Dr. John Ziehr, D.C.
3540 Austin Bluff Parkway, Suite 7
Colorado Springs, CO 80918
Phone: 719.271.1236
www.thrivewellness.life

# Welcome to THRIVE

Please fill out this confidential health history form as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask for help.

Today's Date: ___/___ / ___ Whom may we thank for referring you to our office? ___________________________________

## PERSONAL HISTORY

Last Name: ____________________________________ First Name: ____________________________________ MI: ________

Address__________________________________________ City: _____________________________________ State: _________

Zip Code: _________ Home Phone: (___) ____ - _______ Cell phone: (___) ____ - _______ Email: _____________________

Birth Date: _____/ _____/ _____ Age: ______ Gender: ☐ Female ☐ Male

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Drivers License Number: ________________________________________ Social Security Number: ______-____-_________

Employer: __________________________________________ Type of Work: _________________________________________

Address: ________________________________________ City: _____________________________________ State: _________

Zip Code: _________ Work Phone: (___) ____ - _______

Spouse's Name: _________________________________ Cell Phone: (___) ____ - _______

Name & Ages of Children (if applicable):______________________________________________________________________

In an emergency, whom do we contact? _____________________________________________ Phone: (___) ____ - _______

## MAIN HEALTH CONCERNS

1. The symptom(s) that have prompted me to seek care today include: _____________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

2. And are the result of (check box):

☐ An accident: ☐ Work ☐ Auto ☐ Other __________________________________________________________________

☐ An injury : ☐ Work ☐ Auto ☐ Other ___________________________________________________________________

☐ A worsening long-term problem

3. Onset (When did you first notice your current symptoms?) ____________________________________________________

____________________________________________________________________________________________________________

____________________________________________________________________________________________________________

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Wellness Centre LLC
Your health, Your body, Your choice.

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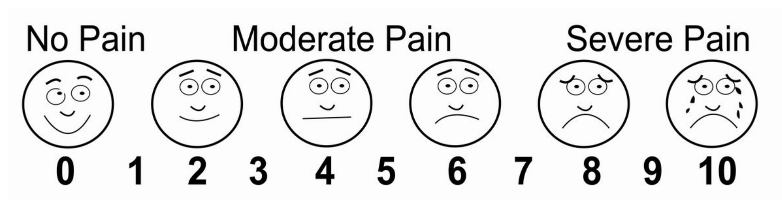
4. Intensity (Please circle the number that describes your degree of pain).




5. Duration and Timing (When did it start and how often do you feel it?)

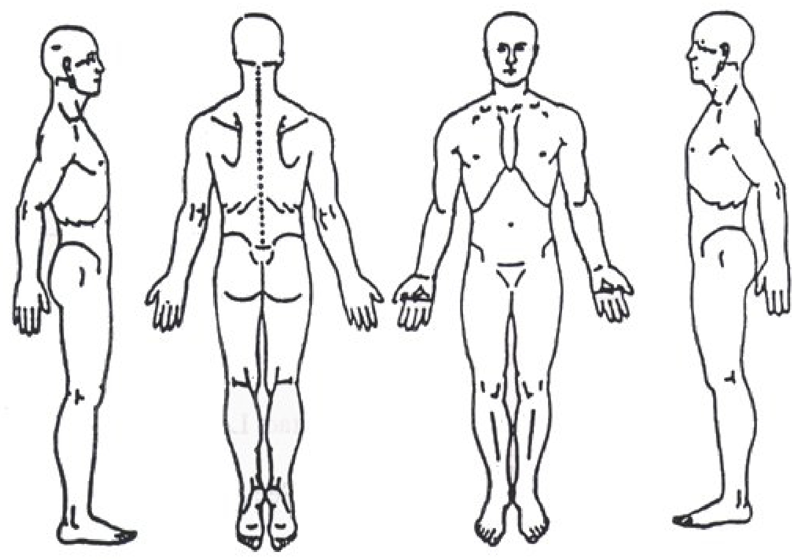
______________________________________________________________

☐ Constant ☐ Comes and goes. How Often? ______________________________________

6. Quality of symptoms (What does it feel like?)

☐ Numbness ☐ Tingling ☐ Stiffness ☐ Dull Aching ☐ Cramps
☐ Nagging ☐ Sharp ☐ Burning ☐ Shooting ☐ Throbbing
☐ Stabbing ☐ Other ________________

7. Location (Please shade in your areas of pain on the illustration below.)



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)

______________________________________________________________

______________________________________________________________

______________________________________________________________

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9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)

   What makes it worse? ______________________________

   ______________________________

   What makes it better? ______________________________

   ______________________________

10. Prior interventions (What have you done to relieve the symptoms?) ______________________________

    ______________________________

    ______________________________

11. What else should Dr. Ziehr know about your current condition?

    ______________________________

    ______________________________

    ______________________________

12. How does your current condition interfere with your work or career, recreational activities, household responsibilities, and personal relationships?

    ______________________________

    ______________________________

13. On a scale of 1-10 (ten highest) rate your commitment to getting rid of this problem: ______________

    Is getting rid of this problem, and what caused it, a top priority for you? ______________

## PAST HISTORY

Surgeries/Operations: ☐ Appendix ☐ Tonsils ☐ Hernia ☐ Spinal ☐ Cosmetic ☐ Other: ______________

Major accidents or falls since birth: ______________________________

Hospitalizations (other than above): ______________________________

Please list all medications you presently take: (please include all medications, including over the counter and vitamins):

______________________________

______________________________

______________________________

______________________________

Please list any know allergies/sensitivities: ______________________________

______________________________

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please indicate for what condition: ______________________________

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Please list the physician's name, phone number, and approximate date of last treatment: ______________________________

______________________________________________________________________________

Have you had previous chiropractic care? ☐ Yes ☐ No

Please list doctor's name and approximate date of last visit: ______________________________

Are you presently under the care of any other health care practitioners?

