

# UPDATED CONTACT INFORMATION

Whalen Chiropractic Clinic, PC  
Dr. Mary A. Whalen  
Fort Collins, Colorado  
Ph: 970-493-7340  
Fax: 970-416-1746  
mary@maryawhalenc.com  
www.maryawhalenc.com

Please fill in your name and other demographic information that may need to be changed or updated in our files.

Today's Date (MM/DD/YYYY)

Patient Number (office use only)

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

Your Social Security Number

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

City

State/Province

ZIP/Postal Code

Preferred Language

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

City

State/Province

ZIP/Postal Code

Preferred method of contact?

Home Phone  Cell Phone  
 Work Phone  Email

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

I certify that any changes to my personal information have been updated above for your records.

Signature

UPDATED CONTACT INFORMATION

# UPDATED PATIENT HISTORY

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I have new contact information

Today's Date (MM/DD/YYYY) \_\_\_\_\_

Patient Number  
(office use only)

Your Last Name \_\_\_\_\_

Your First Name \_\_\_\_\_

Your Middle Name (or Initial) \_\_\_\_\_

**Please select one:**

- Progress evaluation** – I've been under active care and this is a periodic reevaluation.     **New condition** – I've been under care and a new or returning condition has emerged.  
 **Maintenance patient** – I'm under maintenance care with a new or returning health issue.     **Returning patient** – After a period of inactivity, I've had a relapse or an all-new health issue.

**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 \_\_\_\_\_

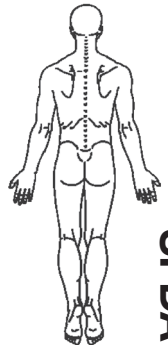
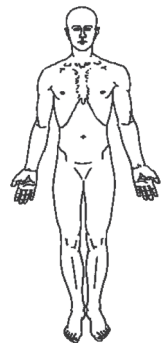
**Onset** (When did you first notice your current symptoms?) \_\_\_\_\_

**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.  
 "0" for current condition  
 "X" for conditions experienced in the past



**1. Review of systems** (Identify any changes since your most recent evaluation with us):

- |   | Worse                 | No Change             | Improved              |
|---|-----------------------|-----------------------|-----------------------|
| <b>a. Musculoskeletal System</b> – Such as osteoporosis, arthritis, neck pain, back problems, poor posture, etc.          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>b. Neurological System</b> – Such as anxiety, depression, headache, dizziness, pins and needles, numbness, etc.        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>c. Cardiovascular System</b> – Such as high blood pressure, low blood pressure, high cholesterol, angina, etc.         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>d. Respiratory System</b> – Such as asthma, apnea, emphysema, hay fever, shortness of breath, pneumonia, etc.          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>e. Digestive System</b> – Such as anorexia/bulimia, ulcer, food sensitivities, heartburn, constipation, diarrhea, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>f. Sensory System</b> – Such as blurred vision, ringing in ears, hearing loss, chronic ear infection, etc.             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>g. Skin System</b> – Such as skin cancer, psoriasis, eczema, acne, hair loss, rash, etc.                               | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>h. Endocrine System</b> – Such as thyroid issues, immune disorders, hypoglycemia, frequent infection, etc.             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>i. Genitourinary System</b> – Such as kidney stones, infertility, bedwetting, prostate issues, PMS symptoms, etc.      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <b>j. Constitutional System</b> – Such as fainting, low libido, poor appetite, fatigue, sudden weight, weakness, etc.     | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

**UPDATED PATIENT HISTORY**

Doctor's Initials \_\_\_\_\_

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**2. Illnesses, operations, injuries or treatments since your most recent evaluation with us:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Medications (please list all prescription and over-the-counter):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4. 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: _____	

**5. 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"/>	Grocery shopping _____
Rising out of chair _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Household chores _____
Standing _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lifting objects _____
Walking _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Reaching overhead _____
Lying down _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Showering or bathing _____
Bending over _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dressing myself _____
Climbing stairs _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Love life _____
Using a computer _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Getting to sleep _____
Getting in/out of car _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Staying asleep _____
Driving a car _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Concentrating _____
Looking over shoulder _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Exercising _____
Caring for family _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Yard work _____

**6. Is there anything else Dr. Whalen should know about your current condition, your progress or ways your current condition is affecting your life?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Patient name

\_\_\_\_\_  
Patient Number  
(office use only)

Consultation Notes

\_\_\_\_\_  
Patient (or Guardian's) signature

\_\_\_\_\_  
Date (MM/DD/YYYY)

\_\_\_\_\_  
Doctor's Initials

**UPDATED PATIENT HISTORY**