

**Columbine Chiropractic Health Center, P.C.**  
**329 S. Camino Del Rio**  
**Durango, CO 81303**  
**Phone: 970-259-0077**

**Confidential Case History**

DATE \_\_\_\_\_

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ SS# \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_

NUMBER OF CHILDREN \_\_\_\_\_ SPOUSE/PARTNER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PLACE OF EMPLOYMENT/OCCUPATION \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CELL PHONE \_\_\_\_\_ OFFICE PHONE \_\_\_\_\_

PLEASE INDICATE THE BEST NUMBER TO CONTACT YOU. HOME \_\_\_\_\_ CELL \_\_\_\_\_ WORK \_\_\_\_\_

WHO IS RESPONSIBLE FOR THIS ACCOUNT \_\_\_\_\_

WHOM MAY WE THANK FOR REFERRING YOU \_\_\_\_\_

**PRESENT COMPLAINTS**

NUMBER ONE CONDITION YOU WANT HELP WITH TODAY \_\_\_\_\_

WHAT OTHER CONDITIONS WOULD YOU LIKE HELP WITH \_\_\_\_\_

\_\_\_\_\_

HOW LONG HAVE YOU HAD THIS CONDITION \_\_\_\_\_ HAVE YOU EVER HAD A SIMILAR

CONDITION \_\_\_\_\_ WHEN AND FOR HOW LONG \_\_\_\_\_

WHAT TREATMENTS HAVE YOU HAD IN THE PAST FOR SIMILAR CONDITIONS \_\_\_\_\_

\_\_\_\_\_

WHAT AGGRAVATES YOUR CONDITION \_\_\_\_\_

**IS THIS CONDITION:** GETTING WORSE \_\_\_\_\_ CONSTANT \_\_\_\_\_ COMES AND GOES \_\_\_\_\_ GETTING BETTER \_\_\_\_\_

**IS THIS CONDITION INTERFERING WITH:** WORK \_\_\_\_\_ SLEEP \_\_\_\_\_ DAILY ROUTINE \_\_\_\_\_ OTHER \_\_\_\_\_

WHAT DO YOU BELIEVE IS WRONG WITH YOU \_\_\_\_\_

\_\_\_\_\_

**PREVIOUS ILLNESSES**

LIST SURGICAL OPERATIONS YOU HAVE HAD AND WHEN \_\_\_\_\_

\_\_\_\_\_

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**HAVE YOU EVER HAD OR DO YOU NOW HAVE:**

RHEUMATOID-ARTHRITIS\_\_\_ DEGENERATIVE-ARTHRITIS\_\_\_ PSORIASIS/ECZEMA\_\_\_ MULTIPLE-

SCLEROSIS\_\_\_ STROKE\_\_\_ FAINTING SPELLS OR DIZZYNESS\_\_\_ CANCER\_\_\_ BONE-TUMOR\_\_\_

OSTEOPOROSIS\_\_\_ LUPUS\_\_\_ CRACKING OR GRATING IN ANY JOINT\_\_\_ POPPING JAW\_\_\_

DIABETES\_\_\_ HIGH BLOOD PRESSURE\_\_\_ SPINAL SURGERY\_\_\_ HIGH STRESS\_\_\_

IF YOU ARE CURRENTLY TAKING ANY MEDICATIONS, INCLUDING BIRTH CONTROL, PLEASE LIST THEM:

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**ARE YOU USING:** HEEL LIFTS\_\_\_ ORTHOTICS\_\_\_ BACK BRACE\_\_\_ OTHER BRACE\_\_\_

**HAVE YOU HAD ANY MAJOR INJURIES TO ANY OF THE FOLLOWING:** HEEL\_\_\_ FEET\_\_\_ LEGS\_\_\_ KNEE\_\_\_  
HIPS\_\_\_ SHOULDER\_\_\_

LIST ANY TRAUMATIC INJURIES YOU MAY HAVE HAD \_\_\_\_\_

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**HAVE YOU EVER:** BEEN KNOCKED UNCONSCIOUS\_\_\_ USED A CANE OR CRUTCHES\_\_\_ BEEN TREATED FOR  
NERVE/SPINE DISORDER\_\_\_ FRACTURED A BONE\_\_\_ BEEN HOSPITALIZED OTHER THAN CHILDBIRTH\_\_\_

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**PRESENT GOALS**

**ARE YOU INTERESTED IN:** ACUTE CARE ONLY\_\_\_ REHABILITATIVE CARE\_\_\_ HEALTH MAINTANCE CARE\_\_\_  
PREVENTATIVE CARE\_\_\_

**ARE YOU HERE FOR:** NERVE/SPINAL COMPLAINT\_\_\_ ACUTE ILLNESS\_\_\_ JOINT INJURY/PAIN\_\_\_  
CHRONIC ILLNESS MANAGEMENT\_\_\_ HEALTH MAINTENANCE\_\_\_

**HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE**\_\_\_ HOW LONG AGO\_\_\_ FOR WHAT CONDITION

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WAS IT EFFECTIVE\_\_\_ WAS ANY SPECIAL TECHNIQUE USED\_\_\_

**DO YOU HAVE:** POOR DIGESTION\_\_\_ CHRONIC INFECTIONS\_\_\_ CHRONIC EXHAUSTION\_\_\_

CHRONIC PAIN (WHERE) \_\_\_\_\_

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**DO YOU:** SMOKE \_\_\_\_\_ HOW MUCH \_\_\_\_\_ DRINK ALCOHOL \_\_\_\_\_ HOW MUCH \_\_\_\_\_

TAKE NON-PRESCRIPTION DRUGS EG: TYLENOL, ADVIL \_\_\_\_\_ HOW MUCH \_\_\_\_\_

DRINK COFFEE \_\_\_\_ HOW MUCH/OFTEN \_\_\_\_\_ EXERCISE \_\_\_\_ HOW MUCH/OFTEN \_\_\_\_\_

SLEEP WELL \_\_\_\_ HAVE A GOOD APPETITE \_\_\_\_\_

LIST ANY CHRONIC OR RECURRENT ILLNESSES YOU HAVE HAD IN THE PAST 10 YEARS \_\_\_\_\_

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**IN CASE OF EMERGENCY NOTIFY:** NAME: \_\_\_\_\_

PHONE/CELL NUMBER: \_\_\_\_\_ ADDRESS \_\_\_\_\_

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