Colorado Family Chiropractic

Bradley K. Boyd, D.C., F.I.C.P.A **Date_____**

PATIENT INFORMATION

Patient First Name: _____ Last Name: _____ DOB: __/__/____

Address: _____ City:_____ State:_____ Zip:_____

Home Phone: ( ) _____-_____ Mobile Phone: ( ) _____-_____Work Phone( ) _____-_____

Email Address: _____

Patient Employer: _____ Title/Occupation: _____

SSN:_____ Marital Status: _____ Spouse Name: _____

Contact Spouse in Emergency Y☐ N☐Spouse Phone: ( ) ___-____ Spouse Employer_____

Emergency contact not living in your home?_____

Children: Y☐ N☐Names/Ages: _____ Pregnant: Y☐N☐ #of Weeks: _____

Who may we thank for your referral to us? _____

Complaint/Reason For Visit: _____

_____

Date of Onset: __/__/____ How did this happen? _____ Where? _____

Is this a recurrent issue? Y☐N☐ Date of previous episode:_____

Restrictions on work or play? Y☐ N☐ What activities aggravate your symptoms?_____

Are your symptoms worse during different parts of the day? Y☐ N☐ Times: _____

Do changes in weather affect your symptoms? Y☐N☐

Does pain wake you up at night? Y☐N☐

Do you experience pain daily? Y☐N☐

Have you been treated for this before? Y☐ N☐By whom? _____

Previous chiropractic experience? _____

Do you have any other medical problems you think we should be aware of? _____

_____

I understand and agree to the following:

1. Payment is due at the time of each visit, and I am fully financially responsible unless previous financial arrangements are made and signed by the doctor or office manager.
2. I grant permission to Colorado Family Chiropractic and Dr Bradley Boyd to release any pertinent information to my insurance company and/or any other entity requiring this information for the completion of this case.

SIGNED _____ DATE _____