DEL VECCHIO
Back & Neck Care Center
7595 W. 66th Ave. • Arvada, CO 80003
303.422.3657 • Fax 303.422.0153

HEALTH HISTORY

KEEPING YOU HEALTHY FOR LIFE!
www.backcare4you.com

Name _____ Date _____

Address _____ City _____

State _____ Zip _____ SS# _____

e-mail _____ Birthdate _____ Age _____

Phone (home) _____ (Cell) _____

Occupation _____

Marital Status: ❒ single ❒ married ❒ separated ❒ divorced ❒ widowed

Referred by: ❒ friend ❒ relative ❒ yellow pages ❒ mailing ❒ other _____

Do you have any pets? ❒ No ❒ Yes If yes, please tell us what kind(s) _____

_____

Emergency Contact Name _____

Relationship _____ Phone # _____

Favorite Hobbies or Interests _____

Have you ever had Chiropractic care before? ❒ Yes ❒ No

If yes, approximately how long? ❒ 1 year or less ❒ 2-3 years or more

Please list any drugs or medications you are taking _____

_____

Women: Are you pregnant? ❒ No ❒ Yes If yes, due date:

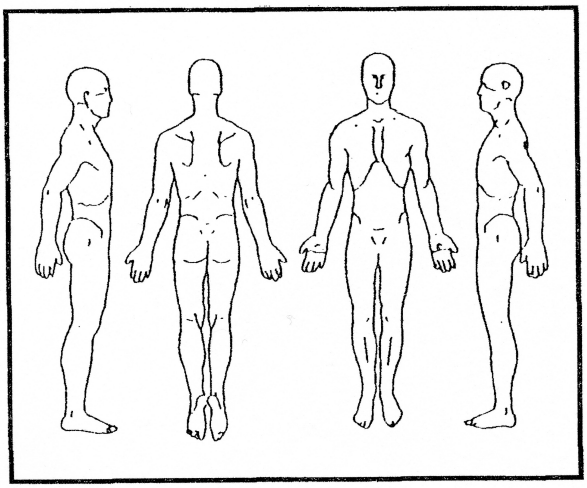
If no, date of last menstrual period: _____

Please check your current symptoms:

❒ Headaches	❒ Neck Pain	❒ Upper Back Pain
❒ Chest Pain	❒ Numbness	❒ Stomach Pain
❒ Arthritis	❒ Sciatica	❒ Hip/Pelvis Pain
❒ Stress	❒ Arm Pain	❒ Shoulder Pain
❒ Neck Stiffness	❒ Allergies	❒ Asthma
❒ Mid Back Pain	❒ Sinus Issues	❒ Low Back Pain

❒ Other: _____

Please Mark Your Symptom Areas:



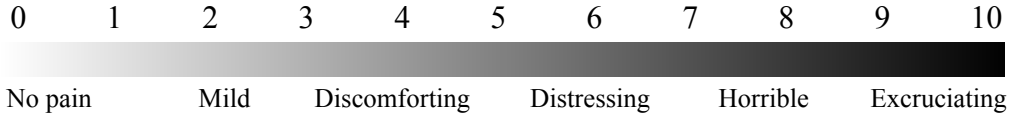
(OVER)

What is the primary reason you are seeking treatment today? _____

_____

_____

How much does it hurt?



My symptoms are due to: ❒ Auto Accident ❒ Work Accident ❒ Home Accident ❒ Gradual Onset

Have you ever had spinal surgery? ❒ Yes ❒ No

List any serious conditions or diagnoses the doctor should be aware of: _____

_____

_____

Past injuries can affect present health (please check all that apply)

❒ Falls/accidents	❒ Head injuries	❒ Broken bones	❒ Fights
❒ Sports injuries	❒ Dislocations	❒ Dental appliances	❒ Extensive dental work
❒ Surgery	❒ Knocked unconscious	❒ Motor vehicle accident	❒ Work injury

In an attempt to improve communication with all of our patients, we ask that you take a moment to answer the following:

Do you see yourself as more: ❒ Outgoing or ❒ Reserved?

Do you see yourself as more: ❒ People oriented or ❒ Task oriented?

Which best describes your learning style:

❒ Visual/seeing ❒ Auditory/hearing ❒ Tactile/touch

Office Policies: *If I am accepted as a patient at the DelVecchio Back & Neck Care Center, I agree to pay for all services, including services not covered by my insurance company. If I suspend (or terminate) my treatment without the doctor's permission, it will be understood that I have reached maximum healing for my condition. I then agree to be fully responsible for my condition and future care. I understand that no medical records or x-rays will be released from this office if I owe any money on my account.*

Consent to Treat: *I also understand that no cures are promised (or implied) and any risks regarding care at this office will be explained to me upon my request. I now authorize Dr. DelVecchio to proceed with any necessary treatment. I have read Dr. DelVecchio's office policies and consent to treat information, and I agree with them by signing below:*

Signature:_____ **Parent/Guardian's Signature:**_____

Date_____ **Date**_____

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