

ABOUT THE PATIENT

Chris E. Cembalistry D.C., P.C
 1036 N. 4th Street, Grand Junction, CO 81501
 970-256-7604

Name _____ Today's Date _____ Birthdate _____ Age _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Cell Phone _____ Work Phone _____ Gender M F
 Significant Other's Name _____ Social Security Number _____ - _____ - _____
 Single Married Widowed Divorced Drivers License Number _____ - _____
 Your Employer _____ Type of Work _____
 e-Mail Address _____ Kid's Names and ages _____
 Emergency Contact _____ ph # _____
 Name of Medical Doctor(s) _____ Referred by: _____

- I authorize the doctor or his staff to render care as deemed appropriate for me and / or my child.
- I authorize Chris E. Cembalistry D. C., P. C. to release and / or request records to or from other providers as may be necessary.
- I understand I am responsible for all bills incurred in this office.
- I authorize assignment of my insurance benefits (if applicable) directly to the provider.
- Person responsible for this account if other than the patient? _____
- I understand that after any initial promotional services all care is rendered at usual and customary fees .

 Patient / Parent Signature (This represents a long term authorization for all occasions of service) Date

REASON FOR SEEKING CARE

PRESENT COMPLAINTS

1. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

2. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

3. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

4. _____ How long has this been an issue? _____
 Is it: Dull Sharp Ache Numb / Tingle Stabbing Constant Occasional Staying the same Getting worse
 Mild Moderate Severe Worse in the morning Worse in evening Pain radiates to _____

5. Does your condition affect: Sleep Work Daily Routine Sitting Driving

6. What makes it better? _____

7. What makes it worse? _____

8. What Doctor's have you seen for this? _____

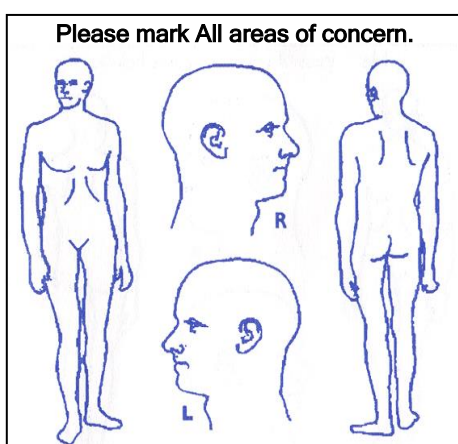
9. Type of treatment: _____

10. Results: _____

NOTES: _____

Are you pregnant?
 Yes No

Please mark All areas of concern.



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GENERAL HEALTH HISTORY

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Patient Name _____ *Mark the conditions that apply to you.*

Past Present

- Headaches
- Migraines
- Shortness of Breath
- Allergies / Asthma
- Medication Side Effects
- Diabetes
- Hands or Feet cold
- Muscle aches
- Trouble Walking
- Leg / Foot Numbness
- Fainting
- Gall Bladder Trouble
- Ringing in Ears
- Ear Problems
- Sleeping Problems
- Vision Problems
- Thyroid Problems
- Liver Disease
- Kidney Problems
- Light Bothers Eyes
- Other _____

Past Present

- Urinary Problems
- Easy Bruising
- Tobacco Use
- Dental Problems
- Fibromyalgia
- Blood Thinner use
- HIV Positive
- Cancer
- Depression
- Alcohol Use
- ___High or ___Low Blood Pressure
- Stroke History
- High Cholesterol
- TMJ
- Digestive Problems
- Pain all Over
- Tension / Irritability
- Chest Pains
- Heart Pacemaker
- Heart Problems

1. List any medications are you taking: _____

2. Please list all doctors you are currently seeing: _____

3. Has any Doctor or other professional advised you to "Go to a Chiropractor ": No Yes, Name _____

PAST HISTORY

4. List any past auto collisions: _____ Was any care received? _____

5. List any past work injuries: _____ Was any care received? _____

6. List any past sport, recreational, or home injuries _____

7. Please describe any past conditions and treatment received: _____

8. Please list any past hospitalizations and surgeries: _____

FAMILY HISTORY

Father's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Mother's side: Heart Disease Cancer Diabetes Heavy Medication use Arthritis Other _____

Is there any other family history you want us to know? _____