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*:* O Yes O No

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

Genetic Testing O Yes O 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 the 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):

- ❑ African American ❑ Hispanic ❑ Mediterranean ❑ Asian
- ❑ Native American ❑ Caucasian ❑ Northern European ❑ 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)		
Other (describe)		
Other (describe)		
Other (describe)		
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)		

FEMALE MEDICAL HISTORY

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

❑ Pregnancies_____ ❑ Caesarean _____ ❑ Vaginal deliveries_____

❑ Miscarriage _____ ❑ Abortion _____ ❑ Living Children_____

❑ Post partum depression____ ❑ Toxemia _____ ❑ Gestational diabetes_____

GYNECOLOGICAL HISTORY

Age at first menses?_____ Frequency:_____ Length:_____

Painful: Yes_____ No_____ Clotting: Yes____ No____

Date of last menstrual period:____/____/_____

Do you currently use contraception? Yes____ No____ If yes, what please indicate which form:

Non-hormonal

- ❑ Condom
- ❑ Diaphragm
- ❑ IUD
- ❑ Partner vasectomy
- ❑ Other (non-hormonal-please describe)_____

Hormonal

- ❑ Birth control pills
- ❑ Patch
- ❑ Nuva Ring
- ❑ Other (please describe)_____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long._____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes _____ No _____

Please advise of any other symptoms that you feel are significant._____

_____

_____

Are you menopausal? Yes_____ No_____ If yes, age of menopause_____

Do you currently take hormone replacement? Yes___ No___ If yes, what type and for how long?_____

❑ Estrogen ❑ Ogen ❑ Estrace ❑ Premarin ❑ Progesterone ❑ Provera

❑ Other _____

DIAGNOSTIC TESTING

Last PAP test:_____/_____/_____ Normal:_____Abnormal_____

Last Mammogram_____/_____/_____ Breast biopsy? Date:_____/_____/_____

Date of last bone densitiy_____/_____/_____ Results: High____ Low____ Within normal range____

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 Dimentia									
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		Spotting	
Stiffness		Pain under right front rib cage		Heavy Bleeding	
Swelling		Nervous stomach		Uterine fibroid(s)	
Lumps		Full feeling after small meal		Polycystic ovaries/ovarian cyst	
Neck glands swell		Indigestion		Painful periods/cramps	
CIRCULATION/RESPIRATION:		Heartburn		Irregular periods	
Swollen ankles		Poor appetite		Breast tenderness before periods	
Sensitive to hot		Hernias		Endometriosis	
Sensitive to cold		Nausea		Vaginal dryness	
Extremities cold or clammy		Vomiting		Vaginal discharge	
Hands/Feet go to sleep/numbness/tingling		Excessive appetite		Yeast infections	
High blood pressure		Abdominal Pains/Cramps		Vaginal lesions	
Chest pain		Frequent gas		Hot Flashes	
Pain between shoulders		Diarrhea		Mood Swings/PMS	
Dizziness upon standing		Constipation		Breast Cancer	
Fainting spells		Changes in bowels		Ovarian Cancer	
High cholesterol		Rectal bleeding		Infertility	
High triglycerides		Tarry stools		Loss of bladder control	
Wheezing		Rectal itching		Decreased libido	
Irregular heartbeat		Use laxatives		Pregnancy	
Palpitations		Bloating		Partial/total hysterectomy	
Low exercise tolerance		Frequent belching		Clotting during periods	
Frequent coughs		Anal itching		Headaches around period/monthly	
Breathing heavily		Light colored stools			
Frequently sighing		Blood in stool			
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		**FEMALE RELATED SYMPTOMS**			
GASTROINTESTINAL:		Fibrocystic breasts			
Peptic/Duodenal Ulcer		Painless lumps in breasts			

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

	Yes	**No**
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 _____

In your job _____

In your social life_____

With close friends_____

With sex_____

With your attitude_____

With your lover_____

With your children_____

With your parents_____

With your spouse_____

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