SHERIDAN PARK
CHIROPRACTIC
303-429-4104

Consultation Admittance Record

(Please Print)

Name _____ Home Ph _____ Bus. Ph _____ Ext. _____

Street _____ Cell Ph _____ Fax # _____

City _____ State _____ Zip _____ Soc.Sec.# _____ Age _____ Mo ____ Day ____ Yr ____

Employer _____ Sex ☐ Male ☐ Female Marital Status S M W D SO

Occupation _____

Address _____ City _____ Zip _____

Spouse's Name _____ Spouse's Employer _____

Insurance Carrier _____ Group No. _____ Is complaint result of

Previous Chiropractic Care ☐ Yes ☐ No Referred by _____ injury? ☐ Yes ☐ No

Person Responsible for Payment _____

Below is a list of conditions which may seem unrelated to the purpose of your appointment; however, these questions must be answered carefully as these problems can affect your overall diagnosis, treatment plan, and possibility of being accepted for care. Please check √.

☐ Neck Pain	☐ Numbness or Tingling	☐ Cancer	☐ Diarrhea / Constipation
☐ Arm Pain	☐ Dental / Jaw Problems	☐ Allergies	☐ Heart Disease
☐ Pain Between Shoulders	☐ Diabetes	☐ Arthritis	☐ Menstrual Problems
☐ Low Back Pain	☐ Thyroid	☐ Digestive Problems	☐ Menopause
☐ Walking Problems	☐ Anemia	☐ Epilepsy	☐ Polio

DOI _____ DPB _____ DFE _____ Re-ex #1 _____ Re-ex #2 _____

Sx 1 _____ Sx 2 _____ Sx 3 _____

Bed _____ Sleep pattern _____

Have you been treated for this condition? ☐ Yes ☐ No When _____

Name of treating doctor _____ Treatment _____

Similar condition before? ☐ Yes ☐ No When _____ Treatment _____

Are you working? ☐ Yes ☐ No If no, last date worked _____

Previous injuries and dates _____

Major illnesses and dates _____

Operations and dates _____

Present medications _____

Diet _____

Sugar _____

Habits: Caffeine _____ Alcohol _____ Smoke _____

Exercise _____