Rock Creek Spine & Rehabilitation Center 413
Summit Blvd #101, Broomfield, CO 80021
303-499-6565
Please print and bring to your first appointment.

Patient Information:

Name (First, Middle, Last): _____

Female _____ Male _____ Date of Birth: _____/ _____/ _____ Age: _____

Address: _____
City/ Zip

Cell #: _____ Home#: _____ Work#: _____

Martial Status: Married _____ Single _____ Divorced _____ Widowed _____

Occupation/ Employer: _____

Address: _____
City/ Zip

Email: _____ How did you hear about us? _____

Please Check any Complaints you have felt in the last 3 – 6 months:

☐**HEADACHES:**	☐Head feels heavy	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant/ Frequent
☐**NECK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**MID BACK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**LOW BACK:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**L / R Shoulder:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**RIB PAIN**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**L / R Hip**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**ARM / HAND:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent
☐**LEG / FOOT:**	☐Pain	☐Stiff	☐Mild	☐Moderate	☐Severe / Constant / Frequent

Please Check any activities that make your complaints worse:

☐Sitting	☐Running	☐Sit to Stand	☐Climbing	☐Standing	☐Pushing/Pulling
☐Walking	☐Driving	☐Sleep/Rolling	☐Bending	☐Reading	☐Dressing/Shaving
☐Lifting	☐Housework	☐Computer Use	☐Exercising	☐Sports	☐Yard work/Gardening

Have you seen another doctor for your pain?

Medical Doctor / Specialist / Physical Therapy / Chiropractor:
Other: _____

*(Please check **ALL** issues whether present now or in the past)*

SKIN:
- Rashes
- Itching
- Dryness

MUSCULOSKELETAL:
- Muscle or joint pain
- Stiffness
- Back pain
- Swelling of joints

NEUROLOGIC:
- Dizziness
- Fainting
- Seizures
- Weakness
- Numbness
- Tingling

EYES:
- Vision Changes
- Pain
- Redness
- Color changes
- Hair / nail changes

HEAD:
- Headache
- Head injury
- Neck Pain

EARS:
- Decreased hearing
- Ringing in ears
- Earache
- Drainage

RESPIRATORY:
- Cough
- Shortness of breath
- Painful breathing
- Blurry/double vision
- Flashing lights
- Specks
- Glaucoma
- Cataracts

NOSE:
- Allergies
- Discharge
- Hay fever
- Nosebleeds
- Sinus pain

CARDIOVASCULAR:
- High Blood Pressure
- Chest Discomfort
- Chest Tightness
- Heart Palpitations
- Shortness of Breath

GASTROINTESTINAL:
- Heartburn
- Change in appetite
- Nausea
- Change in bowel habits
- Constipation
- Diarrhea

History of Past Injuries Surgeries / Medications:
E.g. Date of Car Accidents, Sports Injuries, Slip / Falls, Surgeries, Medications & Reasons:

DATE:	REASON:
__/__/____	_____
__/__/____	_____
__/__/____	_____
__/__/____	_____
__/__/	

Medications currently taking (if any):

_____

_____

Allergies (if any):

_____

_____

Possible Contradictions:

Please check all symptoms you have ever had, even if they do not seem related to your concerns:

Pregnant? Yes ___ No ___

__Thyroid Problems __Cancer __Photo Sensitive __Liver Problems

__ Pacemaker/Heart Disease/Lymphatic Disease/ Stomach Ulcers

__ Kidney Problems/ Gallbladder Issues

__ Epilepsy/ Diabetes/ High Blood Pressure/ Hormone Imbalances

By my signature, I understand and acknowledge that the Doctor(s) will treat my present health issues as they deem necessary. I also understand that all original records and diagnostic studies are the sole property of the clinic and will be maintained in the clinic for the required statutory term. If the patient is a minor, as the parent, guardian or authorized agent. I hereby give permission to the clinic and its doctor(s) to evaluate and provide treatment for the minor patient.

Patient Signature: _____ Date: _____