RIMROCK wellness center

Rimrock Wellness Center
2695 Patterson Road, Suite 13
Grand Junction, Co 81506

.Personal Information

NAME: AGE: MALE: FEMALE:
ADDRESS:
CITY/STATE/ZIP:
HOME PHONE#: WORK PHONE#: CELL PHONE#:
EMAIL ADDRESS:
BIRTHDATE:
SINGLE: MARRIED: DIVORCED: WIDOWED:
NUMBER OF CHILDREN: NAMES: AGE: GENDER:

OCCUPATION: EMPLOYER'S NAME:

WHO MAY WE THANK FOR REFFERING YOU TO OUR OFFICE?:

Payment Information

Payment is due at time of service, no exceptions. We are not in network with any insurance companies and do not bill insurance. If you would like to submit a claim for payment of services to your insurance company, we will provide you with a statement.

Chief Complaints

List chief complaints according to their severity:	Rate 1-10 1=Mild 10=Worst imaginable	When did this episode start?	If you had the condition before, when did it start?	Did the problem begin with an injury?	Are symptoms **intermittent** or **constant**?
1._____					
2._____					
3._____					
4._____					

If you are experiencing pain, what kind of pain is it? ☐ Sharp pain ☐ Dull ache ☐ Other:_____

Does the pain travel/radiate anywhere: ☐ No ☐ Yes-please describe

_____

_____

Since the problem started, it is ☐ About the same ☐ Getting better ☐ Getting worse

What makes it worse?_____

What have you done for this condition that has helped you feel better?_____
_____

What have you done for this condition that was of no help?_____

☐ I do ☐ I do not have a family history of this or similar symptoms (If you do, please explain)_____
_____

Is this condition interfering with your ☐ Work ☐ Leisure ☐ Sleep ☐ Sports/exercise/walking

☐ Positive mental attitude ☐ Hobbies ☐ Other:_____

Have you had to, or felt the need to make any "positive" changes in your life due to your condition? (i.e., eat better, less alcohol or drugs, meditate, less destructive sports, activities, etc.) if so what?_____
_____

Other doctors seen for this condition: ☐ Chiropractor ☐ Medical Dr. ☐ Other

1. Name/Address:_____
   Date:_____ What was the diagnosis?_____
   What was done?_____
2. Name/Address:_____
   Date:_____ What was the diagnosis?_____
   What was done?_____

General History:

Please place a "**C**" for current symptoms, or a "**P**" for past symptoms:

☐-Headaches	☐-Depression	☐-Back pain	☐-Heartburn	☐-Fainting
☐-Pins/needles in arms	☐-Buzzing in ears	☐-Neck pain	☐-Digestive issues	☐-Cold sweats
☐-Dizziness	☐-Numbness in toes	☐-Anxiety	☐-Ringing in ears	☐-Loss of smell
☐-Numbness in fingers	☐-Constipation	☐-Tension	☐-Allergies	☐-Stomach upset
☐-Fatigue	☐-Menstrual pain	☐-Cold feet	☐-Urinary Problems	☐-Loss of taste
☐-Sleeping problems	☐-Stiff neck	☐-Irritability	☐-Hot flashes	☐-Lights bother eyes
☐-Mood swings	☐-Pins/needles in legs	☐-Loss of balance	☐-Menstrual irregularity	

List medications you are taking & reason: (**prescription** and **non-prescription**) _____

_____

Have you had any surgery? (Please include all surgery)

1. Type_____Date_____Doctor_____
2. Type_____Date_____Doctor_____
3. Type_____Date_____Doctor_____

Accidents and/or injuries: auto, work related, or other (especially those related to your present problems).

1. Type_____Date_____ Hospitalized ☐ Yes ☐ No
2. Type_____Date_____ Hospitalized ☐ Yes ☐ No
3. Type_____Date_____ Hospitalized ☐ Yes ☐ No

Have you ever had x-rays taken? (if yes) when? _____Where_____
Area of body:_____

Family Health Profile

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please list below their names and place an "**X**" in the box if any of these health concerns apply:

	Cancer	Heart disease	High Blood Pressure	Diabetes	Autoimmune disease (MS, Parkinson's, etc.)	Other:
Yourself:						
Children:						
Spouse:						
Father:						
Mother:						
Sisters:						
Brother:						

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____Date:_____