helie
CHIROPRACTIC

1885 W. 120th Ave. #500 Westminster, CO 80234

First _____ Last _____ DOB ___/___/___ Date _____

Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed # of Children: _____

Home Address: _____ City: _____ Zip: _____

Home Ph: _____ Cell Ph: _____ Alt. Ph: _____

Email address: _____

Work Address: _____

Employer name: _____ Work Ph: _____

Occupation: _____ Years employed: _____

Work Status: ( ) Working w/ Restrictions ( ) Working without Restrictions ( ) Not working since: _____

What are we seeing you for today? ( ) Work Injury ( ) Sports Injury ( ) Auto Accident ( ) Other: _____

Who referred you to our office? _____

EMERGENCY CONTACT INFORMATION:

Emergency Contact Person: _____ Phone #: _____ Relationship: _____

INSURANCE INFORMATION:

( ) I will be paying for services myself…….or…….Please bill: ( ) Health Insurance ( ) Auto Insurance ( ) Worker's Compensation

Insurance Company name: _____

Insurance Company Phone number: _____ Member ID: _____ Group #: ___ _____

Subscriber's name: _____ DOB: _____ Relationship: _____

Subscriber's Employer: _____

GENERAL CONSENT FORM

The undersigned hereby consents to evaluation and treatment rendered according to the applicable standards of care. It is understood that options exist for treatment and all treatments are choices between risks and benefits. If the risks and benefits of proposed treatments are not clear to me, I understand that further information may be requested from the Doctor. The information within this chart is confidential. I understand that all requests for release of my records must be in writing. Protected Health information will be released with written authorization with minimum disclosure necessary as related to your care. Please see Notice of Privacy Practices for more detailed information. I understand that I have a responsibility to communicate honestly with the Doctor and notify him of any changes in my health status.

FINANCIAL CONSENT AND AWARENESS

I understand that I am financially responsible, WHETHEROR NOT MY INSURANCE COMPANY PAYS, for all charges incurred by me. I hereby assign my major medical insurance benefits, including Medicare, private insurance and other health plans to Dr. Helie. Any overpayment will be promptly refunded. I also authorize Dr. Helie to release any protected health information required to secure payment.

RELEASE OF RECORDS

I authorize Dr. Adam Helie to release all health records necessary for my treatment and/or evaluation.

Patient's Signature: _____ **Date:** _____

Responsible Party's Signature (if patient is a minor): _____

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TESTS: Please list the MOST Recent Dates

Chest X-Ray: _____ EKG: _____ Other X-Ray: _____ MRI/CT Scan: _____

HABITS:	YES	NO	If YES, Please explain:
Smoking	( )	( )	_____
Alcohol Consumption	( )	( )	# per day _____ # per week _____
Coffee or Tea Consumption	( )	( )	Cups per day _____
Other drug use	( )	( )	_____
Exercise	( )	( )	Daily Weekly Monthly Type _____

Do you currently or have you had: Mark all that apply:

	Currently	Past
Back pain or stiffness	( )	( )
Neck pain or stiffness	( )	( )
Shoulder pain	( )	( )
Hip Pain	( )	( )
Foot/Ankle pain	( )	( )
Wrist/Elbow pain	( )	( )
Numbness or Tingling In the arms or hands	( )	( )
Numbness or Tingling In the legs or feet	( )	( )
Painful/Swollen Joints	( )	( )

FEMALES ONLY

Do you have: Menstrual Problems Sex Concerns
Abnormal bleeding Breast lumps/pain
Problems getting pregnant

Age Periods began: _____ Birth Control: Y N
# of Pregnancies: _____ Type: _____
# of Miscarriages:_____ Date of last gynecological
# of Cesarean sections: _____ exam: _____
Are you currently or possibly pregnant? _____

MALES ONLY

Do you have: Sex Concerns Lumps in Testicles
Date of last Prostate Exam: _____

HOBBIES OR INTERESTS:

_____

_____

_____

MEDICATIONS: Please list all currently used medicine. Include all prescription and non-prescription drugs, herbs, and vitamins.

_____

_____

ALLERGIES: Please list all known, esp. to medicine. _____

_____

Treatment you have received or are receiving:

Medical care Chiropractic Care Other: _____

Are you: Right Handed Left Handed Ambidextrous

In general, How would you rate your health? Excellent Average Poor

Do you feel depressed, have trouble falling asleep, poor appetite, lack of interest in normal enjoyable activities or have relationship problems? No Yes If yes, explain: _____

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Do you currently or have you had: Mark all that apply	Current	Past
Sleep Problems	( )	( )
Disabled	( )	( )
Nervous Tension	( )	( )
Irritability	( )	( )
Mood Swings/changes	( )	( )

	Current	Past
Growing moles/lumps	( )	( )
Wear glasses/contacts	( )	( )
Glaucoma	( )	( )
Light bothers eyes	( )	( )
Other eye problems	( )	( )
Date of last eye exam: _____		
Hearing Difficulties	( )	( )
Ringing in the ears	( )	( )
Dental Problems	( )	( )
Date of last Dental Exam: _____		

	Current	Past
More frequent urination	( )	( )
Blood in urine	( )	( )
Leaking urine	( )	( )
Urinating at night	( )	( )
Kidney/Bladder infection	( )	( )
Kidney Stones	( )	( )
Abdominal Pain	( )	( )
Black or bloody stool	( )	( )
Heartburn	( )	( )
Ulcers	( )	( )
Swallowing Problems	( )	( )
Hernia	( )	( )
Hemorrhoids or Polyps	( )	( )

	Current	Past
Arthritis or Gout	( )	( )
Bursitis	( )	( )
Fractured Bones	( )	( )
Seizures/Tremors	( )	( )
Passing Out	( )	( )
Memory Loss	( )	( )
Speech Problems	( )	( )
Trouble Concentrating	( )	( )

Do you currently or have you had: Mark all that apply	Current	Past
Asthma	( )	( )
Eczema	( )	( )
Hay Fever	( )	( )
Diabetes	( )	( )
High Cholesterol	( )	( )
Thyroid Problems	( )	( )
Liver trouble	( )	( )
Anemia	( )	( )

	Current	Past
Low Blood Pressure	( )	( )
High Blood Pressure	( )	( )
Chest Pain	( )	( )
Racing/Pounding Heart	( )	( )
Ankle Swelling	( )	( )
Lung/Breathing problems	( )	( )
Pneumonia	( )	( )
Shortness of Breath	( )	( )
Stroke	( )	( )
Heart Disease/murmur	( )	( )

	Current	Past
History of Trauma	( )	( )
Loss of Consciousness	( )	( )
Direct Head Trauma	( )	( )
Poor Coordination	( )	( )
Muscle weakness	( )	( )
Headaches	( )	( )
Dizziness/Poor balance	( )	( )
Loss of Bladder Control	( )	( )
Fecal Incontinence	( )	( )
Numbness in Groin	( )	( )
History of Cancer	( )	( )
History of Osteoporosis	( )	( )
Unexplained Weight Loss	( )	( )
Unusual Fatigue	( )	( )
Pain greater than 4 weeks	( )	( )
Pain continues with rest	( )	( )
Use of Corticosteroids	( )	( )
Use of anticoagulants	( )	( )
Fever/Night Sweats	( )	( )
Loss of Smell	( )	( )