**Lopour Chiropractic & Wellness**

**Genetic Methylation Testing**

2001 S. Shields E201 \* Fort Collins, CO. 80526

Phone: 970-377-0055 \* Fax: 970-449-0148

**Confidential Patient History**

(Please Print)

**Patient Information Acct # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dr./Mr./Mrs./Ms./Miss (*circle one*) Marital Status (*circle*) M S W D

Last Name First Name Middle Initial Nickname

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City State Zip

Mobile Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like an appointment reminder? text \_\_\_\_\_\_\_\_\_\_ email \_\_\_\_\_\_\_\_\_\_ phone call \_\_\_\_\_\_\_\_\_\_\_\_

Cell Carrier (ie. Verizon, Sprint, T-Mobile) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May Lopour Chiropractic communicate with you via email? (Circle) Yes No

Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender \_\_\_\_\_\_\_\_\_\_

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Person to contact in an emergency \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party**

Name of person responsible for payment on account \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Patient Introduction Form**

Patient Name: Date:

1. Chief Concerns:
2. Previous treatments for this concern:
3. Medications and/or Nutritional Supplements currently taking:
4. Any known allergies to food, supplements, medications, etc.?
5. Do you take the following: (if yes, please indicate servings per day)

 Cigarettes \_\_\_\_\_\_\_\_\_\_ Coffee \_\_\_\_\_\_\_\_\_\_ Alcohol \_\_\_\_\_\_\_\_\_\_ Soda \_\_\_\_\_\_\_\_\_\_\_

1. Do you have any major illnesses?
2. List any surgeries or operations you have had.
3. How would you rate your overall health?
4. Do you have a family history of any serious illness(s)? (cancer, diabetes, heart conditions, etc)
5. What is your overall goal?

**Symptom Survey Form**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Age \_\_\_\_\_\_\_\_\_\_ Sex M \_\_\_\_\_\_ F \_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Please mark any symptom(s) that apply to you. Mark either “P” for past symptom or “C” for current symptom.

