PATIENT INFORMATION

Dr. Greg Justice, DC
9049 Forsstrom Dr., #102
Lone Tree, CO 80124
(720) 576-1236
www.lonetreewellness.com

Date: _____

Full Name: _____ Name You Prefer: _____

Address: _____ City/State/Zip: _____

Best Phone#: _____ Mobile Home Work

E-mail address: _____ Best way to contact you? Phone E-mail

Birth Date: _____/_____/_____ Age: _____ Sex: _____ Marital Status: S M W D Sep

Spouse's Name: _____

Your Employer: _____ Your Occupation: _____

INSURANCE—Please allow our staff to photocopy your current health insurance card(s)

Name of Insurance: _____ ID#: _____ Group#: _____

Name of Insured: _____ Insured's DOB: _____

Insured's Address: _____ City/State/Zip: _____

Insured's Employer: _____ Patient Relationship to Insured: _____

**Please notify the front desk if you have other insurance that you think may apply.*

MEDICAL HISTORY (please be complete)

List any surgeries (include dates & reason): _____

List any hospitalizations (include dates & reason): _____

List any auto accidents (include dates): _____

List any current or past major medical conditions you have had (cancer, diabetes, heart disease, arthritis, etc.): _____

_____

List all current over-the-counter and prescription medications used (include reason used): _____

_____

List any health conditions that run in your family (cancer, heart disease, diabetes, arthritis, back problems, etc.): _____

_____

Have you been under a physician's care in the past year? ❒ no ❒ yes (reason) _____

When was your last physical examination? _____ Dr: _____

Have you ever been under chiropractic care? ❒ no ❒ yes (describe) _____

If female, is there a possibility that you are pregnant? ❒ no ❒ yes

Do you smoke/use tobacco? ❒ no ❒ yes Exercise habits? ❒ never ❒ occasional ❒ frequent

HAVE YOU HAD <u>ANY</u> OF THE FOLLOWING:

NOW:

- ❒ Pain worse at night
- ❒ Constant pain
- ❒ Unexplained weight loss
- ❒ Recent bacterial infection (30 days)
- ❒ Loss of bowel or bladder control
- ❒ Recent surgery (30 days)

EVER:

- ❒ History of cancer
- ❒ History of IV drug use
- ❒ History of blood transfusion

CONFIDENTIAL CASE HISTORY FILE

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Check any of the following symptoms you have noticed: (❒ = Now, ❍ = Previously)

❒❍ Headaches
❒❍ Dizziness or light-headed
❒❍ Jaw pain, clicking, or locking
❒❍ Pain or difficulty swallowing
❒❍ Neck pain or stiffness
❒❍ Shoulder pain
❒❍ Mid back pain
❒❍ Chest pain or cough
❒❍ Pain/trouble breathing
❒❍ Arm/hand numbness/tingling
❒❍ Arm/hand fatigue/weakness
❒❍ Low back pain
❒❍ Leg/foot numbness/tingling
❒❍ Leg/foot fatigue/weakness
❒❍ Leg pain with walking
❒❍ Nausea or vomiting
❒❍ Diarrhea or constipation
❒❍ Blood in urine or stool
❒❍ Difficulty or pain w/ urination
❒❍ Difficulty with sexual function
❒❍ Abnormal menstrual periods
❒❍ Abdominal pain
❒❍ Sensitive to light or sound
❒❍ Visual or hearing disturbance
❒❍ Memory loss/problems
❒❍ Irritability or depression
❒❍ Fatigue or loss of energy
❒❍ Fainting or convulsions
❒❍ Trouble with balance or coordination
❒❍ Sleep disturbances/problems
❒❍ Rashes (face, body, limbs)
❒❍ Joint pain or swelling
❒❍ Pain with exertion (climbing stairs, etc.)

What is your primary complaint / problem? _____

List other symptoms: _____

When did your symptoms first begin (give date if possible)? _____

How did your symptoms first begin? _____

Pain is: ❒ Constant ❒ Intermittent Is your condition getting worse? _____

What words best describe your present condition? (ex. ache, stabbing, burning) _____

Circle the number that matches your level of pain at its worst (0 = No Pain, 10 = Most Severe)

0 1 2 3 4 5 6 7 8 9 10

What activities aggravate your condition? (list) _____

What activities lessen your symptoms? (list) _____

List *all* Doctors/therapists/specialists seen for this problem & treatment given (use back of page if necessary):

1._____

2._____

3._____

Have you had: ❒ Xray ❒ MRI or CAT Scan ❒ EMG ❒ Bone Scan ❒ Blood Work

Who is your family medical doctor? _____

List all home remedies tried for this problem: _____

Is your condition worse at certain times of the day or night? _____

Does your condition interfere with: (yes/no) work_____ sleep_____ normal daily routine _____

Have you had symptoms like this before? ❒ no ❒ yes (describe) _____

Is your condition related to an accident? ❒ NO ❒ YES

Date of accident: _____ Type: ❒ Auto ❒ Work ❒ Other _____

Referred by: _____

- I authorize payment of medical benefits to this office.
- I will allow this office to treat me, with other health care providers present, and to record my medical information, including consultation and examination, for documentation purposes, if necessary.
- Authorization may be denied or retracted by notifying the office manager.
- I acknowledge having the right to review and obtain a copy of the Notice of Privacy Practices of this office. (Once information is disclosed, it may not be protected by law.)
- This office automatically sends appointment reminders via text and email.

