Patient Name:_____

1536 Cole Blvd., Suite 120
Lakewood, CO 80401
Ph: 303-423-8334 F: 303-456-1856

1330 S. Potomac, #100 · Aurora, CO 80012 ·
Ph: 303-781-2500 F: 303-761-4888

7447 E. Berry Ave., Suite 150 Greenwood Village, CO 80111 Ph: 303-781-2500 F: 303-761-4888

8158 E. 5th Ave., Ste 220 · Denver, CO 80230 · Ph: 303-916-5607 F: 303-456-1856

Patient Information

Name _____ Date _____

Address _____ City, State, Zip _____

Phone _____ ☐ Cell ☐ Home Can we leave messages on this line? ☐ Yes ☐ No

Alternate Phone _____ ☐ Cell ☐ Home Can we leave messages on this line? ☐ Yes ☐ No

Email Address _____

Date of Birth _____ Social Security # _____

Primary Language _____ Secondary Language _____

Insurance Carrier _____ Group # _____

Member ID# _____

Is your visit related to a work related injury? ☐ Yes ☐ No If so, what was the date of your injury or accident? _____

Employer _____ Employer Address: _____

Employer Phone _____ Employer Fax _____

Is your visit related to an auto accident? ☐ Yes ☐ No

Patient Medical History

Medications you currently take including dosage: _____

_____

Are you allergic to any medication? ☐ Yes ☐ No ☐ Unknown

If yes, please list: _____

Do you have any other allergies? ☐ Yes ☐ No ☐ Unknown

If yes, please list: _____

Please indicate if you currently have, or have ever had in the past, any of the following conditions:

- ☐ Alcoholism
- ☐ Allergies/Hayfever
- ☐ Anemia
- ☐ Anxiety
- ☐ Asthma
- ☐ Depression
- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Epilepsy
- ☐ Fracture
- ☐ Kidney Infections
- ☐ Kidney Stone
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Myocardial Infarction

Patient Name:_____

Please indicate if you currently have, or have ever had in the past, any of the following conditions:

- ☐ Atrial Fibrillation
- ☐ Blood Transfusions
- ☐ Coronary Artery Disease
- ☐ Cancer
- ☐ Cardiac Pace Maker
- ☐ Cardiovascular Disease
- ☐ Congestive Heart Failure
- ☐ Chicken Pox
- ☐ Cirrhosis
- ☐ Colitis
- ☐ COPD
- ☐ Chronic Renal Failure
- ☐ Crohn's Disease
- ☐ Blood Clots
- ☐ CVA/Stroke
- ☐ Gastric Ulcer
- ☐ Gastrointestinal Disease
- ☐ Gastroesophageal Reflux Disease
- ☐ Gestational Diabetes
- ☐ Glaucoma
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insulin Pump
- ☐ Joint Pain
- ☐ Kidney Disease
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Progressive Neurological Disorder
- ☐ Pulmonary Disease
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Shingles
- ☐ STD
- ☐ Terminal Illness
- ☐ Thyroid Disease
- ☐ TIA
- ☐ Tuberculosis
- ☐ Valvular Problems

Hospitalizations

Have you ever been hospitalized? ☐ Yes ☐ No If Yes, please list reason for hospitilazation and when it took place.

_____

Smoking Status

- ☐ Current Every Day Smoker
- ☐ Current Some Days Smoker
- ☐ Heavy Tobacco Smoker
- ☐ Light Tobacco Smoker
- ☐ Former Smoker
- ☐ Never Smoked

Are you interested in help with quitting? ☐ Yes ☐ No

# of years smoked: _____ Packs per day: _____ When did you quit? _____

Social History

Alcohol Use:

- ☐ Non Drinker
- ☐ Occasional
- ☐ Social Drinker
- ☐ Moderate consumption
- ☐ Heavy consumption
- ☐ Recovering Alcoholic
- ☐ Never Drank Alcohol

Caffiene Use:

- ☐ 0 Servings/Day
- ☐ Occasional
- ☐ 1 Serving/Day
- ☐ 2 Servings/Day
- ☐ 3 Servings/Day
- ☐ 4 or More Servings/Day

