All information confidential

Patient Information Form

Welcome to our office

DAVID G. DENTON, D.C., D.I.C.S.

2038 Vermont Drive, Suite 207, Fort Collins, CO 80525
(720) 454-2490 or (970) 657-4182

Name _____ **Email:** _____
First MI Last

Address _____ **City** _____ **State** _____ **Zip** _____

Telephone: Home ( ) _____ **Work ( )** _____ **Cell ( )** _____

Birth Date: _____ **Sex: F ☐ M ☐ Are you: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Minor ☐**

Occupation: _____ **Employer:** _____

Emergency Contact: _____ **Ph ( )** _____ **Relationship ( )** _____

If Patient is Minor : Legal Guardian : _____

Are you on Medicare? Yes ☐ No ☐ Medicare number : _____

Symptoms

Reason for visit: (Chief Complaint) _____

Date of onset: _____ **Related to Accident or Injury?** _____ **Date of Injury?** _____

Describe Accident or Injury: _____

_____ **Is condition getting worse?** _____

Where specifically is the problem(s) located? _____

Type of Pain: ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Numbness ☐ Aching ☐ Dull
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

Which activities are difficult? ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down ☐ Other

Rate the severity of your pain (1 = mild pain or discomfort to 10 — severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you already received for your condition?

☐ Medication ☐ Chiropractic ☐ Surgery ☐ Acupuncture ☐ Physical Therapy ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

_____

HEALTH HISTORY

Check only those conditions which are applicable:

☐ AIDS/HIV	☐ Cataracts	☐ Hepatitis	☐ Osteoporosis	☐ Suicide Attempt
☐ Alcoholism	☐ Chemical Dependency	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Allergy Shots	☐ Chicken Pox	☐ Herniated Disc	☐ Parkinson's Disease	☐ Tonsillitis
☐ Anemia	☐ Depression	☐ Herpes	☐ Pinched Nerve	☐ Tuberculosis
☐ Anorexia	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Tumors, Growths
☐ Appendicitis	☐ Emphysema	☐ Kidney Disease	☐ Polio	☐ Typhoid Fever
☐ Arthritis	☐ Epilepsy	☐ Liver Disease	☐ Prostate Problems	☐ Ulcers
☐ Asthma	☐ Fractures	☐ Measles	☐ Prosthesis	☐ Vaginal Infections
☐ Bleeding Disorders	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Venereal Disease
☐ Breast Lump	☐ Goiter	☐ Miscarriage	☐ Rheumatoid Arthritis	☐ Whooping Cough
☐ Bronchitis	☐ Gonorrhea	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other _____
☐ Bulimia	☐ Gout	☐ Multiple Sclerosis	☐ Scarlet Fever	_____
☐ Cancer	☐ Heart Disease	☐ Mumps	☐ Stroke	_____

Do you have any multiple chemical sensitivities? (Please list):

_____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

List any types of surgeries that you have had and the dates that they occurred:

_____

What medications are you currently taking? _____

What nutritional supplements and vitamins do you take (if any)?

_____

What type of exercise do you do each week? _____

Do you smoke? _____ Do you consume alcohol? _____ How much? _____ Sugar or Sweets? _____

How much coffee or caffenated beverages and soft drinks do you consume on a daily basis? _____

Any additional health information? _____

_____

Referred to this office by: _____

Authorization

I certify that I have read, understand and accurately answered the above questions to the best of my knowledge. Providing correct information is essential to my health, and I understand that anything that is not asked, that I feel is important, I have added above to help Dr. Denton be better informed about my condition.
I am also aware that there are new health laws titled (HIPAA) Health Insurance Portability and Accountability Act of 1996, wherein I have certain rights to privacy regarding my protected health information. I will sign an additional Release form, if I want any information disclosed from this private health record. Unless you are authorized in writing by me, I understand that you will not disclose any information from my records. I also understand that you do not bill Insurance for my treatment, and that I am responsible for payment for all services at the time of each treatment.

X _____

SIGNATURE OF PATIENT **DATE**