☐ Acupuncturist ☐ Massage Therapist ☐ Nutritionist ☐ Other: ______________________________

Please check any of the following conditions that you have had in the past:

| | | |
|---|---|---|
| ☐ Pneumonia | ☐ Tuberculosis | ☐ Rheumatic Fever |
| ☐ Measles | ☐ Thyroid Disorder | ☐ Small Pox |
| ☐ Mumps | ☐ Influenza | ☐ Eczema/Psoriasis |
| ☐ Arthritis | ☐ Polio | ☐ Whooping Cough |
| ☐ Heart Disease | ☐ Cancer | ☐ Other: ______________ |
| ☐ Pleurisy | ☐ Anemia | ☐ Other: ______________ |

## FAMILY HISTORY

Please list family members who have the following conditions:

| | |
|---|---|
| ☐ Cancer: ______________ | ☐ Autoimmune disease: ______________ |
| ☐ Eczema: ______________ | ☐ Arthritis: ______________ |
| ☐ Diabetes: ______________ | ☐ Allergies: ______________ |
| ☐ Heart disease: ______________ | ☐ Asthma: ______________ |
| ☐ High blood pressure: ______________ | ☐ Addictions: ______________ |
| ☐ Stroke: ______________ | ☐ Liver disease: ______________ |
| ☐ Thyroid disease: ______________ | ☐ Mental illness: ______________ |

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## REVIEW OF SYSTEMS

Please mark each item below for each sign or symptom you presently have or previously had:

**GENERAL SYMPTOMS**
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Nervousness
- ☐ Numbness
- ☐ Wheezing

**MUSCLES & JOINTS**
- ☐ Low Back Problems
- ☐ Pain between Shoulders
- ☐ Neck Problems
- ☐ Arm Problems
- ☐ Leg Problems
- ☐ Swollen Joints
- ☐ Painful Joints
- ☐ Stiff Joints
- ☐ Sore Muscles
- ☐ Weak Muscles
- ☐ Walking Problems
- ☐ Sprains/Strains
- ☐ Broken Bones

**CARDIOVASCULAR**
- ☐ High Blood Pressure
- ☐ Heart Attack
- ☐ Pain over Heart
- ☐ Poor Circulation
- ☐ Heart Trouble
- ☐ Rapid Heart
- ☐ Slow Heart
- ☐ Strokes
- ☐ Swelling Ankles
- ☐ Varicose Veins

**EAR/NOSE/THROAT**
- ☐ Earache
- ☐ Ear Noises
- ☐ Enlarged Thyroid
- ☐ Frequent Colds
- ☐ Hay Fever
- ☐ Nasal Blockage
- ☐ Nose Bleeds
- ☐ Pain Behind Eyes
- ☐ Poor Vision
- ☐ Sinusitis
- ☐ Sore Throats
- ☐ Tonsillitis

**GASTROINTESTINAL**
- ☐ Belching/Gas
- ☐ Colon Problems
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gall Bladder Trouble
- ☐ Hemorrhoids
- ☐ Liver/Gallbladder
- ☐ Nausea
- ☐ Abdominal Pain
- ☐ Ulcer
- ☐ Poor Appetite
- ☐ Poor Digestion
- ☐ Vomiting
- ☐ Vomiting Blood
- ☐ Black Stool
- ☐ Bloody Stool
- ☐ Weight Loss/Gain

**FOR MEN ONLY**
- ☐ Prostate Problems
- ☐ Loss of libido
- ☐ Sexual dysfunction

**RESPIRATORY**
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Spitting Blood
- ☐ Spitting Phlegm

**GENITOURINARY**
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Kidney Infection
- ☐ Painful Urination
- ☐ Loss of Bladder Control

**SKIN OR ALLERGIES**
- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Eczema/Rash/Dermatitis
- ☐ Hives
- ☐ Itching
- ☐ Sensitive Skin
- ☐ Allergy _______________

**FOR WOMEN ONLY**
- ☐ Birth Control __________
- ☐ Hormone Replacement
- ☐ Cramps/Backaches
- ☐ Excessive Flow
- ☐ Hot Flashes
- ☐ Irregular Cycle
- ☐ Miscarriage
- ☐ Painful Periods
- ☐ Vaginal Discharge
- ☐ Breast Pain

Pregnant at this Time ☐ Yes ☐ No

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As a patient, I have the right to be informed about my health condition(s) and recommended treatments. Dr. Ziehr will discuss the potential benefits, risks and hazards involved. After signing this consent form, I understand I can withdraw consent at any time.

I may request a copy of the Privacy Policy and understand that it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.

I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information as a part of my care at this office.

I acknowledge that any health insurance I may have is an agreement between the carrier and me. I am responsible to pay for my services when they are rendered. If you have insurance that offers chiropractic benefits and you intend to submit bills, please let us know as we will print you out a statement at the time of checkout that you can submit to your health insurance provider. A charge of $25.00 will be applied for statements that need to be reissued.

I give my written consent for evaluation and treatment. I intend this as a consent form to cover my entire course of treatments including any future conditions for which I seek treatment.

_______________________________________ Signature

_______________________ Date

_______________________________________ Print Name