

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Requesting records of Dr. _____

Address: _____

Telephone number () ____ - _____

Fax number () ____ - _____

THE PURPOSE FOR THIS RELEASE

You are hereby authorized to furnish and release to _____

all information from my medical, psychological, and other health records, with no limitation placed on history of illness or diagnostic or therapeutic information, including the furnishing of photocopies of all written documents pertinent thereto.

In addition to the above general authorization to release my protected health information, I further authorize release of the following information if it is contained in those records:

Alcohol or Drug Abuse: Yes No

Communicable disease related information, including AIDS or ARC diagnosis and/or HIT or HTLA-III test results or treatment: Yes No

Genetic Testing Yes No

Please note: With respect to drug and alcohol abuse treatment information, or records regarding communicable disease information, the information is from confidential records which are protected by State and Federal laws that prohibit disclosure with the specific written consent of the person to who they pertain, or as otherwise permitted by law. A general authorization for the release of the protected health information is not sufficient for this purpose.

This authorization can be revoked in writing at any time except to the extent that disclosure made in good faith has already occurred in reliance on this authorization.

I hereby release _____
(Name of physician, clinic name, or health organization)

employees of or agents managing members, and the attending physician(s) from legal responsibility or liability for the release of the above information to the extent authorized. A copy of this authorization shall be as valid as the original.

I understand there may be a fee for this service depending on the number of pages photocopied. However; no such fee will be charged if these records are requested for continuing medical care.

Patient's Name: _____ D.O.B. _____

Please Print

Signature: _____ Date _____

Records Requested by:

Doctor's Name: __Amy Denicke, D.C., C.F.M.P/ PO BOX 2019 Aspen, CO 81612

Signature: _____

COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist you with your health care. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information in which you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. This will assist our goal to provide you with an optimal plan of health care, enhance our efficiency, and will provide effective use of your scheduled time.

Date: _____

First Name: _____ Middle: _____ Last: _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) ____ - _____ Work (____) ____ - _____ Cell (____) ____ - _____

Email _____

Age _____ Date of Birth ____/____/____ Place of birth _____ Gender: Female __ Male __

City or town & country, if not US

Referred by: _____

Name, address, & phone number of primary care physician: _____

Marital Status:

Single _____ Married _____ Divorced _____ Widowed _____ Long Term Partnership _____

Emergency Contact: _____

Relationship

Name

Phone

Address

Occupation _____ Hours per week _____ Retired _____

Nature of Business _____

Genetic Background: Please check appropriate box(es):

- | | | | |
|---|------------------------------------|--|--------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Hispanic | <input type="checkbox"/> Mediterranean | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Native American | <input type="checkbox"/> Caucasian | <input type="checkbox"/> Northern European | <input type="checkbox"/> Other |

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time that you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? _____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESS/CONDITION	WHEN/ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Sinus infections/Sinusitis		
Chronic Fatigue Syndrome		
Chron's Disease or Ulcerative colitis		
Gall Stones		
Gout		
Heart Attack, Angina		
Hepatitis		

Herpes Lesions/Shingles/Chicken Pox		
High Cholesterol		
High Triglycerides		
Hypertension		
Irritable bowel (chronic diarrhea)		
Kidney Stones		
Pneumonia		
Strep Throat		
Sleep Apnea		
Stroke		
Hyper/hypo Thyroid		
Emotional disturbances		
Other (describe)		

CURRENT AND PAST INJURIES

INJURIES	WHEN	COMMENTS
Spine injury		
Broken bones or fractures (describe)		
Head injury/Concussion(s)		
Motor Vehicle Collision injuries		
Extremity Injury(s) (knee, shoulder, ankle, etc...)		
Other (describe)		
Other (describe)		
Other (describe)		

SURGERIES

SURGERIES / PROCEDURES	WHEN	COMMENTS

List all medications taken in the last 6 months, both prescription and over the counter (attach extra sheet if necessary)

MEDICATION NAME	Date started	Date stopped (?)

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage. (attach extra sheet if necessary)

Type	Date Started	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes___ No ___
Please list:

CHILDHOOD HISTORY

Please be as accurate as possible

	Yes	No	Comments
Where you a full term baby?			
Breast fed?			
Were you immunized? If so, which vaccines were used?			
Did you have strep infections?			
Did you have digestive problems?			
Did you miss a lot of school due to illness?			
Did you undergo antibiotic therapy more than 5 times?			
When pregnant with you, did your mother:			
Smoke tobacco?			
Use recreational drugs?			
Drink alcohol?			
Use estrogen?			
Other prescription or non-prescription medications?			

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Comment
Sugar? (Sweets, Candy, Cookies, etc)			
Soda?			
Fast food, pre-packaged foods, artificial sweeteners?			
Milk, cheeses, other dairy products?			
Vegetarian only diet?			
Diet high in white breads?			

