MOUNTAINVIEW CHIROPRACTIC CENTER
1650 38TH STREET, SUITE 204W
BOULDER, CO 80302

Dr. Dale A. Hameister Dr. Eliu J. Hernandez
Phone: (303) 447-9700 Fax: (303) 447-0795

PERSONAL HEALTH / HISTORY QUESTIONNAIRE

DATE:_____
NAME:_____ S.S. #_____-_____-_____
ADDRESS:_____
CITY:_____ STATE:_____ ZIP: _____
PHONE: HOME-_____ CELL-_____ WORK-_____
E-MAIL ADDRESS:_____
BIRTH DATE:_____/_____/_____ AGE:_____ MARITAL STATUS:_____ # OF CHILDREN:____
OCCUPATION: _____ EMPLOYER: _____
NAME OF SPOUSE: _____ OCCUPATION:_____
EMERGENCY CONTACT: _____ PHONE:_____
REFERRED BY:_____

HAVE YOU RECEIVED CHIROPRACTIC CARE IN THE PAST? YES:_____ NO:_____
IF YES, WHO AND WHEN: _____
WERE X-RAYS TAKEN? YES:____ NO:____ DATE: _____
DATE OF LAST PHYSICAL EXAM:_____
OPERATIONS YOU HAVE HAD: _____
SERIOUS ILLNESSES:_____

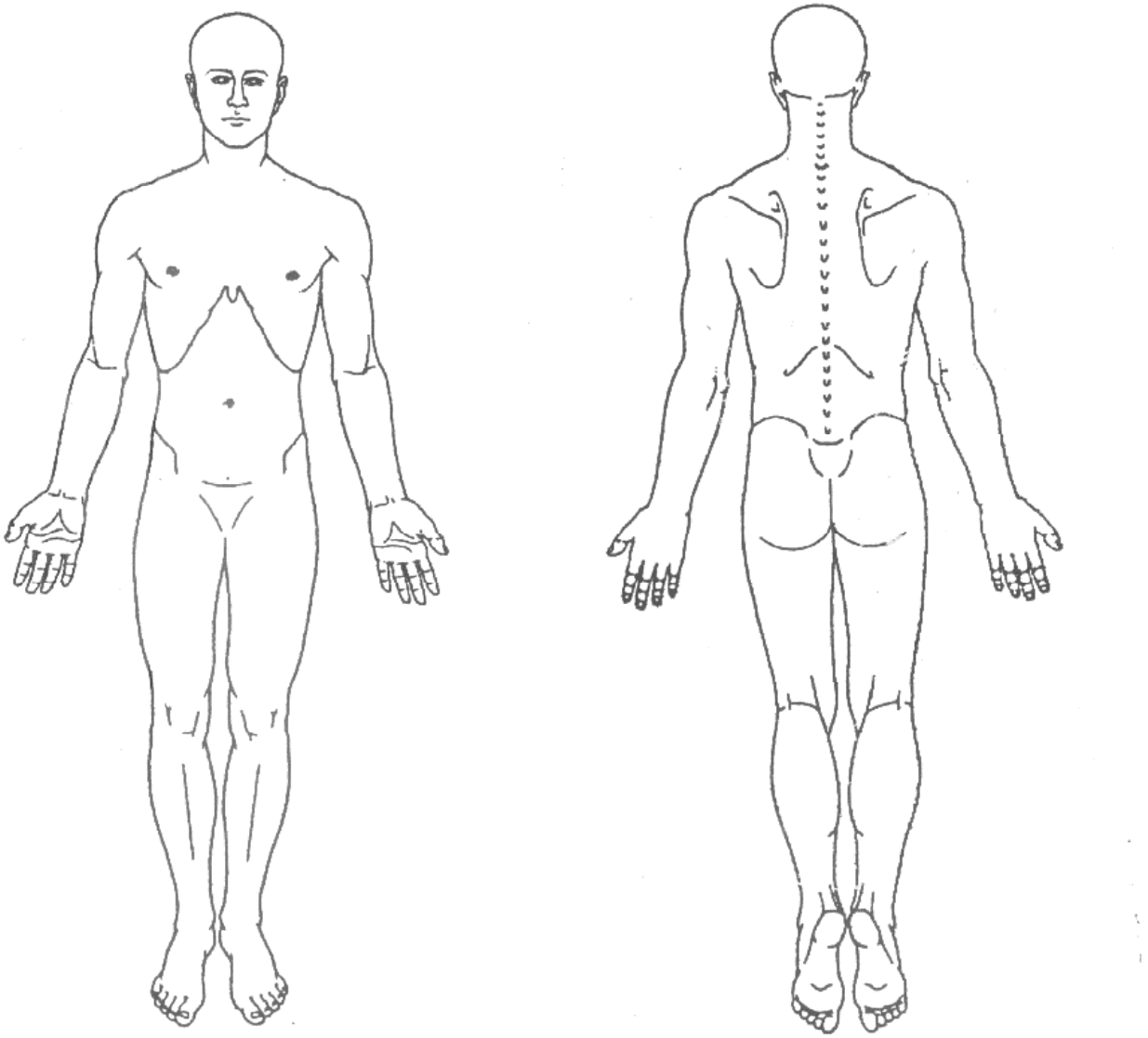
MAJOR COMPLAINT: _____
OTHER COMPLAINTS: _____
HOW LONG HAVE YOU HAD THIS CONDITION? _____
HAVE YOU HAD THIS OR SIMILAR CONDITIONS IN THE PAST? _____
WHAT AGGRAVATES YOUR CONDITION? _____
IS IT GETTING PROGRESSIVELY WORSE: YES:____NO:____CONSTANT:____COMES AND GOES:____
DOES IT INTERFERE WITH YOUR: WORK:____ SLEEP:____ DAILY ROUTINE:____ OTHER:_____
HOW LONG HAS IT BEEN SINCE YOU'VE REALLY FELT GOOD?_____
DRUGS YOU NOW TAKE: PAINKILLERS:_____ MUSCLE RELAXERS:_____ "PEP"-PILLS:____
ANTI-INFLAMMATORIES: ____TRANQUILIZERS:____ BIRTH CONTROL:____
INSULIN:____OTHER: _____
ARE YOU WEARING: HEEL LIFTS:_____ SOLE LIFTS:_____ ORTHOTICS:_____

