HEALTH FOR LIFE

DR. DERRICK STANBRIDGE D.C.

6033 S. FASHION POINT DR. # 120 SOUTH OGDEN, UT 84403

PHONE: 801.475.6800 FAX:801.475.6802

Thank you for choosing Health For Life for your Chiropractic needs. Please complete this form in ink. All information provided is confidential. If you have questions or concerns, please ask for assistance.

Name: _____ DOB: _____ Sex: M or F

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____)_____ Email: _____

Marital Status: _____ Spouse's Name: _____ Phone: (_____)_____

Emergency Contact: _____ Phone: (_____)_____

Nearest Relative Not Living With You: _____ Phone: (_____)_____

Referral/How did you hear about us? _____

Responsible Party/Insurance Information

Person responsible for account: _____ DOB:_____

Relationship: _____ Phone: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

Primary Health Insurance Information

Carrier: _____Phone: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

Name of Insured: _____ DOB:_____

Policy #: _____ Group #:_____

Patient Relationship to Insured: Self Spouse Child Other: _____

Secondary Health Insurance Information

Carrier: _____Phone: (_____)_____

Address: _____ City: _____ State:_____ Zip:_____

Name of Insured: _____ DOB:_____

Policy #: _____ Group #:_____

Patient Relationship to Insured: Self Spouse Child Other: _____

Medical Conditions: (Check all that apply)

- ☐ Arthritis
- ☐ Cancer
- ☐ Stroke
- ☐ Cancer Hypertension
- ☐ Cholesterol elevated
- ☐ Psychiatric illness
- ☐ Diabetes
- ☐ Skin Disorder

Surgeries: (Check all that apply)

- ☐ Appendectomy
- ☐ Joint replacement
- ☐ Cardiovascular procedure
- ☐ Laminectomies
- ☐ Cervical Disc Procedure
- ☐ Radical Prostatectomy
- ☐ Hysterectomy
- ☐ Transuretheral Prostate Surgery

Allergies: (Check all that apply)

- ☐ Eggs
- ☐ Soy
- ☐ Fish & Shellfish
- ☐ Sulfites
- ☐ Milk or Lactose
- ☐ Wheat/Gluten
- ☐ Peanuts

Social History: (Check all that apply)

- ☐ Caffeine used occasionally
- ☐ Drink alcohol occasionally
- ☐ Exercise often
- ☐ Smoke more than 1 pack a day
- ☐ Caffeine used often
- ☐ Drink alcohol often
- ☐ Experience stress occasionally
- ☐ Wear seatbelts always
- ☐ Chew tobacco occasionally
- ☐ Exercise not al all
- ☐ Experience stress often
- ☐ Wear seatbelts never
- ☐ Chew tobacco often
- ☐ Exercise occasionally
- ☐ Smoke 1 pack or less per day
- ☐ Wear seatbelts usually

Family History: (Check all that apply)

- ☐ Arthritis (parent)
- ☐ Cholesterol (parent)
- ☐ Heart problems (parent)
- ☐ Psychiatric (parent)
- ☐ Thyroid (parent)
- ☐ Arthritis (sibling)
- ☐ Psychiatric (sibling)
- ☐ Thyroid (sibling)
- ☐ Cancer (parent)
- ☐ Diabetes (parent)
- ☐ High Blood Pressure (parent)
- ☐ Stroke (parent)
- ☐ Cancer (sibling)
- ☐ Diabetes (sibling)
- ☐ High Blood Pressure (sibling)
- ☐ Stroke (sibling)
- ☐ Cholesterol (silbing)
- ☐ Heart Problems (sibling)

Substance Use: (Check all that apply)

- ☐ Alcohol (past)
- ☐ Barbiturates (past)
- ☐ Crystal Meth
- ☐ Marijuana (present)
- ☐ Alcohol (present)
- ☐ Barbiturates (present)
- ☐ Heroin (past)
- ☐ Amphetamines (past)
- ☐ Cocaine (past)
- ☐ Heroin (present)
- ☐ Amphetamines (present)
- ☐ Cocaine (present)
- ☐ Marijuana (past)

Male Children: (Check all that apply)

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

Female Children: (Check all that apply)