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___
 If yes, please explain: (Example: milk – diarrhea) _____

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Autism/Aspergers									
ADD/ADHD									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Melanoma									
ALS or other Motor Neuron Diseases									
Alzheimer's or Dementia									
Autoimmune Diseases (such as Lupus)									
Diabetes									
Genetic Disorders									
Cardiovascular Disease									
High Blood Pressure									
Atherosclerosis									
Autoimmune (Rheumatoid, Lupus, Psoriasis, Celiac)									
Inflammatory Bowel Disease									
Kidney disorders									
Liver disorders									
Obesity									
Osteoporosis									
Parkinson's									
Psychiatric disorders									
Sleep Apnea									
Smoking addiction									
Substance abuse (such as alcoholism, or narcotics)									
Other									
Other									

REVIEW OF SYMPTOMS

Place a “P” by those items that applied to you in the *Past 12 months*. Place a “C” by those that *Currently* apply.

GENERAL	Is your skin sensitive to:	Deafness/Hearing loss
Fever	Sun	Itching
Chills/Cold all over	Fabrics	Pressure
Aches/Pains	Detergents	Hearing aid
General Weakness	Lotions/Creams	Frequent infections
Difficulty sweating	HEAD:	Tubes in ears
Excessive Sweating	Poor Concentration	Sensitive to loud noises
Swollen Glands	Confusion	Hearing hallucinations
Cold hands & Feet	Headaches:	NOSE/SINUSES:
Fatigue	After Meals	Stuffy
Difficulty falling asleep	Severe	Bleeding
Sleepwalker	Migraine	Running/Discharge
Nightmares	Frontal	Watery nose
No dream recall	Afternoon	Congested
Early waking	Occipital	Infection
Daytime sleepiness	Certain time of the month	Polyps
Distorted vision	Make you nauseated	Acute smell
SKIN:	Relieved by:	Drainage
Cuts heal slowly	Eating Sweets	Sneezing spells
Bruise easily	Concussion/Whiplash	Post nasal drip
Rashes	Mental sluggishness	No sense of smell
Pigmentation	Forgetfulness	Seasonal allergies
Changing Moles	Indecisive	MOUTH:
Calluses	Face twitch	Coated tongue
Eczema	Poor memory	Sore tongue
Psoriasis	Hair loss	Teeth problems
Dryness/cracking skin	EYES:	Bleeding gums
Oiliness	Feeling of sand in eyes	Canker sores
Itching	Double vision	TMJ
Acne	Blurred vision	Cracked lips/ corners
Strong body odor	Poor night vision	Chapped lips
Hives	See bright flashes	Fever blisters
Fungus on Nails	Halo around lights	Wear dentures
Peeling Skin	Eye pains	Grind teeth when sleeping
Shingles	Dark circles under eyes	Bad breath
Nails Split	Strong light irritates	Dry mouth
White Spots/Lines on Nails	Cataracts	THROAT:
Crawling Sensation	Floaters in eyes	Mucus
Burning on Bottom of Feet	Visual hallucinations	Difficulty swallowing
Athletes Foot	EARS:	Frequent hoarseness
Cellulite	Aches	Tonsillitis
Bugs love to bite you	Deafness/hearing loss	Enlarged glands
Bumps on back of arms & front of thighs	Pains	Constant clearing of throat
Skin cancer	Ringing	Throat closes up

NECK:	Gallstones	Prostate enlargement
Stiffness	Pain under right front rib cage	Prostate infection
Swelling	Nervous stomach	Change in libido
Lumps	Full feeling after small meal	Impotence
Neck glands swell	Indigestion	Prostate enlargement
CIRCULATION/RESPIRATION:	Heartburn	Impotence
Swollen ankles	Poor appetite	Diminished/poor libido
Sensitive to hot	Hernias	Infertility
Sensitive to cold	Nausea	Lumps in testicles
Extremities cold or clammy	Vomiting	Genital lesions
Hands/Feet go to sleep/numbness/tingling	Excessive appetite	Genital pain
High blood pressure	Abdominal Pains/Cramps	Hernia
Chest pain	Frequent gas	Prostate cancer
Pain between shoulders	Diarrhea	Low sperm count
Dizziness upon standing	Constipation	Difficulty obtaining erection
Fainting spells	Changes in bowels	Difficulty maintaining an erection
High cholesterol	Rectal bleeding	Nocturia (urination at night)
High triglycerides	Tarry stools	How many times at night? ____
Wheezing	Rectal itching	
Irregular heartbeat	Use laxatives	Urgency/Hesitancy/Change in Urinary Stream
Palpitations	Bloating	Joint pains
Low exercise tolerance	Frequent belching	Headaches
Frequent coughs	Anal itching	Weight gain
Breathing heavily	Light colored stools	Loss of bladder control
Frequently sighing	Blood in stool	Palpitations
Shortness of breath	Undigested food in stools	JOINT/MUSCLES/TENDONS
Night sweats	KIDNEY/URINARY TRACT:	Severe pain
Varicose veins/spider veins	Burning	Pain wakes you
Mitral valve prolapse	Frequent urination	Weakness in legs and arms
Murmurs	Blood in urine	Balance problems
Skipped heartbeat	Night time urination	Muscle cramping
Heart enlargement	Problem passing urine	Head injury/Concussion
Angina pain	Kidney pain	Muscle stiffness in morning
Bronchitis/Pneumonia	Kidney stones	Damp weather bothers you
Emphysema	Painful urination	
Croup	Bladder infections	
Frequent colds	Kidney infections	
Heavy/tight chest	Syphilis	
Prior heart attack? When ___/___/___	Bedwetting	
Phlebitis	MALE RELATED SYMPTOMS	
GASTROINTESTINAL:	Elevated PSA	
Peptic/Duodenal Ulcer	Lumps in chest area	

