

CONFIDENTIAL
HEALTH INFORMATION

Whalen Chiropractic Clinic, PC

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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 standards.
Please print clearly.

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?

Patient Number (office use only)

Whom may we thank for referring you?

No Yes

When?

If so, whom?

Age

Gender

Male Female

Race

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

Ethnicity

Hispanic or Latino
 Not Hispanic or Latino
 Decline to specify

Birth Date (MM/DD/YYYY)

Your Last Name

Smoking Status (age 13 and over)

Never A Smoker Former Smoker
 Current Every Day Smoker Current Some Day Smoker
 Heavy Smoker Light Smoker

Your First Name

Your Middle Name (or Initial)

Address

Marital Status Married

Single Divorced

Widowed Separated

Preferred Language

City

State/Province

ZIP/Postal Code

Home Phone

Cell Phone

Spouse's Name

Email Address

Child's Name and Age

Emergency Contact

Emergency Contact's Phone

Child's Name and Age

Your Occupation

Child's Name and Age

Your Employer

Work Phone

Address

May we contact you at work?

Yes No

Preferred method of contact?

Home Phone Cell Phone
 Work Phone Email

City

State/Province

ZIP/Postal Code

Primary Care Provider's Name

Insurance Carrier

Policy Number

Insured's Last Name

Birth Date (MM/DD/YYYY)

Who carries this policy?

Self Spouse Parent

Insured's First Name

Insured's Middle Name (or Initial)

Insured's Employer

Address

City

State/Province

ZIP/Postal Code

Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

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: _____

And are the result of (darken circle):

An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Secondary Complaint

The secondary symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Additional Complaint

The additional symptom that prompted me to seek care today is: _____

And are the result of (darken circle):

An accident or injury
 Work Auto Other _____

A worsening long-term problem
 An interest in: Wellness Other _____

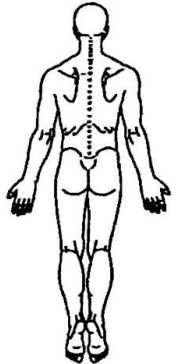
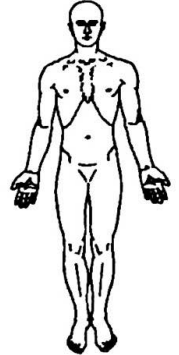
Onset (When did you first notice your current symptoms?) _____

Prior interventions (What have you done to relieve the symptoms?)

- Prescription medication Acupuncture
- Over-the-counter drugs Chiropractic
- Homeopathic remedies Massage
- Physical therapy Ice
- Surgery Heat
- Other _____

Location

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



1. What else should Dr. Whalen 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 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.

- a. Musculoskeletal**
 Had Have Osteoporosis Had Have Arthritis Had Have Scoliosis Had Have Neck pain Had Have Back problems Had Have Hip disorders NONE
 Knee injuries Foot/ankle pain Shoulder problems Elbow/wrist pain TMJ issues Poor posture Initials _____
- b. Neurological**
 Had Have Anxiety Had Have Depression Had Have Headache Had Have Dizziness Had Have Pins and needles Had Have Numbness NONE
 Initials _____
- c. Cardiovascular**
 Had Have High blood pressure Had Have Low blood pressure Had Have High cholesterol Had Have Poor circulation Had Have Angina Had Have Excessive bruising NONE
 Initials _____
- d. Respiratory**
 Had Have Asthma Had Have Apnea Had Have Emphysema Had Have Hay fever Had Have Shortness of breath Had Have Pneumonia NONE
 Initials _____
- e. Digestive**
 Had Have Anorexia/bulimia Had Have Ulcer Had Have Food sensitivities Had Have Heartburn Had Have Constipation Had Have Diarrhea NONE
 Initials _____
- f. Sensory**
 Had Have Blurred vision Had Have Ringing in ears Had Have Hearing loss Had Have Chronic ear infection Had Have Loss of smell Had Have Loss of taste NONE
 Initials _____
- g. Skin**
 Had Have Skin cancer Had Have Psoriasis Had Have Eczema Had Have Acne Had Have Hair loss Had Have Rash NONE
 Initials _____

 Patient name

 Patient Number (office use only)

 Doctor's Initials

Whalen Chiropractic Clinic, PC
 Dr. Mary A. Whalen

(Continued from previous page)

h. Endocrine

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

NONE
Initials _____

i. Genitourinary

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

NONE
Initials _____

j. Constitutional

- Had Have Fainting
- Had Have Low libido
- Had Have Poor appetite
- Had Have Fatigue
- Had Have Sudden weight gain/loss (circle one)
- Had Have Weakness

