RIMROCK wellness center

Rimrock Wellness Center
Dr. Greg Haitz D.C.
2695 Patterson Road, Suite 3
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.

Health Concerns

List health concerns according to their severity:	Rate 1-10 1=Mild 2=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 and why: (**prescription** and **non-prescription**)_____

_____

Do you wear orthotics or heal lifts? ☐ Yes ☐ No

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:_____

Please list you top three stresses in each category:

1. Physical stress (falls, accidents, work postures, etc.)

   _____ _____ _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)

   _____ _____ _____

3. Psychological stress (work, relationships, finances, self-esteem, etc.)

   _____ _____ _____

On a scale of **1-10** describe you psychological/emotional stress levels: (1=None/10=Extreme)
Occupational:_____Personal:_____

On a scale of **1-10** (1 being very poor and 10 being excellent) describe your:
Eating habits:_____ Exercise habits:_____ Sleep:_____ Mind-set:_____ General Health:_____

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:
Children:						
Spouse:						
Mother:						
Father:						
Brothers:						
Sisters:						
Other:						

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:_____