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Divorced
- ☐ Widow/Widower
- ☐ Significant Other

Occupation: _____

Educational Level: _____

Use Sunscreen? ☐ Yes ☐ No

Wear Seatbelts? ☐ Yes ☐ No

Drug Use ☐ Yes ☐ No

Marijuana Use ☐ Yes ☐ No

Sexually Active: ☐ Yes ☐ No

Birth Control Method: _____

Patient Name:_____

Social History Continued

Exercise Habits:

- ☐ Sedentary
- ☐ Moderate less than 3x/w
- ☐ Moderate more than 3x/
- ☐ Strenuous less than 3x/w
- ☐ Strenuous more than 3x/

Race/Ethnicity:

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Hispanic or Latino
- ☐ Native Hawaiian or Pacific Islander
- ☐ White

Are you, or have you been, the victim of physical or sexual abuse? ☐ Yes ☐ No

Are you, or have you been, the victim of any form of domestic violence? ☐ Yes ☐ No

Fall Prevention

How many times have you fallen in the last year? _____ Did it result in injujry? ☐ Yes ☐ No

If yes, how many times? _____ What was the resulting injury? _____

Depression Screening

Do you have little interest or pleasure in doing things?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Are you feeling down, depressed, or hopeless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

If you answered not at all to both of the above questions you may proceed to the next section. If not, please answer the next few questions about how you are feeling.

Trouble falling asleep or sleeping too much?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling tired or having little energy?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Poor appetite or overeating?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Feeling bad about yourself, or that you are a failure?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Trouble concentrating?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Moving/speaking slowly, being fidgety or restless?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

Thoughts of suicide or that you'd be better off dead?

- ☐ Not at all
- ☐ Several days
- ☐ More than half the days
- ☐ Nearly every day

How difficult have these issues made it for you to do your work, take care of things at home, or get along with others?

- ☐ Not difficult at all
- ☐ Somewhat difficult
- ☐ Very difficult
- ☐ Extremely difficult

Surgical/Procedural History

No Prior Surgical History ☐

- ☐ Appendectomy
- ☐ Breast Lumpectomy
- ☐ Cataract Surgery
- ☐ Colectomy
- ☐ Subtotal Colectomy
- ☐ Cone Biopsy
- ☐ D&C
- ☐ Endometrial Ablation
- ☐ Gall Bladder
- ☐ Heart Surgery
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Hysterectomy
- ☐ Joint Replacement
- ☐ Laparoscopy
- ☐ Mastectomy
  - ☐ Right ☐ Left ☐ Bilateral
- ☐ Myomectomy
- ☐ Oophorectomy
- ☐ Ostomy
- ☐ Splenectomy
- ☐ Tonsil/Adenoidectomy
- ☐ Tubal Ligation

Other: _____

Other History

Is there any other information about your health history that you feel we should know?

_____

_____

_____

_____

Patient Name:_____

Family History

☐ No Significant Family History to Report ☐ Adopted
☐ Unknown History

Please indicate if there is a history for any of the following conditions for immediate family members. Please indicate which family member had the condition.

(Mother, Father, Brother, Sister, Son, Daughter)

Family Member	Condition	Family Member	Condition	Family Member	Condition
_____	Alcoholism	_____	Congenital Anomaly	_____	Hypertension
_____	Anemia	_____	COPD	_____	Kidney Disease
_____	Anxiety	_____	Crohn's Disease	_____	Liver Disease
_____	Asthma	_____	Depression	_____	Osteoarthritis
_____	Birth Defects	_____	Diabetes	_____	Osteoporosis
_____	CAD	_____	Epilepsy	_____	Pulmonary Disease
_____	Cardiovascular Disease	_____	GERD	_____	Stroke
_____	CHF	_____	High Cholesterol	_____	Substance Abuse
_____	Chronic Pain				

By signing here you are attesting that the medical history and information provided is true and complete to the best of your knowledge.

Patient Name: _____ _____ _____
Print Name Signature Date

Patient Representative: _____ _____ _____
Print Name Signature Date