Confidential Health Information

We appreciate your cooperation in photocopying your driver's license for our records. Your information is confidential, and we comply with all federal privacy standards. Please use pen, print clearly, complete all sections, and initial each page. Thank you.

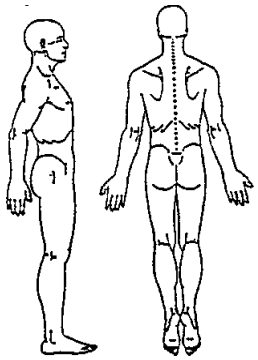
Barnes Chiropractic
Dr. Matthew Barnes, DC
Dr. Kelly Barnes, DC
7180 E. Orchard Rd. Ste 100
Centennial, CO 80111
720-985-0056
BarnesChiroColorado.com

Today's Date: _____ Have you consulted a chiropractor before? __Yes __No If so, whom? _____
Referred by: _____(name) __event(marketing/race) __internet/website __phone book __radio __mailing __other:_____
Your name: _____ Your social security number: _____-___-_____
Birthdate: _____ Age:__ Gender: M/F Race: _____ Preferred Language:_____
Address: _____ Marital status: _____
_____ Spouse/Significant Other:_____
Home Phone: _____ Cell Phone: _____ Child's name, age: _____
email address:_____ Child's name, age: _____
Emergency contact's name and phone number: _____ Child's name, age: _____
Occupation: _____ Work phone:_____ Child's name, age: _____
May we contact you at work? __Yes __No May we contact you by text message? __Yes __No
Preferred method of contact: __home phone __cell phone call __cell phone text message __work phone __email
Primary Care Provider's name and location: _____

1. The reasons or symptoms for which you are seeking care today: _____
_____

CONSULTATION NOTES

2. Are these the result of (check accordingly): __ accident or injury; please specify: __ work __ auto __ other
__ a worsening long-term problem
__ an interest in wellness
__ other: please specify: _____
3. Onset: when did you first notice your current symptoms?: _____
4. Intensity: rate your symptoms by circling one number: (no pain): 0 1 2 3 4 5 6 7 8 9 10: (worst pain imaginable)
5. Duration and timing: when did it start? _____ How often do you notice it? ___constant __comes and goes
6. Quality: how does it feel? _aching _burning _cramping _dull _nagging _numb _sharp _shooting _stabbing _stiff _throbbing _tingling other:_____
7. Location: circle the symptomatic areas on the illustration to the right.



8. Radiation/Traveling: where in your body does it travel, radiate, or shoot?
_____
9. Aggravating or relieving factors: what makes it better or worse? (such as time of day, movements, activities, etc.) Better: _____
Worse: _____
10. Prior interventions, treatment, etc:_____
_____
11. What else should Dr. Barnes know about your current condition? _____
_____
12. How does your current condition interfere with your:
work/career:_____ household responsibilities: _____
recreational activities: _____ personal relationships: _____

Patient's Initials ___

13. Review of Systems: Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've *had* or currently *have* and initial to the right.

CONSULTATION NOTES

a. Musculoskeletal

Osteoporosis		Arthritis		Scoliosis		Hip disorders		Knee injuries		Foot/ankle pain	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○

Neck pain		Back problems		Shoulder problems		Elbow/wrist pain		TMJ issues		Poor posture	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

Initials___

b. Neurological

Anxiety		Depression		Headache		Dizziness		Pins and needles		Numbness	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

c. Cardiovascular

High blood pressure		Low blood pressure		High cholesterol		Poor circulation		Angina		Excessive bruising	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

d. Respiratory

Asthma		Apnea		Emphysema		Hay fever		Shortness of breath		Pneumonia	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

e. Digestive

Anorexia /Bulimia		Ulcer		Food sensitivities		Heartburn		Constipation		Diarrhea	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

f. Sensory

Blurred vision		Ringing in ears		Hearing loss		Chronic ear infection		Loss of smell		Loss of taste	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

g. Skin

Skin cancer		Psoriasis		Eczema		Acne		Hair loss		Rash	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

h. Endocrine

Thyroid issues		Immune disorders		Frequent infection		Hypoglycemia		Swollen glands		Low energy	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

i. Genitourinary

Kidney stones		Infertility		Bedwetting		Prostate issues		Erectile dysfunction		PMS symptoms	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

j. Constitutional

Fainting		Low libido		Poor appetite		Fatigue		Sudden weight gain/loss		Weakness	
Had	Have	Had	Have	Had	Have	Had	Have	Had	Have	Had	Have
○	○	○	○	○	○	○	○	○	○	○	○

None ○
Initials ___

Patient's Initials ___

Past Personal, Family and Social History: Please identify your past health history, including accidents, injuries, illnesses & treatments.