Patient's Signature: _____ Date: _____

Guardian's Signature (if applicable): _____ Date: _____

PAIN DRAWING

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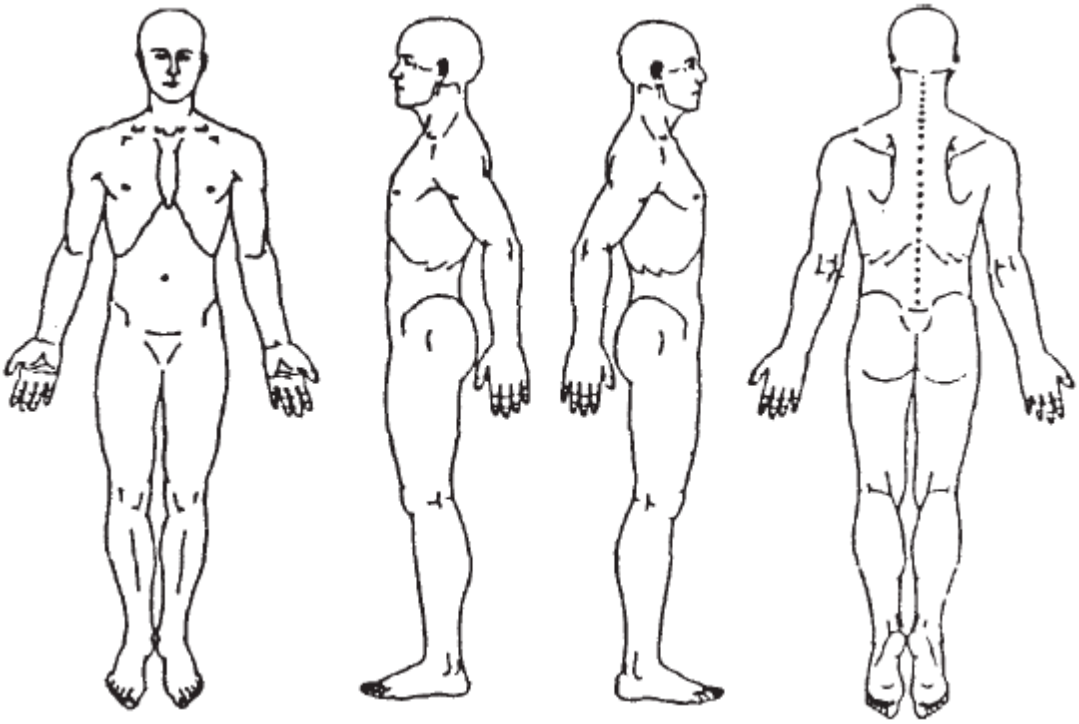
Name: _____ Date: _____

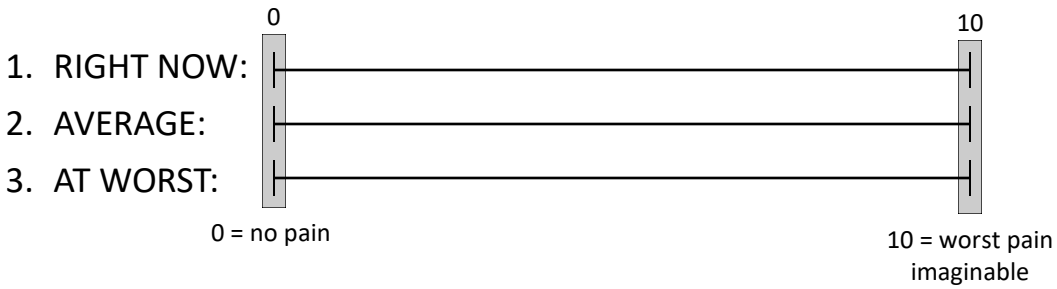
Draw the area of your symptoms using these symbols:
(mark on the figures)

XXX = ache
✶✶ = sharp/stab
○○ = numb/tingle
⟶ = shooting
/ / / = stiff/tight



Regarding your main complaint:

How bad is your pain?
(make a slash on all 3 scales)



Additional Comments:

_____

_____

_____

Informed Consent for Chiropractic Care

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When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

_____ _____ _____

Print Name Signature Date

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

_____ _____

Signature Date