Acupuncture &
Chiropractic
Integrative Clinic

REGISTRATION & HISTORY

SUMMIT HEALTH &
WELLNESS CENTER

6851 S Holly Cir Ste 180
Centennial, CO 80112
(720) 920.9195

Today's Date ____/_____/_____ How did you hear about us? _____

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ ZIP _____

Tel #: Home _____ Cell _____

Work _____X_____

Best time to call _____

Email _____

Birthday _____/_____/_____ Sex: ☐M ☐F Age _____

☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

City _____ State _____ ZIP _____

IN CASE OF EMERGENCY, CONTACT

Name: _____ Relationship _____

Tel#: _____ Other _____

Primary Care Physician: _____

Address _____

City _____ State _____ ZIP _____

Phone: _____ Date Last Seen: _____

Specialist (if any): _____

Address _____

City _____ State _____ ZIP _____

Phone: _____ Date Last Seen: _____

By providing above information, I give Acupuncture & Chiropractic Integrative Clinic permission to contact my other physicians for my medical history, diagnoses, treatment plan and other healthcare related purposes.

Patient's or Responsible Party's Signature:

_____

PATIENT CONDITION

Reason for Visit _____

_____

What treatment have you already received for your condition? ☐Medical ☐Physical Therapy ☐None ☐Other _____

Name and address of other doctor{s} who have treated you for your condition _____

_____

Is condition due to an accident? ☐Yes ☐No If yes, date: _____ Type of accident ☐Auto ☐Work ☐Home ☐Other

To whom have you made a report of your accident? ☐Auto Insurance ☐Employer ☐Worker Comp. ☐Other

Attorney Name and Phone # (if applicable) _____

EXERCISE

- ❑ None
- ❑ Moderate
- ❑ Daily
- ❑ Heavy

WORK ACTIVITY

- ❑ Sitting
- ❑ Standing
- ❑ Light Labor
- ❑ Heavy Labor

HABITS

- ❑ Smoking, Packs/Day _____
- ❑ Alcohol, Drinks/Day or Week_____
- ❑ Coffee/Caffeine Drinks, Cups/Day_____
- ❑ High Stress Level, Reason: _____

MEDICATIONS conditions

_____ for _____

_____ for _____

_____ for _____

_____ for _____

_____ for _____

ALLERGIES

_____

_____

_____

_____

_____

SUPPLEMENTS

_____

_____

_____

_____

_____

Please use additional sheet if you need more space. patient's Initials _____

■ HEALTH HISTORY

Have you had any of the followings:

AIDS/HIV	□Yes □No	Diabetes	□Yes □No	Measles	□Yes □No	Scarlet Fever	□Yes □No
Alcoholism	□Yes □No	Emphysema	□Yes □No	Miscarriage	□Yes □No	Stroke	□Yes □No
Allergy Shots	□Yes □No	Epilepsy	□Yes □No	Mononucleosis	□Yes □No	Suicide Attempt	□Yes □No
Anemia	□Yes □No	Fractures	□Yes □No	Multiple Sclerosis	□Yes □No	Thyroid Problems	□Yes □No
Anorexia	□Yes □No	Glaucoma	□Yes □No	Mumps	□Yes □No		□Yes □No
Appendicitis	□Yes □No	Goiter	□Yes □No	Osteoporosis	□Yes □No	Tonsillitis	□Yes □No
Arthritis	□Yes □No	Gonorrhea	□Yes □No	Pacemaker	□Yes □No	Tuberculosis	□Yes □No
Asthma	□Yes □No	Gout	□Yes □No	Parkinson's Disease	□Yes □No	Tumors, Growths	□Yes □No
Bleeding Disorders	□Yes □No	Headaches	□Yes □No				
		Heart Disease	□Yes □No	Pinched Nerve	□Yes □No	Typhoid Fever	□Yes □No
Breast Lump	□Yes □No	Hepatitis	□Yes □No	Pneumonia	□Yes □No	Ulcers	□Yes □No
Bronchitis	□Yes □No	Hernia	□Yes □No	Polio	□Yes □No	Urinary Tract Infections	□Yes □No
Bulimia	□Yes □No	Herniated Disk	□Yes □No	Prostate Problem	□Yes □No		
Cancer	□Yes □No	Herpes	□Yes □No			Vaginal Infections	□Yes □No
Cataracts	□Yes □No	High Blood Pressure	□Yes □No	Prosthesis	□Yes □No		
Chemical Dependency	□Yes □No			Psychiatric Care	□Yes □No	Venereal Disease	□Yes □No
		High Blood Cholesterol	□Yes □No	Rheumatoid Arthritis	□Yes □No		
Chicken Pox	□Yes □No					Whooping Cough	□Yes □No
Depression/ Anxiety	□Yes □No	Kidney Disease	□Yes □No	Rheumatic Fever	□Yes □No		
		Liver Disease	□Yes □No			Other _____	

Are you pregnant? (**Female Only**) □Yes □No Due Date _____

Injuries/Surgeries you have had	Description	Date
Falls or Injuries		
Broken Bones		
Surgeries		

■ FAMILY HISTORY

Have your immediate family members had any of the following:

□ High Blood Pressure	□ HIV Positive	□ Back Problems	□ Headaches
□ Heart Disease	□ Asthma	□ Ulcer or Stomach Problems	□ Thyroid Disease
□ Emphysema	□ Diabetes	□ Stroke	□ Circulation Problems
		□ Arthritis-Rheumatism	□ Cancer

Patient's or Responsible Party's Signature: _____ Date:_____

If signed by Responsible Party, please provide below information:

Name (PLEASE PRINT) **Relationship to patient** **Witness**

BELOW IS FOR OFFICE USE ONLY

Clinician's Name (PRINT) **Clinician's Signature** **Date**