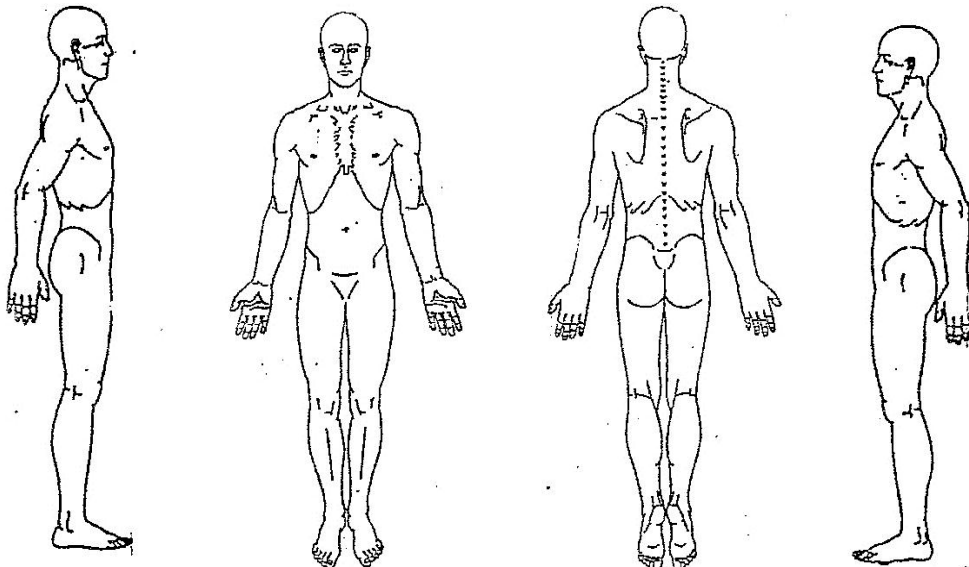


BoulderBodyworks

Patient History

Name:		Date of Birth:		Today's Date:	
Email:		Phone #s: <small>(Please check your preferred contact number)</small>	<input type="checkbox"/> Cell		
Address:			<input type="checkbox"/> Home		
City, State & Zip:			<input type="checkbox"/> Work		
Referred By / How did you hear about us?:		Height:		Weight:	
Emergency Contact:		Emergency Contact Phone & Relationship:			
Primary Medical Care Providers:					
Are you pregnant?	Y / N	How many weeks?		When is your due date?	
				Are you a high risk pregnancy?	Y / N
Presenting Complaint(s):					
Goals For Treatment (fitness, health, diet, wellness goals):					

Please mark regions of **pain with X's**, mark **P** for "pins & needles" and **N** for "numbness"



3020 Carbon Place, Suite 330 Boulder CO 80301
 303.444.2739, fax 303.938.1311
www.boulderbodyworks.com

List all surgeries (include approximate dates):

List all motor vehicle and other types of accidents (include approximate dates):

List all fractured bones, sprains and major falls:

Do you remember any falls on your tailbone? (think of episodes on snow or ice):

List previous medical diagnostic tests and finds (blood chemistry, MRI, etc.) pertinent to presenting complaint(s):

List previous treatments for presenting complaint(s) and results:

List all medications/nutritional supplements you take (include brand name & dosage):

Please describe your current diet and activities:

Diet:

Activities:

Are you interested in making changes to your diet/activities? If so, what changes?

