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 the 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 □ Mild □Occasional
□ Moderate □ Often
□ Heavy □ Daily

■ WORK ACTIVITY

□ Sitting □ Standing
□ Light Labor
□ Heavy Labor

■ HABITS

□ Smoking, Packs/Day ______________________________
□ Alcohol, Drinks/Day or Week_________________________
□ Coffee/Caffeine Drinks, Cups/Day_____________________

■ MEDICATIONS conditions

_____________________ 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:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
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	□Yes □No
Anorexia	□Yes □No	Glaucoma	□Yes □No	Mumps	□Yes □No	Problems	□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
Chicken Pox	□Yes □No	High Blood Cholesterol	□Yes □No	Rheumatoid Arthritis	□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
- □ Heart Disease
- □ Emphysema
- □ HIV Positive
- □ Asthma
- □ Diabetes
- □ Back Problems
- □ Ulcer or Stomach Problems
- □ Stroke
- □ Arthritis-Rheumatism
- □ Headaches
- □ Thyroid Disease
- □ Circulation Problems
- □ 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**