Rock Integrated Health

Parker, C0 303-840-2092

Patient Application Pg1

Confidential Health Information

Date:

1 PATIENT CONTACT

Last Name:	First Name:	Middle Initial:
Preferred to be Called:	Occupation:	
Address:		
City/State: / Zip Code:	How were you referred to us?	
Home Phone:	Cell Phone:	
Work Phone:	E-mail:	
Primary Physician:	Insurance:	

Are you an active or former member of Military or Law Enforcement? ◯ YES ◯ NO

2 PATIENT PERSONAL

Age: / Date of Birth:	Social Security #:	Gender: ◯ M ◯ F	
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced			
Name of Spouse:	Names and Ages of Children:		

3 EMERGENCY CONTACT

Name:	Home Phone:
Relationship:	Cell Phone:

4 PRIMARY COMPLAINT

What is your ***primary complaint*** that you are seeing the doctor for? (Specific complaint, describe the pain at its worst)

How long have you had this problem?

How severe is the problem **(10 *being the worst possible)*** 1 2 3 4 5 6 7 8 9 10

What treatment(s) have you tried in the past?

Are you taking an medications/injections for the problem(s)?

What activities have you given up due to this problem?

Before you began to suffer with this problem, was there an earlier accident, injury or condition that may or may not have been directly related to this problem? (i.e. falls, sports injuries, repetitive motion, auto accident) ◯ **YES** ◯ **NO**

If yes, please explain:

Clinician Reviewed:_____ Date:_____

5 CURRENT ACTIVITY LEVEL **Please check what is your current activity level.**

☐ **INACTIVE**: No regular physical activity with a sit-down job.

☐ **LIGHT ACTIVITY**: Occassionally involved in activities such as walking, jogging, cycling, tennis or golf.

☐ **MODERATE ACTIVITY**: Participation in extensive physical exercise, for a least 60 minutes per session, 2-3 times per week

☐ **VIGOUROUS ACTIVITY**: Consistent lifting, stair climbing, heavy construction or regular participation in jogging, swimming cycling or active sports at least 3-5 times per week.

LIST your hobbies/activites that **you like to do**:

6 GENERAL HEALTH

Any General Allergies? (ie. Food, Hay Fever) (Specify)

Any Drug Related (Medication) Allergies? (Specify)

Any Sulfa Allergies? ◯ YES ◯ NO | Any Latex Allergies? ◯ YES ◯ NO

Use of: ***(click on answer)***

Tobacco/Vaping: Never Rare Occasional Moderate Daily **Alcohol:** Never Rare Occasional Moderate Daily

Recreational Drugs: Never Rare Occasional Moderate Daily **Exposure to:** Fumes Dust Solvents Noise

1. Are you diabetic? YES NO Type 1 or Type 2 ***(please circle)*** Date of Diagnosis:

Last HA1C Level: Date: Last Fasting Blood Sugar Level: Date:

2. Implantable devices? YES NO If Yes, please list:

3. History of seizures? YES NO If Yes, list your last episode date:

4. History of cellulitis? YES NO

5. Any current wounds, rashes or skin infections? YES NO If yes, please list:

Please list all Medications/Vitamins you are *currently* taking:

Medications	Dosage	Vitamins	Frequency

SYMPTOM SURVEY

Please click on and rate all *symptoms* that apply to you *currently* or in the past *2-3 months*:

0 = Never; 1 = Rare; 2 = Occasionally; 3 = Frequently; 4 = Constant

Headaches/Migraines	**0 1 2 3 4**	**Muscle Aches**	**0 1 2 3 4**	**Insomnia**	**0 1 2 3 4**
Numbness Arms/Hands	**0 1 2 3 4**	**Dizziness/Lightheaded**	**0 1 2 3 4**	**Fatigue/Weakness**	**0 1 2 3 4**
Fogginess/Forgetful	**0 1 2 3 4**	**Constipation/Diarrhea**	**0 1 2 3 4**	**Arthritis Pain**	**0 1 2 3 4**
Numbness Legs/Feet	**0 1 2 3 4**	**Difficulty Breathing**	**0 1 2 3 4**	**Fibromyalgia**	**0 1 2 3 4**

Clinician Reviewed:_____ Date:_____

Check the box if applicable and Click on L or R	Please describe your symptoms (Click all that apply)
☐ **FOOT PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **HAND PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **KNEE PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **HIP PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **SHOULDER PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **ELBOW PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **WRIST PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **NECK PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic
☐ **LOW BACK PAIN** (Right / Left) **When did this pain start?**	sharp / dull / aching / burning / stabbing / other:_____ constant / daily / sporadic

1 Have you had any previous testing, workup, or imaging for the above selected symptoms? Y / N
If YES, then who did you see and what was done? _____

2 Have you experienced any motor weakness? Y / N Please describe:_____

3 Have you fallen in the past 3 months? Y / N Do you have a fear of falling? Y / N

4 Do you have to hold onto walls/furniture to help you walk or get up from the floor? Y / N

Please click on *all conditions* that you ***currently*** have or have had ***in the past***?

Ear Infection	Frequent Colds	Broken or Fractured Bones
Glaucoma/Eye Vision Problems	Lung Problems/Disorders	Osteoarthritis
Sinus Problems	Rheumatic Fever	Rheumatoid Arthritis
Thyroid Problems	Bronchitis/Pneumonia	Psychiatric Problems/Disorders
High Blood Pressure/Hypertension	Measles/Mumps/Chickenpox	Suicide Attempts
Low Blood Pressure/Hypotension	Unusual Child Illness	Depression/Anxiety
Pacemaker	Atopic Dermatitis	HIV Positive/AIDS
Mitral Valve Prolapse	Hives/Eczema	Polio
Strokes/CVA	Scarlett Fever	Diphtheria
Heart Problems/Disorders	Rash	Hernia
Blood or Plasma Transfusion	Digestive Problems	CRPS/RSD
Sickle Cell Anemia	Hemorrhoids	ADD/ADHD
Excessive Bleeding	Liver Disease	Congenital Disease
Anemia	Hepatitis	Cancer
Asthma	Kidney Disease	Epilepsy
Whooping Cough	Chronic Bladder Infections	Fetal Drug Exposure
Infectious Mono	Prostate Problems/Disorders	Difficult or Painful Urination

Clinician Reviewed:_____ Date:_____

GYNECOLOGICAL HISTORY:

Are you currently pregnant? YES NO # of Pregnancies _____ # of Miscarriages _____

Natural Delivery or C-Section? _____ Last menstrual cycle: _____

Are your cycles regular? YES NO Any pain associated with your cycles? YES NO

FAMILY HISTORY:

			Condition (of Health or reason for Death)
Father:	Alive	Deceased	_____
Mother:	Alive	Deceased	_____
Sibling:	Alive	Deceased	_____
Sibling:	Alive	Deceased	_____
Son(s):	Alive	Deceased	_____
Daughter(s):	Alive	Deceased	_____

PREVIOUS HOSPITALIZATIONS OR SURGERIES:

6 COMMUNICATIONS

We request the opportunity to call or text you for reminding you of your appointments, to obtain feedback on an experience within our office, and/or to provide general health reminders/information. If you would like to receive this feature in the future, please read the consent below and sign.

I would like to receive communication(s) from Rock Integrated Health via:

- ☐ Telephone (Voicemail or Text)
- ☐ Email
- ☐ Both are fine

I give Rock Integrated Health permission to send messages to me via email and/or text messaging as a means of communication as indicated by my selection above.

Patient Signature:_____ Date:_____

Clinician Reviewed:_____ Date:_____