NONE
Initials _____

Patient name _____

Patient Number (office use only) _____

All other systems negative

Past Personal, Family and Social History

Please identify your past health 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 <input type="radio"/> | Have <input type="radio"/> | AIDS | Had <input type="radio"/> | Have <input type="radio"/> | Tuberculosis |
| <input type="radio"/> | <input type="radio"/> | Alcoholism | <input type="radio"/> | <input type="radio"/> | Typhoid fever |
| <input type="radio"/> | <input type="radio"/> | Allergies | <input type="radio"/> | <input type="radio"/> | Ulcer |
| <input type="radio"/> | <input type="radio"/> | Arteriosclerosis | <input type="radio"/> | <input type="radio"/> | Other: _____ |
| <input type="radio"/> | <input type="radio"/> | Cancer | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Chicken pox | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Diabetes | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Epilepsy | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Glaucoma | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Goiter | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Gout | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Heart disease | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Hepatitis | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | HIV Positive | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Malaria | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Measles | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Multiple Sclerosis | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Mumps | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Polio | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Rheumatic fever | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Scarlet fever | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Sexually transmitted disease | _____ | _____ | _____ |
| <input type="radio"/> | <input type="radio"/> | Stroke | _____ | _____ | _____ |

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: _____

6. Treatments

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

- | Past | Currently | |
|-----------------------|-----------------------|---------------------|
| <input type="radio"/> | <input type="radio"/> | Acupuncture |
| <input type="radio"/> | <input type="radio"/> | Antibiotics |
| <input type="radio"/> | <input type="radio"/> | Birth control pills |
| <input type="radio"/> | <input type="radio"/> | Blood transfusions |
| <input type="radio"/> | <input type="radio"/> | Chemotherapy |
| <input type="radio"/> | <input type="radio"/> | Chiropractic care |
| <input type="radio"/> | <input type="radio"/> | Dialysis |
| <input type="radio"/> | <input type="radio"/> | Herbs |
| <input type="radio"/> | <input type="radio"/> | Homeopathy |
| <input type="radio"/> | <input type="radio"/> | Hormone replacement |
| <input type="radio"/> | <input type="radio"/> | Inhaler |
| <input type="radio"/> | <input type="radio"/> | Massage therapy |
| <input type="radio"/> | <input type="radio"/> | Physical therapy |
| <input type="radio"/> | <input type="radio"/> | Medications |

(Please list below all prescription, over-the-counter, natural supplements, enzymes, vitamins and minerals): _____

8. Injuries

Have you 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 support
- Used neck or back bracing
- Received a tattoo
- Had a body piercing

9. Family History

Some health issues are hereditary. Tell Dr. Whalen about the health of your immediate family members.

FAMILY

Relative	Age (if living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Father	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Sister 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 1	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>
Brother 2	_____	<input type="radio"/>	<input type="radio"/>	_____	_____	<input type="radio"/>	<input type="radio"/>

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

11. Social History

Tell Dr. Whalen about your health habits and stress levels.

- | | | | |
|---|-----------------|-----------------------|--|
| Alcohol use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Prayer or meditation? | <input type="radio"/> Yes <input type="radio"/> No |
| Coffee use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Job pressure/stress? | <input type="radio"/> Yes <input type="radio"/> No |
| Tobacco use <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Financial peace? | <input type="radio"/> Yes <input type="radio"/> No |
| Exercising <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Vaccinated? | <input type="radio"/> Yes <input type="radio"/> No |
| Pain relievers <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Mercury fillings? | <input type="radio"/> Yes <input type="radio"/> No |
| Soft drinks <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | Recreational drugs? | <input type="radio"/> Yes <input type="radio"/> No |
| Water intake <input type="radio"/> Daily <input type="radio"/> Weekly | How much? _____ | | |
| Hobbies: _____ | | | |

SOCIAL

Consultation Notes

Doctor's Initials _____

Whalen Chiropractic Clinic, PC
Dr. Mary A. Whalen

12. Activities of Daily Living

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

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rising out of chair	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Standing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lying down	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bending over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using a computer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting in/out of car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Driving a car	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Looking over shoulder	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Caring for family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Household chores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lifting objects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Reaching overhead	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Showering or bathing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dressing myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Love life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting to sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staying asleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exercising	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Yard work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Patient name

Patient Number
(office use only)

13. What is the major stressor in your life? _____ 14. How much sleep do you average per night? _____ Hours
15. What is the type and approximate age of your mattress and pillow? _____ 16. What is your preferred sleeping position? _____
17. Describe your typical eating habits: Skip breakfast Two meals a day Three meals a day Snacking 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? _____

Consultation Notes

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 chiropractor to deliver the care that, in his or her professional judgement, 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 art from medicine and does not proclaim to cure any named disease or entity.

Initials _____ I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

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 an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

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.

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.

Patient (or Guardian's) signature

Date (MM/DD/YYYY)

Doctor's Initials
Whalen Chiropractic Clinic, PC
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