ULTIMATE HEALTH
Medical Clinic

Ultimate Health Medical Clinic
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Littleton, CO 80123
(303) 904-0331
www.uhmedical.com

CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details. All information you supply is confidential. We comply with all federal privacy statements. Please print clearly.

Today's Date (MM/DD/YYYY) _____ **Whom may we thank for referring you?** _____ **Patient Number (office use only)** _____

Your Personal Info

Your Last Name _____ **Your Social Security Number** _____

Your First Name _____ **Your Middle Name (or Initial)** _____

Address _____

City _____ **State/Province** _____ **ZIP** _____

Cell Phone _____ **Home Phone** _____

Email Address _____

Preferred method of contact? ○ Call ○ Text ○ Email

Age _____ **Birth Date (MM/DD/YYYY)** _____ **Gender** ○ Male ○ Female

Marital Status
○ Single ○ Married ○ Separated
○ Divorced ○ Widowed

Ethnicity
○ Hispanic of Latino
○ Not Hispanic or Latino
○ Decline to specify

Smoking Status
(age 13 and over)
○ Never a Smoker
○ Former Smoker
○ Current Every Day Smoker
○ Current Some Day Smoker
○ Heavy Smoker
○ Light Smoker

Race
○ American Indian
○ Alaskan Native
○ Asian
○ Black or African American
○ Native Hawaiian
○ Other Pacific Islander
○ White
○ Decline to answer

Preferred Language _____

I.C.E

Emergency Contact _____ **Relationsip to Patient** _____ **Emergency Contact's Phone** _____

Work

Your Occupation _____ **Your Employer** _____ **Work Phone** _____

Address _____

Insurance

Insurance Carrier _____ **Policy Number** _____

Who Carries this Policy?
○ Self ○ Spouse
○ Parent ○ Other

Is this appointment auto or work accident related? ○ Yes ○ No

Incident Date: (MM/DD/YYYY) _____

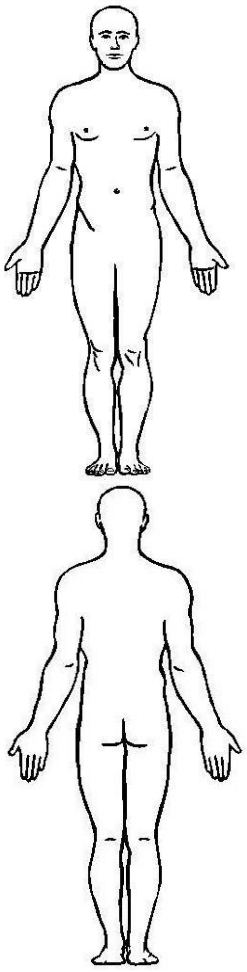
In your own words, please describe the incident_____

_____

Please describe your Primary Complaint in the space below.
Use the Secondary and Additional Complaint boxes if they apply.

Primary Complaint The primary symptom that prompted me to seek care today is:_____ _____	**Secondary Complaint** The primary symptom that prompted me to seek care today is:_____ _____	**Additional Complaint** The primary symptom that prompted me to seek care today is:_____ _____
And are the result of: ○ An auto accident or injury ○ Work accident or injury ○ A worsening long-term problem ○ Other_____	**And are the result of:** ○ An auto accident or injury ○ Work accident or injury ○ A worsening long-term problem ○ Other_____	**And are the result of:** ○ An auto accident or injury ○ Work accident or injury ○ A worsening long-term problem ○ Other_____
Onset (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____	**Onset** (When did you first notice your current symptoms?) _____
Prior Interventions (What have you done to relieve the symptoms?) ○ Prescription medication ○ Over-the-counter drugs ○ Acupuncture ○ Chiropractic ○ Massage ○ Physical therapy ○ Surgery ○ Ice ○ Heat ○ Other_____	**Prior Interventions** (What have you done to relieve the symptoms?) ○ Prescription medication ○ Over-the-counter drugs ○ Acupuncture ○ Chiropractic ○ Massage ○ Physical therapy ○ Surgery ○ Ice ○ Heat ○ Other_____	**Prior Interventions** (What have you done to relieve the symptoms?) ○ Prescription medication ○ Over-the-counter drugs ○ Acupuncture ○ Chiropractic ○ Massage ○ Physical therapy ○ Surgery ○ Ice ○ Heat ○ Other_____

Location
(Where does it hurt?) Circle the area(s) on the illustration. "0" for current conditions "X" for conditions experienced in the past



1. What else should we know about your current condition?

_____

_____

2. How does your current condition interfere with your:

Work or career: _____.