Other information you would like to include:

Your Medical History

Please mark all that apply with an X

- Arthritis
- Allergies/Hayfever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- High blood pressure
- Low blood pressure
- Bronchitis
- Cancer
- Chronic Fatigue
- Carpal Tunnel
- Elevated Cholesterol
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticulitis
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Ear, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux
- Genetic disorder
- Glaucoma
- Gout
- Heart Disease
- Chronic infections
- Kidney disease
- Learning disabilities
- Liver/gall bladder disease
- Mental illness
- Migraine headaches
- Neurologic disease
- Sinus problems
- Stroke
- Thyroid dysfunction
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease

- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____
- Other _____
- Other _____

Female Health

- Menstrual Irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Uteran fibroids
- Ovarian Cysts
- PMS
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Diminished sex drive

Age of 1st period _____
Date of last GYN exam _____
Mammogram + ___ - ___
Pap + ___ - ___
Form of birth control _____
of children _____
of pregnancies _____
___ C-section
___ Hysterectomy
___ Menopause
Date of last period _____
recent changes in menstrual flow?

Male Health

- Benign prostate hyperplasia
- Prostate cancer
- Diminished sex drive
- Infertility
- Other _____

Family Health History

- Arthritis, rheumatoid
- Arthritis, osteoarthritis
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorders
- Genetic disorders
- Glaucoma
- Heart disease
- Infertility
- Mental illness
- Migraine headaches
- Neurologic disorder
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____
- Other _____

Health Habits

- Tobacco
- # cigarettes per day _____
- ___ Alcohol
- Wine: glasses per day/wk _____
- Beer: # per day/wk _____
- Liquor: oz. per day/wk _____
- ___ Caffeine
- Coffee: #6oz cups per day _____
- Espresso: #oz per day _____
- Tea: #6oz cups per day _____
- Soda: #cans per day _____
- ___ Water
- # of glasses per day _____

Exercise

- 1-2 days/wk
- 3-4 days/wk
- 5-7 days/wk
- 45+ min/workout
- 30-45min/workout
- <30min/workout
- Walk
- Run, jog, jump rope
- Weight lifting
- Swim
- Martial arts
- Yoga
- Pilates
- Tai Chi
- Cycling
- Other _____
- Other _____

Diet

- Omnivore (meat & vegetables)
- Vegetarian (vegetarian + milk/eggs)
- Vegan (vegetarian & NO eggs/ milk)
- Salt restriction
- Fat restriction
- High Carbohydrate diet
- Calorie restriction

Known Food Sensitivities

- Dairy
- Wheat
- Eggs
- Citrus
- Soy
- Corn
- Nuts
- Other _____
- Other _____
- Other _____

Food Frequency

- *** servings per day
- Fruit
- Vegetables
- Cooked grains
- Beans
- Dairy
- Eggs
- Meat, poultry, fish
- Water

Eating Habits

- Three meals/day
- Two meals/day
- One meal/day
- Graze (small frequent meals)
- Food rotation
- Eat constantly whether hungry or not
- Generally eat on the run
- Add salt to food

Do you consider yourself

- Underweight
- Overweight
- Ideal weight
- Unintentional weight loss/gain lately
- Your weight today

Do you experience any of these general symptoms daily?

- Fatigue
- Depression
- Disinterest in sex
- Disinterest in eating
- Shortness or breath
- Panic attacks
- Headaches
- Dizziness
- Insomnia
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Urinary incontinence
- Fecal incontinence
- Low grade fever
- Chronic pain/inflammation
- Bleeding
- Mucous or pus discharge
- Itching/Rash

Is your job associates with

- Extensive stress
- Harmful chemicals
- Repetitive movement
- Heavy lifting
- Life threatening activities (e.g. firefighter)

Sleep Habits

- Sleep well-no problems
- Sleep disturbance-mild
- Sleep disturbance-moderate
- Sleep disturbance-extreme
- Sleep apnea
- Awaken to urinate
- Recent changes in sleep
- Awaken same time each night at _____ a.m./p.m.
- Use medication to sleep

Generally sleep _____ hrs/night

Your primary treatment goals are

- Pain relief
- More energy
- Improved digestion
- Increased strength
- Increased sex drive
- Improved skin, hair, nails
- Improved moods
- Improved brain function
- Headache relief
- Improved range of motion
- Improved sleep
- Allergy relief
- General wellness
- Lower risk of disease
- Other _____
- Other _____
- Other _____