

Please submit to **Hotz Family Chiropractic 1639 S. Lemay, Fort Collins CO 80525**  
**Confidential Patient Information**

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home / Cell Telephone: ( ) \_\_\_\_\_ Work Telephone: ( ) \_\_\_\_\_

Email address: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Name of  Wife,  Husband, or  Guardian: \_\_\_\_\_

Names & Ages of Children \_\_\_\_\_

Marital Status:  M  S  W  D Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Pregnant? Y / N Occupation: \_\_\_\_\_

Employer's Name & Address: \_\_\_\_\_

Insurance Company Name and Phone Number \_\_\_\_\_ (Please present your card for us to copy)

Method of Payment (circle one)      Cash                      Check                      Credit Card

WHO MAY WE THANK FOR REFERRING YOU TO US ? \_\_\_\_\_

List your problems or complaints according to <u>severity of pain</u> :	Date Started, or for how long.	If you had the condition before, when?	Did problem begin with an injury?
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

Is this condition interfering with your:  work  sleep  daily routine  sports\exercise  Other \_\_\_\_\_

Indicate any function below that is aggravated or affected by your condition: (circle)

Walking      Step Climbing      Driving      Working      Recreation      Family / Play Time      Digestion  
Vision      Breathing      Sinuses      Hearing      Smelling      Sleeping      If female, Menstrual

Other Doctor's seen for this Condition:  Medical Dr.  Chiropractor  Dentist  Other \_\_\_\_\_

Have you ever been diagnosed with cancer and / or any serious disease? Y / N \_\_\_\_\_

Are you taking any medications (drugs)? \_\_\_\_\_ What Kind? \_\_\_\_\_

Have you had any x-rays taken?      When? \_\_\_\_\_      Where? \_\_\_\_\_      Area of Body : \_\_\_\_\_

Accidents and/or injuries: auto, work related, sports, or other (Especially those related to your present problem).

1. Type: \_\_\_\_\_ When: \_\_\_\_\_ Hospitalized?  yes  no

2. Type: \_\_\_\_\_ When: \_\_\_\_\_ Hospitalized?  yes  no

3. Type: \_\_\_\_\_ When: \_\_\_\_\_ Hospitalized?  yes  no

Have you had any surgery? (Please include all surgery)

1. Type: \_\_\_\_\_ When: \_\_\_\_\_ Doctor: \_\_\_\_\_

2. Type: \_\_\_\_\_ When: \_\_\_\_\_ Doctor: \_\_\_\_\_

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**Please check off any of the following symptoms you are experiencing**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> Cold sweats          | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Dizziness            | <input type="checkbox"/> Neck stiff           | <input type="checkbox"/> Buzzing in ears     | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Light Bothers Eyes   | <input type="checkbox"/> Pins/Needles in arms | <input type="checkbox"/> Loss of taste       | <input type="checkbox"/> Irritability        |
| <input type="checkbox"/> Neck Pain            | <input type="checkbox"/> Sleeping problems    | <input type="checkbox"/> Numbness in toes    | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Pins/Needles in legs | <input type="checkbox"/> Loss of balance     | <input type="checkbox"/> Ear ring            |
| <input type="checkbox"/> Loss of memory       | <input type="checkbox"/> Face flushed         | <input type="checkbox"/> Tension             | <input type="checkbox"/> Loss of smell       |
| <input type="checkbox"/> Stomach upset        | <input type="checkbox"/> Fever                | <input type="checkbox"/> Feet cold           | <input type="checkbox"/> Hands cold          |

**Check the following conditions you may have had or do have now:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Allergy          | <input type="checkbox"/> Diarrhea            | <input type="checkbox"/> Measles            | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> Eczema              | <input type="checkbox"/> Miscarriage        | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Heart Attack     |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Gall Bladder        | <input type="checkbox"/> Mumps              | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Gout                | <input type="checkbox"/> Neuritis           | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nervousness        | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Depression         | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Convulsions      | <input type="checkbox"/> Malaria             | <input type="checkbox"/> Pleurisy           | <input type="checkbox"/> Whooping Cough   |
| <input type="checkbox"/> Constipation     | <input type="checkbox"/> Menstrual Cramps    | <input type="checkbox"/> Pneumonia          | <input type="checkbox"/> Low Blood Sugar  |
| <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Irregular Periods   | <input type="checkbox"/> Polio              | <input type="checkbox"/> Neck Pain        |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Migraines           | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Back Pain        |
| <input type="checkbox"/> Sinus Problems   | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Ringing in ears    |   |

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that Hotz Chiropractic may prepare any necessary reports to assist me in making collection from the insurance company and that any amount authorized to be paid directly to Hotz Chiropractic will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient's signature \_\_\_\_\_ Date \_\_\_\_\_

Guardian or Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

Information taken by \_\_\_\_\_ Date \_\_\_\_\_