Dale Retzer, DC
609 W Littleton Blvd, Suite 210 – Littleton, CO 80120
303-730-2414

Name ______________________ Age ______ Sex: M F DOB ________ Today's Date __________

Address ______________________ City ______________________ State ________ Zip ______________

Home Phone ______________ Work Phone ______________ Cell Phone ______________ e-mail: ______________

May we leave a voice mail? Y N Height ______ Weight: ______ How Did You Hear About Us? ______________________

Employer ______________ Occupation ______________ Length of Employment ______ SSN _____-_____-_____

Type of Care Desired: ___ Temporary Relief ___ Lasting Correction ___ Doctor's Recommendation

Insurance (circle): Health / Auto / Workers' Compensation How Payment will be Made (circle): Cash / Check / Credit Card

Company / Phone: ______________________________________

I certify that I, and/or my dependents, have insurance with the above listed company and assign such benefits to Dr. Retzer, DC, all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance.

Patient______________________________________ Date ____________________

Present Complaints

Chief complaint #1

a. What and where is the pain/problem? ______________________

b. Onset/cause – when did it first start? ______________________

c. What causes it to return? ______________________

d. What relieves it? ______________________

e. What is the quality of the pain sharp, dull, stabbing, color, etc.?

f. Does this pain/problem occur at a specific time, place, or environment?

g. When and for how long does the pain problem last each episode?

h. Does the pain radiate anywhere? Y N where: ______________

k. Severity (circle 1= lowest): 1 2 3 4 5 6 7 8 9 10

l. Associated signs/symptoms? ______________

Chief complaint #2

a. What and where is the pain/problem? ______________________

b. Onset/cause – when did it first start? ______________________

c. What causes it to return? ______________________

d. What relieves it? ______________________

e. What is the quality of the pain sharp, dull, stabbing, color, etc?

f. Does this pain/problem occur at a specific time, place, or environment?

g. When and for how long does the pain problem last each episode?

h. Does the pain radiate anywhere? Y N where: ______________

k. Severity (circle 1= lowest): 1 2 3 4 5 6 7 8 9 10

l. Associated signs/symptoms? ______________

Other complaints: ____

Medical and Social History

Surgeries/Hospitalizations Date

Trauma Date

Past/Recent Illness Date

Marital Status: S/ M/ W/Sep./D Spouse ______________

Children / ages:

Family History (mother, father, siblings, spouse, children) Date

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

___ drinks/week ___ pack/day ___ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

P C Good General Health
P C Recent weight change
P C Fever
P C Fatigue
P C Headaches

EYES

P C Eye disease or injury
P C Glasses/contacts
P C Blurred/double vision
P C Glaucoma

EAR/NOSE/MOUTH/THROAT

P C Hearing loss or ringing
P C Earaches or drainage
P C Chronic sinus problems or rhinitis
P C Nose bleeds
P C Mouth sores
P C Bleeding gums
P C Bad breath / bad taste
P C Sore throat or voice change
P C Swollen glands in neck

CARDIOVASCULAR:

P C Heart disease
P C Chest pain or angina pectoris
P C Palpatation
P C Shortness of breath walking/lying
P C Feet or ankle swelling
P C Shortness of breath
P C Spitting up blood
P C High or Low Blood Pressure
P C Mitral Valve Prolapse

PSYCHIATRIC

P C Memory loss or confusion
P C Nervousness
P C Depression
P C Insomnia

GENITOURINARY

P C Frequent urination
P C Burning or painful urination
P C Blood in urine
P C Change in force or strain urinating
P C Incontinence or dribbling
P C Kidney stones
P C Sexual difficulty
P C Male : testicle pain
P C Female: pain / irregular periods
P C Female: vaginal discharge
P C Female: pregnant
P C Female: # of pregnancies: ____
P C Female: # of miscarriages: ____
P C Female: last pap smear: _______
P C Bladder Infections
P C Kidney Disease
P C Thyroid Disease
P C Bleeding Tendency
~~P C Kidney Disease~~
P C Hemorrhoids

INTEGUMENTARY (skin, breast)

P C Change in skin color
P C Change in Hair or Nails
P C Varicose veins
P C Breast pain
P C Breast lump
P C Breast discharge
P C Rash or itching
P C Hives or Eczema

RESPIRATORY

P C Spitting up blood
P C Pneumonia
P C Shortness of breath
P C Wheezing
P C Asthma
P C Chronic or frequent cough:
P C Bronchitis

ENDOCRINE

P C Glandular or hormone problem
P C Excessive thirst or urination
P C Heat or cold intolerance
P C Skin becoming dryer
P C Change in hat or glove size
P C Diabetes
P C Thyroid Disease

MUSCUOSKELETAL

P C Back pain
P C Joint pain
P C Joint stiffness and swelling
P C Muscle pain or cramps
P C Muscle or joint weakness
P C Difficulty walking
P C Cold extremities
P C Polio

GASTROINTESTINAL

P C Nausea or Vomiting
P C Rectal bleeding/blood in stool
P C Painful bm / constipation
P C Ulcer
P C Loss of appetite
P C Change in bowel movement
P C Frequent diarrhea
P C Abdominal pain

NEUROLOG ICAL

P C Freq./ recurring headaches
P C Migraine headache
P C Convulsions or seizures
P C Numbness or tingling
P C Tremors
P C Paralysis
P C Head injury
P C Light headed or dizzy
P C Stroke

HEMATOLOGIC/LYMPHATIC

P C Slow to heal after cuts
P C Easy bleeding or bruising
P C Anemia
P C Phlebitis
P C Past transfusion
P C Enlarged glands
P C Blood or Plasma Transfusions
P C Hepatitis

GENERAL

P C Infectious Mono
P C Cancer
P C Rheumatic Fever
P C AIDS or HIV+
P C Venereal
P C Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental) ____________________

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RECENT TESTS (lab work, x-rays, CT, MRI) ____________________

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MEDICATION (Rx, OTC, botanicals, homeopathic, and supplements)

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Doctor's Notes

Refer to medical doctor: Y N

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