HAVE YOU BEEN IN AN AUTO ACCIDENT? YES:____ NO:____ DATE: _____
DESCRIBE:_____
ANY OTHER PERSONAL INJURY OR ACCIDENT? YES:____ NO:____ DATE:_____
DESCRIBE:_____

SENSATION DIAGRAM

Mark the areas on your body where the described sensations are felt. Use the appropriate symbols. Additional symbols are offered; fill in the blank with the type of sensation you're feeling. Be sure to mark the areas of radiation. Include all affected areas.

Dull / aching- O O O	Pins & needles- * * *	Numbness- = = =
Burning- X X X	Stabbing-●●●	Sharp- + + +
Radiating- ▸ ▸ ▸	_____- / / /	_____-> > >



PLEASE CHECK THE FOLLOWING PRACTICES THAT APPLY TO YOU:

	Heavy	Moderate	Light	None		Heavy	Moderate	Light	None
Alcohol					Exercise				
Coffee					Sleep				
Tobacco					Appetite				
Drugs									
Sugar Intake									

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL SYSTEM:		GASTRO-INTESTINAL:		GENITAL-URINARY:	
Low Back Pain		Poor or Excessive Appetite		Bladder Trouble	
Pain Between Shoulders		Excessive Thirst		Painful Urination	
Neck Pain		Frequent Nausea		Discolored Urination	
Arm Pain		Vomiting			
Joint Pain or Stiffness		Diarrhea		EENT:	
Walking Problems		Constipation		Vision Problems	
Difficult Chewing		Hemorrhoids		Dental Problems	
General Stiffness		Liver Problems		Sore Throat	
		Gall Bladder Problems		Ear Aches	
NERVOUS SYSTEM:		Weight Problems		Hearing Problems	
Nervousness		Abdominal Cramps		Stuffed Nose	
Numbness		Gas or Bloating After Meals			
Dizziness		Heartburn		MALE:	
Forgetfulness		Black or Bloody Stool		Prostate Problems	
Confusion		Colitis			
Depression				FEMALE:	
Fainting		C-V-R:		Menstrual Irregularity	
Convulsions		Chest Pains		Vaginal Pain or Infections	
Cold Extremities		Short Breath		Breast Pain or Lumps	
Stress		Blood Pressure Problems			
		Irregular Heartbeat			
GENERAL:		Heart Problems		Date of last period:	
Fatigue		Lung Problems or Congestion		Are you pregnant?	
Allergies		Varicose Veins		Yes:_____ No:_____ Unsure:_____	
Loss of Sleep		Ankle Swelling			
Fever		Stroke			
Headaches					

FOLLOWING IS A LIST OF DISEASES WHICH MAY SEEM UNRELATED TO THE PURPOSE OF YOUR APPOINTMENT. HOWEVER, THESE PROBLEMS CAN AFFECT YOUR OVERALL COURSE OF CARE. PLEASE CHECK ANY OF THE FOLLOWING DISEASES THAT APPLY TO YOU OR YOUR FAMILY MEMBERS:

Condition	Self	Father	Mother	Brother	Sister	Children
Acid Reflux						
Anemia						
Arthritis						
Asthma/Hayfever						
Back Trouble						
Bursitis						
Cancer						
Chicken Pox						
Constipation						
Diabetes						
Disc Problem						
Epilepsy						
Headaches						
Heart Disease						
High Blood Pressure						
Influenza						
Insomnia						
Kidney Trouble						
Liver Trouble						
Measles						
Migraines						
Mumps						
Nervousness						
Pinched Nerves						
Pneumonia						
Polio						
Rheumatic Fever						
Rheumatoid Arthritis						
Scoliosis						
Sinus Trouble						
Stomach Trouble						
Stroke						
Whooping Cough						
Other:						

I GIVE MY CONSENT TO RECEIVE TREATMENT AT MOUNTAINVIEW CHIROPRACTIC CENTER.
I UNDERSTAND PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED.
I UNDERSTAND I MAY BE CHARGED FOR ANY APPOINTMENTS I MISS IF I DO NOT GIVE 24 HOURS CANCELLATION NOTICE.
PATIENT'S SIGNATURE:_____ DATE:_____
GUARDIAN AUTHORIZING CARE: _____ DATE:_____

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL RECORDS, OR INFORMATION NECESSARY TO PROCESS MY CLAIM, TO MY INSURANCE COMPANY, ADJUSTER, OR ATTORNEY.
PATIENT'S SIGNATURE:_____ DATE:_____
GUARDIAN AUTHORIZING CARE:_____ DATE:_____