Dr. Joel Kinch, D.C., D.PhC.S.
Dr. Kathy Kinch, D.C.
Dr. Jake Long, D.C.

610 E. 5th Street #100
Castle Rock, CO 80104
303-814-3980
www.WellWithinChiropractic.com

Please complete this confidential application fully and accurately to help us determine if our office is right for you. The more we know about the overall picture of your health, the better we will be able to serve you.

We are a concierge practice with over 30 years experience serving elite athletes, weekend warriors and ambassadors of the home. Our mission is to lead families to their God given health potential by delivering the very best in specific chiropractic care. We are committed to delivering an extraordinary chiropractic experience, continually leading 500 families to outrageous health.

If you have any questions, please don't hesitate to ask any one of the WWC Team for assistance.

Your Health Goals:

Drs. Joel and Jake will weigh your expectations for care with their office mission when making any care recommendations. Please check the type of care desired so that we may be guided by your wishes whenever possible.

☐ **Pain Management Only** - I am here for pain mgmt only.

☐ **Chiropractic Care** - I am here for focused Neuro-Structural Restoration and lifestyle coaching to not only help with my current health concern but to also enhance my health and well being for a lifetime.

☐ **I want the Doctor to select the type of care most appropriate based on his or her findings.**

PATIENT INFORMATION

Name _____

Address _____

City _____ State _____ Zip _____

☐ Male ☐ Female Number of Children (<18) _____

Birth Date _____ Age _____ Ht/Wt _____

Occupation _____

Employer _____

RELATIONSHIP STATUS:

Circle: Single Married Separated Divorced Widow

Name of Spouse / Significant Other _____

Number/Age of Children: _____

CONTACT INFORMATION

Best Number to Reach You / Cell # _____

Email _____

3RD PARTY INFORMATION:

Company _____

Phone Number _____

ID Number / SSN _____

Group Number _____

Primary Member _____

CHIROPRACTIC CARE EXPERIENCE:

Who may we thank for referring you to our office? _

_____

Have you ever been evaluated by another chiropractor?

☐ **Yes** ☐ **No**

Reasons for those visits? _____

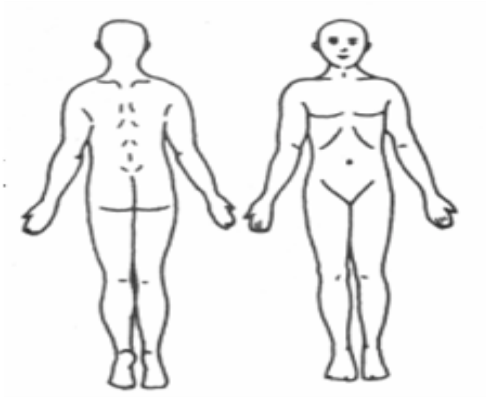
Were X-rays taken? ☐ **Yes** ☐ **No**

Office name? _____

Approximate date of last visit? _____

Did care meet your expectations? ☐ **Yes** ☐ **No**

WHAT BRINGS YOU HERE TODAY:



Primary Reason? _____

Please identify physical region on diagram: _____

_____

When did this start concerning you? _____

Have you had this before? ☐ Yes ☐ No When? _____

What activities aggravate your condition? _____

_____

Is this related to (Check all that apply)

☐ Work ☐ Stress ☐ Sports ☐ Auto ☐ Fall ☐ Chronic Condition ☐ Repetitive ☐ Trauma ☐ Check up

Is this concern ☐ getting worse ☐ staying the same ☐ comes and goes

How does this concern interfere with: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Childcare ☐ Sports

Explain: _____

_____

Have you seen any other health care providers for diagnosis or management of this concern? ☐ Yes ☐ No (if yes, explain below)

Practitioner's Name _____ Type of care _____

Date _____ Results (if any): _____

_____

HEALTH HISTORY:

Please check each of these secondary conditions that you have now or have had in the past. While some secondary conditions may seem unrelated to the purpose of this appointment, they can affect your care recommendations, being accepted as a patient or, if necessary, the need for referral to another specialist.