Recreational activities: _____.

Household responsibilities: _____.

Personal relationships: _____.

3. Review of Systems

Chiropractic care focuses on the integrity of our 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.

a. Musculoskeletal

Had Have	Had Have	Had Have	Had Have	
○ ○ Osteoporosis	○ ○ Arthritis	○ ○ Scoliosis	○ ○ Neck Pain	○ None of these
○ ○ Knee Injuries	○ ○ Foot/Ankle Pain	○ ○ Shoulder Problem	○ ○ Elbow/Wrist Pain	
○ ○ Back Problems	○ ○ TMJ Issues	○ ○ Hip Disorders	○ ○ Poor Posture	Patient Initials_____

b. Neurological

Had Have	Had Have	Had Have	Had Have	
○ ○ Anxiety	○ ○ Depression	○ ○ Headache	○ ○ Dizziness	○ None of these
○ ○ Pins and Needles	○ ○ Numbness			Patient Initials_____

c. Cardiovascular

Had Have	Had Have	Had Have	Had Have	
○ ○ High Blood Pressure	○ ○ Low Blood Pressure	○ ○ High Cholesterol	○ ○ Poor Circulation	○ None of these
		○ ○ Angina	○ ○ Excessive Bruising	Patient Initials_____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Asthma	○	○	Apnea	○	○	Shortness of Breath	○	○	Emphysema	○ None of these
○	○	Pneumonia	○	○	Hay Fever							Patient Initials_____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Anorexia/Bulimia	○	○	Ulcer	○	○	Food Sensitivities	○	○	Heartburn	○ None of these
○	○	Constipation	○	○	Diarrhea							Patient Initials_____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Blurred Vision	○	○	Ringing in Ears	○	○	Chronic Ear Infection	○	○	Hearing Loss	○ None of these
○	○	Loss of Smell	○	○	Loss of Taste							Patient Initials_____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Skin Cancer	○	○	Psoriasis	○	○	Eczema	○	○	Acne	○ None of these
○	○	Hair Loss	○	○	Rash							Patient Initials_____

h. Endocrine

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Thyroid Issues	○	○	Immune Disorders	○	○	Hypoglycemia	○	○	Frequent Infection	○ None of these
○	○	Swollen Glands	○	○	Low Energy							Patient Initials_____

i. Genitourinary

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Kidney Stones	○	○	Infertility	○	○	Erectile Dysfunction	○	○	Prostate Issues	○ None of these
○	○	Bedwetting	○	○	PMS Symptoms							Patient Initials_____

j. Constitutional

Had	Have		Had	Have		Had	Have		Had	Have		
○	○	Fainting	○	○	Low Libido	○	○	Sudden Weight Gain/Loss (Circle one)	○	○	Poor Appetite	○ None of these
○	○	Fatigue	○	○	Weakness							Patient Initials_____

Past Personal, Family and Social history

Please identify your past history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

Personal

4. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have	
○	○	AIDS
○	○	Alcoholism
○	○	Allergies
○	○	Arteriosclerosis
○	○	Cancer
○	○	Chicken Pox
○	○	Diabetes
○	○	Epilepsy
○	○	Glaucoma
○	○	Goiter
○	○	Gout
○	○	Heart Disease
○	○	Hepatitis
○	○	HIV Positive
○	○	Malaria
○	○	Measles
○	○	Multiple Sclerosis
○	○	Mumps
○	○	Polio
○	○	Rheumatic Fever
○	○	Scarlet Fever
○	○	Sexually Transmitted Disease
○	○	Stroke
○	○	Tuberculosis
○	○	Typhoid Fever
○	○	Ulcer
○	○	Other:_____

_____

7. Allergies

Are you allergic to any medications?

Yes	No
○	○

If yes, please list: _____

_____

_____

5. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix Removal
- ○ Bypass Surgery
- ○ Cancer
- ○ Cosmetic Surgery
- ○ Elective Surgery:_____ _____
- ○ Eye Surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine:_____ _____ _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other:_____ _____

8. Injuries

Darken the circle is you have ever…

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other supports
- ○ Received a tattoo
- ○ Had a body piercing

6. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Current	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth Control Pills
○	○	Blood Transfusions
○	○	Chemotherapy
○	○	Chiropractic Care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone Replacement
○	○	Inhaler
○	○	Massage Therapy
○	○	Physical Therapy
○	○	Medications (Please list below all prescription, other-the-counter, natural supplements, enzymes, vitamins and minerals):_____

_____

_____

_____

9. Family History

Some health issues are hereditary, let us know about the health of your immediate family members.