- ☐ Under 6 years
- ☐ Under 10 years
- ☐ Under 19 years

Occupational Activities: (Check all that apply)

- ☐ Administration
- ☐ Construction
- ☐ Healthcare
- ☐ Household
- ☐ Military
- ☐ Teacher
- ☐ Business owner
- ☐ Daycare/childcare
- ☐ Heavy equipment operator
- ☐ Light manual labor
- ☐ Police/fire
- ☐ Truck driver
- ☐ Clerical/secretarial
- ☐ Executive/legal
- ☐ Heavy manual labor
- ☐ Manufacturing
- ☐ Professional services
- ☐ Computer user
- ☐ Food service industry
- ☐ Home serves
- ☐ Medium manual labor
- ☐ Retail worker

Recreational Activities: (Check all that apply)

- ☐ Backpacking
- ☐ Golf
- ☐ Soccer
- ☐ Weight lifting
- ☐ Biking
- ☐ Racket ball
- ☐ Swimming
- ☐ Boating
- ☐ Running
- ☐ Tennis
- ☐ Football
- ☐ Skiing
- ☐ Walking.

Patient: Account Number:

HAVE YOU HAD TROUBLE WITH ANY OF THE FOLLOWING: (Check all that apply)

Cardiovascular:	Present	Past	No
Poor circulation	o	o	o
High Blood Pressure	o	o	o
Aortic Aneurism	o	o	o
Heart Disease	o	o	o
Heart Attack	o	o	o
Chest Pain	o	o	o
High Cholesterol	o	o	o
Pace Maker	o	o	o
Jaw Pain	o	o	o
Irregular Heartbeat	o	o	o
Swelling of Legs	o	o	o

Genitourinary:	Present	Past	No
Kidney Disease	o	o	o
Lower Side Pain	o	o	o
Burning Urination	o	o	o
Blood In Urine	o	o	o
Kidney Stone	o	o	o

Hematologic/ Lymphatic:	Present	Past	No
Hepatitis	o	o	o
Blood Clots	o	o	o
Cancer	o	o	o
Easy Bruising	o	o	o
Easy Bleeding	o	o	o

Respiratory:	Present	Past	No
Asthma	o	o	o
Tuberculosis	o	o	o
Shortness of Breath	o	o	o
Emphysema	o	o	o
Cold/Flu	o	o	o
Cough/Wheezing	o	o	o

Ears/Nose/Throat:	Present	Past	No
Dizziness	o	o	o
Hearing Loss	o	o	o
Sinus Infection	o	o	o
Nosebleed	o	o	o
Sore Throat	o	o	o
Difficulty Swallowing	o	o	o
Bleeding Gums	o	o	o

Eyes	Present	Past	No
Glaucoma	o	o	o
Double Vision	o	o	o
Blurred Vision	o	o	o

Integumentary:	Present	Past	No
Skin Ulcers	o	o	o
Skin Disease	o	o	o
Eczema	o	o	o
Psoriasis	o	o	o
Rashes	o	o	o

Allergic/ Immunologic:	Present	Past	No
Hives	o	o	o
Immune Disorder	o	o	o
HIV/AIDS	o	o	o
Allergy Shots	o	o	o
Cortisone Use	o	o	o

Gastrointestinal:	Present	Past	No
Gallbladder issues	o	o	o
Bowel Problems	o	o	o
Constipation	o	o	o
Liver Problems	o	o	o
Ulcers	o	o	o
Diarrhea	o	o	o
Nausea/Vomiting	o	o	o
Bloody Stools	o	o	o
Poor Appetite	o	o	o

Musculoskeletal:	Present	Past	No
Gout	o	o	o
Arthritis	o	o	o
Joint Stiffness	o	o	o
Muscle Weakness	o	o	o
Osteoporosis	o	o	o
Broken Bones	o	o	o
Joints Replaced	o	o	o

Neurological:	Present	Past	No
Stroke	o	o	o
Seizures	o	o	o
Head Injury	o	o	o
Brain Aneurysm	o	o	o
Numbness	o	o	o
Severe Headaches	o	o	o
Pinched Nerves	o	o	o
Parkinson's disease	o	o	o
Carpal Tunnel	o	o	o
Spinning/Balance	o	o	o