PERSONAL

CONSULTATION NOTES

14. Illnesses: Check the illnesses you have *had* in the past or *have* now.

Had	Have		Had	Have	
O	O	AIDS	O	O	Malaria
O	O	Alcoholism	O	O	Measles
O	O	Allergies	O	O	Multiple Sclerosis
O	O	Arteriosclerosis	O	O	Mumps
O	O	Cancer	O	O	Polio
O	O	Chicken pox	O	O	Rheumatic fever
O	O	Diabetes	O	O	Scarlet fever
O	O	Epilepsy	O	O	Sexually transmitted disease
O	O	Glaucoma	O	O	Stroke
O	O	Goiter	O	O	Tuberculosis
O	O	Gout	O	O	Typhoid fever
O	O	Heart disease	O	O	Ulcer
O	O	Hepatitis	O	O	Other: _____
O	O	HIV positive	O	O	_____

15. Operations: with or without hospitalization

- O Appendix removal
- O Bypass surgery
- O Cancer
- O Cosmetic surgery
- O Elective surgery:_____
- O Eye surgery
- O Hysterectomy
- O Pacemaker
- O Spinal: _____
- O Tonsillectomy
- O Vasectomy
- O Other: _____

16. Injuries: have you ever:

- O Had a fractured or broken bone?
- O Had a spine or nerve disorder?
- O Been knocked unconscious?
- O Been injured in an accident?
- O Used a crutch or other support?
- O Used neck or back bracing?
- O Received a tattoo?
- O Had a body piercing?

17. Treatments: Check those you have had in the *past* or are receiving *currently*

Past	Currently		Past	Currently	
O	O	Acupuncture	O	O	Hormone replacement
O	O	Antibiotics	O	O	Inhaler
O	O	Birth control pills	O	O	Massage therapy
O	O	Blood transfusions	O	O	Medications (prescription or over-the counter):_____ _____
O	O	Chemotherapy			
O	O	Chiropractic care			
O	O	Dialysis	O	O	Nutritional supplements:_____ _____
O	O	Herbs			
O	O	Homeopathy	O	O	Physical therapy

18. FAMILY HISTORY: Some health issues are hereditary. Indicate the health of our immediate family members.

Relative	Age (if living)	State of health		Illnesses	Age of death	Cause of death	
		Good	Poor			Natural	illness
Mother	_____	O	O	_____	_____	O	O
Father	_____	O	O	_____	_____	O	O
Sister 1	_____	O	O	_____	_____	O	O
Sister 2	_____	O	O	_____	_____	O	O
Brother 1	_____	O	O	_____	_____	O	O
Brother 2	_____	O	O	_____	_____	O	O
_____	_____	O	O	_____	_____	O	O

19. Are there any other hereditary health issues of which you are aware? _____

Patient's Initials ___

20. SOCIAL HISTORY: Please tell Dr. Barnes about your health habits and stress levels.

CONSULTATION NOTES

darken applicable frequency:

Alcohol use	○Day	○ Week	○ Month	Amount: _____	Prayer or meditation?	○ Yes	○ No
Coffee use	○Day	○ Week	○ Month	Amount: _____	Job pressure/stress?	○ Yes	○ No
Tobacco use	○Day	○ Week	○ Month	Amount: _____	Financial peace?	○ Yes	○ No
Pain relievers	○Day	○ Week	○ Month	Amount: _____	Vaccinated?	○ Yes	○ No
Soft drinks	○Day	○ Week	○ Month	Amount: _____	Mercury fillings?	○ Yes	○ No
Water intake	○Day	○ Week	○ Month	Amount: _____	Recreational drugs?	○ Yes	○ No
Exercise	○Day	○ Week	○ Month	Amount: _____			
Hobbies	○Day	○ Week	○ Month	Amount: _____			

21. Activities of daily living: How does this current condition interfere with your ability to function?
Please state whether there is no effect, mild effect, moderate effect, or severe effect for each item:

a. Sitting:_____
b. Rising out of a chair:_____
c. Standing:_____
d. Walking:_____
e. Lying down:_____
f. Bending over:_____
g. Climbing stairs:_____
h. Using a computer:_____
i. Getting in/out of a car:_____
j. Driving a car:_____
k. Looking over shoulder:_____
l. Caring for family:_____
m. Grocery shopping:_____
n. Household chores:_____
o. Lifting objects:_____
p. Reaching overhead:_____
q. Showering or bathing:_____
r. Dressing self:_____
s. Love life:_____
t. Getting to sleep:_____
u. Staying asleep:_____
v. Concentrating:_____
w. Exercising:_____
x. Yard work:_____

22. What is the major stressor in your life?_____
23. How much sleep do you average per night? ____hours. 24. What is your preferred sleeping position? _____
25. What is the type and approximate age of your mattress and pillow? _____
26. Describe your typical eating habits: ○ skip breakfast ○ 2 meals per day ○ 3 meals per day ○ snacks
27. What would be the most significant thing you could do to improve your health? _____
_____
28. In addition to the main reason(s) for your visit today, what additional health goals do you have? _____
_____

Acknowledgements: To set clear communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials: ___I instruct the chiropractor(s) to deliver the care that, in his and/or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct subluxations. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.

initials:___ I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails, or health information as an extension of my care in this office.

initials:___ To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity, or cause of my health concern.

If the patient is a minor, please print child's full name: _____

_____ _____

Signature Date (MM/DD/YYYY)

Patient's Initials ___