Family

Relative	Age (if living)	State of Health: Good	State of Health: Poor	Illnesses	Age at Death (if dead)	Cause of Death: Natural	Cause of Death: Illness
Mother		○	○			○	○
Father		○	○			○	○
Sister 1		○	○			○	○
Sister 2		○	○			○	○
Brother 1		○	○			○	○
Brother 2		○	○			○	○
		○	○			○	○

10. Are there any other hereditary health issues that you know about? _____

_____

11. Social History

Tell us about your health habits and stress levels

Social

Alcohol use	○ Daily	○ Weekly	How Much?_____	Job pressure/stress?	○ Yes ○ No
Coffee use	○ Daily	○ Weekly	How Much?_____	Financial peace?	○ Yes ○ No
Tobacco use	○ Daily	○ Weekly	How Much?_____	Vaccinated?	○ Yes ○ No
Exercising	○ Daily	○ Weekly	How Much?_____	Mercury fillings?	○ Yes ○ No
Pain relievers	○ Daily	○ Weekly	How Much?_____	Recreational drugs?	○ Yes ○ No
Soft drinks	○ Daily	○ Weekly	How Much?_____		
Water intake	○ Daily	○ Weekly	How Much?_____		

Hobbies: _____

12. Activities of Daily Living

How does your current condition interfere with your life and ability to function?

Please mark an "x" on the line how to indicate how severe the effect is.

Sitting	**None----------Severe**	Grocery shopping	**None----------Severe**
Rising out of chair	**None----------Severe**	Household chores	**None----------Severe**
Standing	**None----------Severe**	Lifting objects	**None----------Severe**
Walking	**None----------Severe**	Reaching overhead	**None----------Severe**
Lying down	**None----------Severe**	Showering or bathing	**None----------Severe**
Bending over	**None----------Severe**	Dressing myself	**None----------Severe**
Climbing stairs	**None----------Severe**	Love life	**None----------Severe**
Using a computer	**None----------Severe**	Getting to sleep	**None----------Severe**
Getting in/out of a car	**None----------Severe**	Staying asleep	**None----------Severe**
Driving a car	**None----------Severe**	Concentration	**None----------Severe**
Looking over shoulder	**None----------Severe**	Exercising	**None----------Severe**
Caring for family	**None----------Severe**	Yard work	**None----------Severe**
Other:_____	**None----------Severe**	Other:_____	**None----------Severe**

13. What makes you stressed?_____ **14. How many hours do you sleep per night?**_____

15. What is the type and approximate age of your mattress and pillow? _____

16. What is your sleeping position? _____

17. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snack between meals

18. What would be the most significant thing that you could do to improve your health? _____

_____

19. In addition to the main reason for your visit today, what additional health goals do you have? _____

_____

Acknowledgements

To set clear expectations, improve 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 chiropractic doctors to deliver the care that, in his 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 vertebral subluxation. Chiropractic is a separate and distinct healing form of medicine and does not proclaim to cure any named disease or entity.

Initials_____ I realize that Ultimate Health Medical Clinic requires all payments, co-payments and co-insurance amounts at the time of service. Should a payment not be made at the time of service, payment is due as soon as possible. Should any outstanding balances remain after 30 days from the date of service, a late payment fee will be assessed.

Initials_____ I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive. I am also responsible for providing Ultimate Health Medical Clinic with accurate insurance information and for obtaining any necessary referrals. Should I experience any changes in my insurance it is my responsibility to promptly present the new information to Ultimate Health Medical Clinic.

Initials_____ I realize that an x-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period(MM/DD/YYYY)_____

Initials_____ I grant permission to be called to confirm or reschedule appointments and to be sent occasional cards, letters, emails or health information to me 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.

I have read a copy of the Privacy Policy (HIPPA) and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties. I acknowledge that I have received or have been given the opportunity to receive a copy Ultimate Health Medical Clinic's Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient or Guardian Signature Date

Office use only: We have made the attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices.

Date:_____ Staff Name:_____ Staff Signature:_____