THE HEALTH INSTITUTE OF WESTERN COLORADO

Patient Information

Name: _____ DOB: _____

Address: _____

Phone: _____ Email: _____

SS#: _____ Employer/Job Title: _____

Emergency Contact: _____ Phone: _____

How did you hear about us? _____

Insurance

❒ Self ❒ Spouse ❒ Auto ❒ Personal Injury ❒ Work Comp ❒ Other

Name of insured (if other than yourself): _____ DOB: _____

Insurance Company: _____ ID/Claim #: _____

Claim Adjuster: _____ Phone: _____

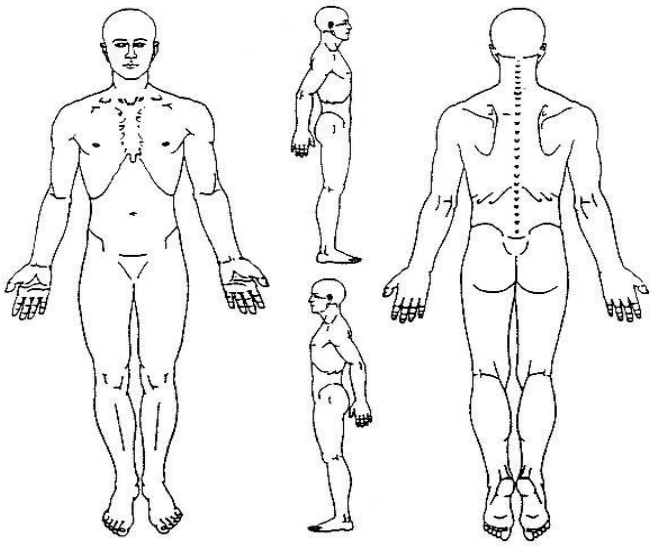
What brought you to our office?

❒ New Injury ❒ Old Injury ❒ Chronic Pain ❒ Wellness

Date of Injury or Onset of Symptom(s): _____ Have you had this problem before? ❒ Yes ❒ No

On a scale of 1-10, with 10 being unbearable, rate your: **CURRENT** pain level _____, **AVERAGE** pain level _____

Please mark where the pain is located.



How would you describe the pain (mark all that apply):

❒ Burning ❒ Dull Ache ❒ Numbness ❒ Sharp
❒ Shooting ❒ Stabbing ❒ Throbbing ❒ Tingling

Does the pain keep you from (mark all that apply):

❒ Working ❒ Daily Activities ❒ Hobbies
❒ Sleeping ❒ Family/Social Time

Since symptoms began, is the problem getting:

❒ Better ❒ Worse ❒ No change

Is the pain: ❒ constant ❒ comes & goes ❒ only with use

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Name_____ Date_____

Medical History

List your four main health concerns/areas of pain or dysfunction. Please list intensity of pain or dysfunction and when it began.

1._____

_____Intensity 1-10_____Date of onset_____

2. _____

_____Intensity 1-10_____Date of onset_____

3. _____

_____Intensity 1-10_____Date of onset_____

4. _____

_____Intensity 1-10_____Date of onset_____

List any accidents/falls experienced through childhood (include work/auto):

1. _____Date_____

2. _____Date_____

3. _____Date_____

List any surgeries/medical procedures, including childhood :

1. _____Date_____

2. _____Date_____

3. _____Date_____

***Do you have any surgical fusions, artificial hips/knees, implants, pacemaker, or other surgical hardware?

YES / NO Describe: _____

Dr. Jeffrey W. McCloskey, D.C.
The Health Institute of Western Colorado, 321 Rood Ave, Suite 103, Grand Junction CO, 81501
Office: (970) 241-2400 Fax: (970) 241-3786

Please mark "C" for Current or "P" for past if you experience any of the following:

Back pain_____	Neck Pain_____	Headaches_____
Numb/Tingling Arms or Hands____	Cancer_____	Digestive problems_____
Gas_____	Bloating_____	Diarrhea_____
Constipation_____	Urination Difficulty_____	Fatigue_____
Loss of memory_____	Dizziness_____	Hemorrhoids_____
Blood in urine, stool or semen_____	Restless Legs_____	Nightmares_____
Hot flashes_____	Breast lumps or tenderness_____	Infertility_____
Miscarriages_____	Depression_____	Mood Swings_____
Anxiety_____	Irritability_____	Chest Pain_____
Shortness of breath_____	Allergies_____	Ulcers_____
Heartburn _____	Insomnia_____	Frequent colds_____
Unexplained weight loss or gain (circle one or both)_____		Hernia_____

Menstrual Difficulties (describe) _____

Please indicate how much weekly use of use of any of the following:

Soda_____	Diet Soda_____	Alcohol _____
Tobacco _____	Coffee _____	Caffeinated Tea _____
Sport/Energy Drinks _____	Artificial Sweeteners _____	Candy/Deserts _____

How much water (in ounces) do you drink in an average day?_____

List any previous medical diagnosis and treatments you have received for present condition:

_____

What aggravates your health concerns?

_____

What is your general state of health? (Circle one) Excellent Good Fair Poor

Date of last Chiropractic treatment _____ Name of Chiropractor_____

Date of last physical Exam _____What prompted exam?_____

Date of last lab work? _____Date of last X ray _____What body part? _____

Name of MD/DO _____City_____ Last Seen_____

List any medications you are currently taking:

_____

_____

_____

I consent to be treated by Dr. Jeff McCloskey for the issues listed above. I understand that no medical or holistic treatment guarantees results.

Signature:_____Date:_____

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