**P C**

**CONSTITUTIONAL**

**🞏 🞏 Fever**

**🞏 🞏 Weight gain**

**🞏 🞏 Weight loss**

**🞏 🞏 Appetite change**

**🞏 🞏 Night sweats**

**🞏 🞏 Fatigue**

**🞏 🞏 Chills**

**EYES**

**🞏 🞏 Blurry**

**🞏 🞏 Double vision**

**🞏 🞏 Vision loss**

**🞏 🞏 Tearing**

**🞏 🞏 Pain**

**🞏 🞏 Sensitivity to light**

**🞏 🞏 Glaucoma**

**EARS, NOSE, MOUTH, THROAT**

**🞏 🞏 Hearing loss**

**🞏 🞏 Ringing in ears**

**🞏 🞏 Ear pain**

**🞏 🞏 Nasal congestion**

**🞏 🞏 Nasal drainage**

**🞏 🞏 Nosebleeds**

**🞏 🞏 Mouth/throat irritation**

**🞏 🞏 Tooth problem**

**CARDIOVASCULAR**

**🞏 🞏 Chest pain/pressure**

**🞏 🞏 Racing heart**

**🞏 🞏 Palpitations**

**🞏 🞏 Uncontrollable sweating**

**🞏 🞏 Leg swelling**

**🞏 🞏 High/Low blood pressure**

**PULMONARY**

**🞏 🞏 Persistent cough**

**🞏 🞏 Yellow/green sputum**

**🞏 🞏 Blood in sputum**

**🞏 🞏 Shortness of breath**

**🞏 🞏 Wheezing**

**GASTROINTESTINAL**

**🞏 🞏 Nausea**

**🞏 🞏 Vomiting**

**🞏 🞏 Diarrhea**

**🞏 🞏 Constipation**

**🞏 🞏 Abdominal pain/cramping**

**🞏 🞏 Blood in stool or vomitus**

**🞏 🞏 Mucus in stool**

**🞏 🞏 Heartburn**

**🞏 🞏 Difficulty swallowing**

**P C**

**GENITOURINARY**

**🞏 🞏 Incontinence**

**🞏 🞏 Abnormal bleeding**

**🞏 🞏 Abnormal discharge**

**🞏 🞏 Frequent urination**

**🞏 🞏 Urinary hesitancy**

**🞏 🞏 Pain**

**🞏 🞏 Impotence**

**🞏 🞏 Sexual problems**

**🞏 🞏 Infection**

**🞏 🞏 Urinary retention**

**🞏 🞏 Flank pain**

**MUSCULOSKELETAL**

**🞏 🞏 Pain**

**🞏 🞏 Stiffness**

**🞏 🞏 Joint redness/warmth**

**🞏 🞏 Arthritis**

**🞏 🞏 Back pain**

**🞏 🞏 Weakness**

**🞏 🞏 Muscle wasting**

**🞏 🞏 Sprain/fracture**

**NEURO**

**🞏 🞏 Headache**

**🞏 🞏 Weakness**

**🞏 🞏 Dizziness**

**🞏 🞏 Change in voice**

**🞏 🞏 Change in taste**

**🞏 🞏 Change in vision**

**🞏 🞏 Change in hearing/Hearing loss**

**🞏 🞏 Trouble walking**

**🞏 🞏 Balance problem**

**🞏 🞏 Coordination problem**

**🞏 🞏 Shaking**

**🞏 🞏 Speech problem**

**ENDOCRINE**

**🞏 🞏 Cold or heat intolerance**

**🞏 🞏 Blood sugar problem**

**🞏 🞏 Weight gain/loss**

**🞏 🞏 Missed periods**

**🞏 🞏 Hot flashes/night sweats**

**🞏 🞏 Change in body hair**

**🞏 🞏 Change in libido**

**🞏 🞏 Increased thirst**

**🞏 🞏 Increased urination**

**HEME/LYMPH**

**🞏 🞏 Swelling**

**🞏 🞏 Bleeding problem**

**🞏 🞏 Anemia**

**🞏 🞏 Bruising**

**🞏 🞏 Enlarged lymph node**

**P C**

**ALLERGIC/IMMUNOLOGIC**

**🞏 🞏 Itch**

**🞏 🞏 Post-Nasal Drip**

**🞏 🞏 Watery/itchy eyes**

**🞏 🞏 Nasal drainage**

**🞏 🞏 Immunosuppressed**

**FEMALE ONLY**

**🞏 🞏 Irregular periods**

**🞏 🞏 Endometriosis**

**🞏 🞏 Pain during intercourse**

**🞏 🞏 Breast tenderness**

**🞏 🞏 Menstrual cramps**

**🞏 🞏 PMS**

**🞏 🞏 Mood swings**

**🞏 🞏 Weight retention**

**🞏 🞏 Sugar craving**

**🞏 🞏 Vaginal discharge**

**🞏 🞏 Hysterectomy**

**🞏 🞏 Hot flashes**

**🞏 🞏 Acne, worse at menses**

**🞏 🞏 Menses scanty or missed**

**Are you pregnant?**

**🞏 Yes 🞏 No**

**# of pregnancies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**# of children? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Complications of pregnancy?**

**🞏 Yes 🞏 No**

**Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Have you had problems getting/staying pregnant?**

**🞏 Yes 🞏 No**

**Which best describes you:**

**🞏 Pre-Menopause**

**🞏 Peri-Menopause**

**🞏 Post-Menopause**

**MALE ONLY**

**🞏 🞏 Prostate trouble**

**🞏 🞏 Difficult urination/dribble**

**🞏 🞏 Frequent urination**

**🞏 🞏 Night urination**

**🞏 🞏 Impotence**

**🞏 🞏 Decreased libido**

**OTHER**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**