Endocrine:	Present	Past	No
Thyroid Disease	o	o	o
Diabetes	o	o	o
Hair Loss	o	o	o
Menopausal	o	o	o
Menstrual Problems	o	o	o

Psychiatric:	Present	Past	No
Depression	o	o	o
Anxiety disorder	o	o	o
Unusual Stress	o	o	o

Constitutional:	Present	Past	No
Weight Loss/Gain	o	o	o
Energy Level Issue	o	o	o
Difficulty Sleeping	o	o	o

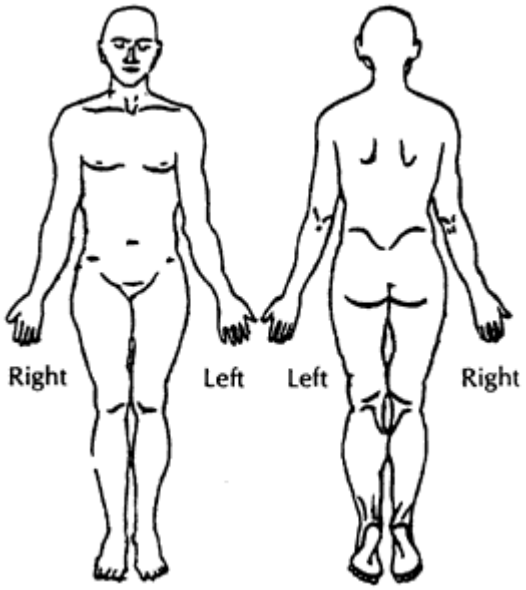
Patient: Account Number:

Chief Complaint: _____

Symptoms began on: _____

Describe complaint in your own words:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____



Indicate the areas where you have pain

1. Average Pain Intensity:

Last 24 hours: (circle one): no pain 1 2 3 4 5 6 7 8 9 10 worst pain

Last week: (circle one): no pain 1 2 3 4 5 6 7 8 9 10 worst pain

2. How often do you experience your symptoms? (circle one)

Constantly (76%-100% of time) Frequently (51%-75% of time)

Occasionally (26%-50% of time) Intermittently (0%-25% of time)

3. How much have your symptoms interfered with your usual daily activities? (Circle one)

Not at all A little bit Moderately Quite a bit Extremely

4. In general what would you say your overall health right now is? (Circle one)

Excellent Very Good Good Fair Poor

5. List any current medications taken:

_____
_____
_____
_____

Patient: Account Number:

Symptoms:

Neck Pain

(Check the areas that the pain runs into from neck)

□ none □ left shoulder □ left arm □ left forearm
□ left hand □ right shoulder □ right arm □ right hand
□ right forearm

□ Headache
□Migraine
□Upper Back Pain

Ringing in Ears? YES NO □ Left □ Right □ Both
Blurry Vision? YES NO □ Left □ Right □ Both
Wrist Pain? YES NO □ Left □ Right □ Both
Jaw Pain? YES NO □ Left □ Right □ Both

Low Back Pain

(Select the areas of radiation)

□ none □ buttocks □ left buttock □ right buttock
□ left thigh □ right thigh □left knee □ right knee
□left foot □ right foot

Hip Pain? □ Left □ Right □Bilateral
Knee Pain? □ Left □ Right □Bilateral
Foot Pain? □ Left □ Right □Bilateral

Additional Symptoms/Complaints

□ Numbness area: _____
□Dizziness
□Nervousness
□Fatigue
□Anxiety
□Depression
□Excessive Irritability
□Jaw clenching
□Grinding of teeth at night
□Nightmares
□Difficulty Sleeping
□Other:_____

How much have your symptoms improved:

Not at all A little bit Moderately Quite a bit

Patient:

Doctor's Notes

Short Term Goals:_____
_____
_____

Long Term Goals:_____
_____
_____

Diagnosis:

1.

2.

3.

4.

Additional dx codes:
_____
_____

Patient Initial Treatment Plan:
_____
_____
_____

Risks/Contraindications: No or Yes?

If yes please explain:
_____
_____

Account Number: