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 _____ E-mail _____
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	❑ Knee / Foot Pain	❑ Arthritis	❑ Menstrual Problems
❑ Low Back Pain	❑ Diabetes	❑ Digestive Problems	❑ Menopause
❑ Walking Problems	❑ Thyroid	❑ Epilepsy	❑ Anemia

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 _____