Alternative Family Medicine & Chiropractic

Dr. Ann-Marie Barter, DC ◊ Dr. Jennifer Christian, DC

Date: _____

PERSONAL INFORMATION

Name: _____

Phone: _____ (H) _____ (W)

Email: _____

Address: _____

_____

Date of Birth: _____
Age: _____ SS#: _____

In Case of Emergency Contact:

Name: _____
Phone: _____
Relationship: _____

SOCIAL HISTORY

Occupation: _____

Employer: _____

Years: _____ Satisfied ? _____

Marital Status: _____

Do you have any children? _____

Do you take care of anyone besides your children?

_____

 # HOURs you spend doing the following:

TV (per day): _____ Outdoors (per day): _____

Working (per work day): _____

List any major hobbies: _____

EXERCISE

Do you exercise as much as you would like to? Y N

Goals: # days/week _____ #minutes _____

Types: _____

_____

_____

HEALTH CONCERNS

Please list in order of importance (to you) any health concerns you would like to address here:

1. _____
2. _____
3. _____
4. _____
5. _____

List any other MAJOR MEDICAL CONDITIONS you have now or have had in the past: _____

_____

_____

_____

_____

_____

List any SURGERIES or HOSPITALIZATIONS: ___

_____

_____

_____

List all PRESCRIPTION DRUGS and the name of the prescribing DOCTOR:

_____

_____

_____

_____

_____

_____

Are you ALLERGIC to any medications? Y N
If Yes, which: _____

List all OVER THE COUNTER medications, vitamins, supplements and herbal formulas that you use on a regular basis: _____

_____

_____

_____

_____

_____

_____

_____

List all other physicians, alternative care providers and therapists you see regularly: _____

_____

_____

_____

_____

_____

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FAMILY HISTORY

Please indicate which conditions listed below an immediate family member has experienced.

G=Grandparent **P**=Parent **S**=Sibling **C**=Child

Heart Disease or Heart Attack:____ G P S C
High Cholesterol:_____ G P S C
Diabetes (Type 2/Adult):_____ G P S C
Rheumatoid Arthritis:_____ G P S C
Auto-Immune Disease:_____ G P S C
Type:_____
Liver Disease_____ G P S C
Kidney Disease _____ G P S C
Cancer:
Type:_____ G P S C
Type:_____ G P S C
Type:_____ G P S C
Epilepsy _____ G P S C
Stroke _____ G P S C
Mental Illness _____ G P S C
Glaucoma _____ G P S C
Cataracts _____ G P S C
Asthma _____ G P S C
Eczema _____ G P S C
Hay fever or Hives _____ G P S C
Other Conditions not listed above:
_____ G P S C

LIFESTYLE

Sleep: Average # hours per night: _____
Usual time to bed: _____
Usual time you get up: _____
Are you satisfied with your sleep? Y N
Explain: _____

Energy: Rate your energy on scale (*circle one)*
Worst 1 2 3 4 5 6 7 8 9 10 *Best*

Mood: Are you satisfied with your mood? Y N
Explain: _____

Do use **tobacco**? Y N
Have you ever used tobacco? Y N
Years: _____ # Packs/day: _____

Do you consume **alcohol**, **beer +/or wine**? Y N

Servings day: _____

Do you consume **caffeine**? Y N

VACCINATIONS

Circle all vaccinations you have received :

DPT *(Diphtheria, Pertussis, Tetanus)*
MMR *(Measles, Mumps, Rubella)*
Gardasil *(HPV)* HiB Pneumococcal Flu Shot
Hepatitis B Polio Chicken Pox Other

SPECIALIZED TESTING

Have you had any of the following (circle & explain):
Ultrasound MRI CT scans X-Ray
Endoscopy Colonoscopy BoneDensityScan
Explain: _____
_____

MEN'S HEALTH

Have you ever experienced any of the following:
Prostate Issues Y N
Dribbling Urine or Difficulty Starting Y N
Premature Ejaculation Y N
Erectile Dysfunction Y N
Testicular Pain or Masses Y N

WOMEN'S HEALTH

Age of first menses _____
Age of last menses (if menopausal) _____
Length of Cycle (e.g. 28 days)_____
Duration of Cycle (e.g. 5 days)_____
Date of last GYN exam or Pap Smear:_____
Do you do self breast exams? Y N
Have you ever experienced any of the following?
Irregular cycles Y N
Painful menses Y N
Endometriosis Y N
Heavy Flow Y N
Spotting between menses Y N
Ovarian cysts Y N
Cervical dysplasia or an "Abnormal Pap" Y N
Breast tenderness Y N
Breast mass or lump Y N
Nipple discharge Y N
PMS Y N
If yes describe: _____
Menopausal Symptoms Y N
If yes describe: _____
Do you use Birth Control? Y N
What Type: _____
#Miscarriages:_____ #Abortions: _____
#Live Births:_____ #Pregnancies: _____

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HIPAA Notice of Privacy Practices and Consent:

- We take your privacy seriously. Your information will never be disclosed to any other party without your written consent. Information requested by our office from another practitioner also requires your written consent.

Reminder Calls:

As a courtesy, it is Alternative Family Medicine & Chiropractic policy to call your home or email on the business day prior to your scheduled appointment to remind you of your appointment time. We may leave a reminder message on your voice-mail or with the person answering the phone. No personal health information will be disclosed.

☐ I agree with Alternative Family Medicine standard method of communication.
☐ Please change as follows:
  ☐ Please contact me at the following telephone number or email:_____
  ☐ I prefer not to receive reminder calls or emails.

Statement of Financial Responsibility: I understand and agree to the following:

- Payment is due at the time of service.
- Additional charges apply for supplements, herbs, homeopathy, lab evaluation, and/or diagnostic testing and are due at the time of service.
- Alternative Family Medicine & Chiropractic does not accept insurance. We are out of network providers and will supply you with the necessary paperwork for reimbursement.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Alternative Family Medicine & Chiropractic to release information necessary to secure payment.
- Missed appointments and those cancelled with less than 24 hours business day notice are subject to a **missed appointment fee** for the total appointment rate.

Consent for Treatment with Dr. Ann-Marie Barter, DC & Dr. Jennifer Christian, DC:

I understand that my care as a patient at Alternative Family Medicine is directed by Dr. Ann-Marie Barter, DC, and Dr. Jennifer Christian, DC, licensed Chiropractors in the State of Colorado. I consent to services rendered and provided to me by Dr. Ann-Marie Barter & Dr. Jennifer Christian. **Please initial here: _____**

I have fully read and understand the above agreements and authorizations. I hereby certify that I have completed this Patient Health History truthfully and to the best of my knowledge.

_____ _____
Patient (18 years or older) **Date**

_____ _____
Parent, Guardian, Responsible Party **Date**