EMOTIONAL:		Considered a nervous person by others	Feeling of hostility/volatile or aggression
Convulsions		worry a lot	Fatigue
Dizziness		Unusual tension	Hyperactive
Fainting Spells		Frustration	Restless leg syndrome
Anxiety/feeling of panic		Emotional numbness	Considered clumsy
Frequently keyed up and jittery		Often break out in cold sweats	Daytime sleepiness
Startled by sudden noises		Profuse sweating	Am a workaholic
Go to pieces easily		Depressed	Have considered suicide
Forgetful		Previously admitted for psychiatric care	Frequent over use of alcohol
Listless/groggy		Often awakened by frightening dreams	Family history of overused alcohol
Withdrawn feeling/Feeling 'lost'		Family member had nervous breakdown	Cry often
Had nervous breakdown		Use tranquilizers	Feel insecure
Unable to concentrate/short attention span		Misunderstood by others	Have overused drugs
Unable to reason		Irritable	Been addicted to drugs

PAIN ASSESSMENT

Are you currently in pain? _____

Is the source of your pain due to an injury? _____

If yes, please describe your injury(s) and the date(s) in which it occurred: _____

If no, please describe the duration and location(s) of this pain and what you believe it is attributed to: _____

DENTAL HISTORY

	<u>Yes</u>	<u>No</u>
Problem with sore gums (gingivitis)?	_____	_____
Ringing in the ears (tinnitus)?	_____	_____
Have TMJ (temporal mandibular joint) problems?	_____	_____
Metallic taste in mouth?	_____	_____
Problems with bad breath (halitosis) or white tongue (thrush)?	_____	_____
Problems chewing?	_____	_____
Floss regularly?	_____	_____
Do you have amalgam dental fillings? How many?	_____	_____
Did you receive these fillings as a child?	_____	_____

Please list extensive dental procedures you have had. Did you have any problems following these dental procedures?

NUTRITIONAL HISTORY

Please list the following:

Typical breakfast food choices	Typical lunch food choices	Typical dinner food choices	Typical snack food choices

Please list any food(s) that you crave or have “binged” on for a period of time. (ex. Ice cream, sugar, meat, starches, etc.)

Please list any food(s) that you find comfort in eating when you are nervous or stressed, or that make you feel better:

Intestinal gas:

- Daily
- Occasionally
- Excessive
- Present with pain
- Foul smelling
- Little odor

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No ____

If yes, what type? Cigarette ____ Smokeless ____ Cigar ____ Pipe ____ Patch/Gum ____

How much? _____

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

ALCOHOL INTAKE

Have you ever used alcohol? Yes ____ No ____

If yes, how often do you now drink alcohol?

- No longer drink alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ____ No ____

Have you ever been told that you have a problem with alcohol? Yes ____ No ____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ____ No ____

If yes, what type(s)? _____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ____ No ____

If yes, indicate which

- Lead
- Arsenic
- Aluminum
- Cadmium

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10__ 8-10__ 6-8__ less than 6__

Do you:

- Have trouble falling asleep?
- Often wake in the middle of the night for no particular reason?
- Have problems with insomnia?
- Use medication to help you sleep?
- Work a night job?

EXERCISE HISTORY

Do you exercise regularly? Yes__ No__

If No, please explain why: _____

If yes, please list type of exercise, weekly frequency and duration: _____

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes__ No__

Do you feel like you can handle stress relatively well? Yes__ No__

If no, do you believe that stress is presently reducing the quality of your life? Yes__ No__

If yes, what do you believe it to be? _____

Have you ever contemplated suicide? Yes__ No__

Have you ever been through counseling? Yes__ No__

If yes, what type? (e.g., coach, psychologist, etc) _____

Did it help? _____

How well have things been going for you? 0=N/A 1=Poorly 2=Just OK 3=Very Well

At school _____

With your spouse _____

In your job _____

With your lover _____

In your social life _____

With your children _____

With close friends _____

With your parents _____

With sex _____

With your attitude _____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Take nutritional supplements each day 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Keep a periodic food diary 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Modify your lifestyle (e.g. work demands, sleep habits) 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Practice relaxation techniques if relevant 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Engage in regular moderate exercise 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Have periodic lab tests to assess progress 5 ____ 4 ____ 3 ____ 2 ____ 1 ____

Comments _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone. Everything written on this form will be held strictly confidential outside of our immediate team of practitioners that will be working on your case.

Our team looks forward to helping you achieve your short and long term goals in personal growth and wellness.

Sincerely,

Dr. Amy Denicke/Core Flex Chiropractic