80027

Date____________________

Patient:
Marital status: **Spouse:**
Date of Birth: **Gender:**
Emergency Contact and Phone #:
Address:
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For appointment reminders and office communication
Phone (Best number to reach you):
Work: Cell:

Occupation: **Years there:**

Email (Best email to reach you):
Would you prefer reminder appointment:
- ☐ Email
- ☐ Phone
- ☐ None

Referred by:
- ####☐ Family member
- ####☐ Friend
- ####☐ Social Media/Online

Patient Health History

Allergies: No ☐ Yes ☐ What kind?

Medication	Dosage	Strength

Date	Surgeries

Family History (deceased)

Relationship	Cause of Death

Date	Hospitalization or Injury

Social History

Smoking status: Yes ☐ No ☐ How many day? Never smoker ☐
Alcohol use: Yes ☐ No ☐ How many per week?
Caffeine use: Yes ☐ No ☐ How many per day?
Other drug use: Yes ☐ No ☐
Exercise: Yes ☐ No ☐ What kind?

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General Health Symptoms (check only YES):

	Current	Past	Notes
Are you wearing any foot supports? Custom?			
Have x-rays of your spine ever been taken? If "Yes", when and where?			
Anemia			
Cancer			
Chicken Pox			
Depression/nervousness			
Diabetes			
Difficulty breathing			
Dizziness			
Epilepsy			
Fainting			
Fatigue			
Gout			
Headaches			
Low back pain			
Loss of sleep			
Loss of weight			
Multiple sclerosis			
Muscle or ligament tears			
Neck pain or stiffness			
Numbness			
Pain between shoulder blades			
Pain when coughing			
Pain when sneezing			
Pain when swallowing			
Swollen glands			
Ulcers			
Weakness			
Weight gain			
Bruise easily			
Rashes			
Sores			
Asthma			
Colds			
Coughing			
Deafness			
Decreased sense of smell			
Difficulty Breathing			

	Current	Past	Notes
Earache			
Ear discharge			
Ear noises			
Eye pain			
Failing eyesight			
Lung problems			
Ringing in the ear			
Sinus infection			
Sinus trouble			
Thyroid trouble			
Wheezing			
Arthritis			
Bursitis			
Hernia			
Jaw/TMJ pain or problems			
Low back pain			
Neck pain or stiffness			
Pain between the shoulders			
Sciatica			
Swollen joints			
Arteriosclerosis (hardening of the arteries)			
Blood clots			
Chest pain/pressure			
Heart Disease			
Heart murmur			
High blood pressure			
Low blood pressure			
Out of breath with mild effort			
Palpitations			
Poor circulation			
Rapid heartbeat			
Swollen ankles or hands			
Varicose veins			
Abdominal pain			
Change in bowel movements			
Colitis or Colon trouble			
Constipation			
Diarrhea			
Digestive problems			
Distention of abdomen			

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	Current	Past	Notes
Gall bladder trouble			
Gas or belching			
Hemorrhoids			
Indigestion			
Jaundice/liver trouble			
Pain over stomach			
Pain when straining at stools			
Poor appetite			
Vomiting/nausea			
Bed wetting			
Frequent urination			
Inability to control bladder			
Kidney infection or stones			
Painful urination			
Urinary tract infection			
Urinating at night			
Pregnant			
Irregular cycles			
Birth control pills			
IUD			
Breast soreness			
Hysterectomy...			
last gynecological exam...			
Medication for your cycle...			
Menopause since...			
Pain on urination			
Difficulty starting urinary flow			
Prostate trouble			
Pain or numb shoulder			
Pain or numb arms			
Pain or numb elbows			
Pain or numb hands			
Pain or numb head			
Pain or numb hips			
Pain or numb leg			
Pain or numb knees			
Pain or numb feet			
Pain or numb tailbone			
Pain or numb other			

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Main Complaint Area(s): pick two maximumͳ ăLJŜŏĂŦè ǿKĂŏK ăĂŘŜ 2Ꞑ ĂŦ Ăǘă ōĂƒl·ǘŜꞐl·ƒ

Neck, headache, midback/chest/ribs, lower back, hips, knees, ankle, Shoulder, wrists, fingers, jaw, other

Location				
How long have you had pain?				
Type of Pain?	Sharp	Dull/Achy	Numb/Pins Needles	Burning
Is it worse:	Morning	As the Day Progresses	Evening	Sleeping
What makes it better?	Nothing	Activity/ Movement	Rest	Other
What makes it worse?	Nothing	Activity/ Movement	Rest	Other
Pain level range 1=least amount 10=most pain	Best	Worst	Notes	
Does your pain radiate?	Yes	No	Notes	
How often is the pain?	Constant	Frequent	Intermittent	Rarely
Numb	Yes	No	Notes	
Weak	Yes	No	Notes	

Details:

Location				
How long have you had pain?				
Type of Pain?	Sharp	Dull/Achy	Numb/Pins Needles	Burning
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How often is the pain?	Constant	Frequent	Intermittent	Rarely
Numb	Yes	No	Notes	
Weak	Yes	No	Notes	

Details:

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