General

- ☐ Allergy
- ☐ Convulsions
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Anxiety / Depression
- ☐ Cancer
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Epilepsy
- ☐ Hyperactivity

Muscle and Joint

- ☐ Arthritis
- ☐ Hernia
- ☐ Low back pain
- ☐ Neck pain
- ☐ Pain between shoulders

Numbness or pain in:

- ☐ Shoulders
- ☐ Upper arms
- ☐ Hands
- ☐ Legs
- ☐ Feet
- ☐ Poor posture
- ☐ Swollen joints
- ☐ Gout
- ☐ Polio

Gastro - Intestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Digestive dysfunction
- ☐ Gall Bladder trouble
- ☐ Hemorrhoids
- ☐ Liver trouble
- ☐ Ulcers

Eyes, Ears, Nose, Throat

- ☐ Asthma
- ☐ Frequent Colds
- ☐ Crossed Eyes
- ☐ Deafness
- ☐ Ear infections
- ☐ Ringing in ears
- ☐ Eye pain
- ☐ Vision problems
- ☐ Nasal obstruction
- ☐ Sinus infections

Cardio - Vascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Poor circulation
- ☐ Irregular heart beat
- ☐ Ankle swelling
- ☐ Anemia
- ☐ Arteriosclerosis
- ☐ Stroke

Respiratory

- ☐ Chest pain
- ☐ Chronic Cough
- ☐ Irregular breathing
- ☐ Wheezing
- ☐ Emphysema

Genito - Urinary

- ☐ Bed - wetting
- ☐ Painful urination
- ☐ Prostate trouble
- ☐ Blood in urine
- ☐ Venereal Disease

Women Only

- ☐ Menstrual cramps
- ☐ Excessive menstruation
- ☐ Irregular cycle
- ☐ Hot flashes
- ☐ Infertility

Are you pregnant ☐ Yes ☐ No

☐ Other not listed: _____

OUR PRIMARY CONCERN AND HOW IT MIGHT AFFECT YOU:

VERTEBRAL SUBLUXATION: STRUCTURAL SHIFTS of the spine that cause nerve system congestion and decrease your body's ability to adapt and function optimally. These **STRUCTURAL SHIFTS** are the result of a lifetime of physical, emotional and chemical stress starting from the birth process and continue each and every day. **STRUCTURAL SHIFTS** can interfere with the ability of the spinal cord and the delicate spinal nerves that pass between the vertebrae to control the proper function and adaptability of your body. When the primary condition of STRUCTURAL SHIFTS are restored towards their normal position, the body's ability to heal secondary conditions often follows.

Please fill out the next sections completely so the Doctor can have a better understanding of your overall past health history.

The most common **STRUCTURAL SHIFT** is Anterior Head Syndrome (AHS - head and neck bending forward and progressively degenerating the cervical spine curvature). **Have you ever been told or felt like you carry your head forward, noticed a rounding in your shoulders or developing a "hump" at the base of your neck?** ☐ Yes ☐ No

Falls

(Details / Dates)

☐ As an infant or child _____

☐ Down stairs _____

☐ Sports impact _____

☐ Physical fight _____

☐ Other _____

Primary Daily Activities

☐ Sitting ☐ Standing ☐ Walking ☐ Desk work ☐ Telephone

☐ Driving ☐ Manual repetitive work ☐ Heavy lifting

Exercise

☐ Heavy/daily ☐ Moderate/2-3 week ☐ Periodic ☐ Never

Sports and Leisure

Were you, or are you active in any sports? ☐ Yes ☐ No

Describe _____

Have you been injured during these activities? ☐ Yes ☐ No

Describe _____

Birth

With respect to your own birth process, check all that apply.

☐ Natural ☐ Epidural / Drug induced

☐ Premature ☐ C-section

☐ Breech ☐ Cord around neck

☐ Forceps ☐ Prolonged delivery

☐ Vacuum extraction ☐ Pulling by delivery doctor

Did your mother sustain any falls, accidents, or injuries during pregnancy? ☐ Yes ☐ No ☐ Unknown

Conditions experienced immediately following birth

☐ Jaundice ☐ Feeding problems ☐ Respiratory problems

☐ Displaced or broken bones ☐ Other _____

Birth Location

☐ Home ☐ Birthing Center ☐ Hospital ☐ Other

Auto Accidents

Have you ever, even as a passenger, even if you did not think you were hurt, been involved in a car accident(s), or near collision?

☐ Yes ☐ No If yes, dates and severity _____

_____

Is your reason for your visit today a result from an auto accident? ☐ Yes ☐ No If yes, please notify one of the WWC Team immediately.

PLEASE BE AS SPECIFIC AS POSSIBLE:

Have you ever been knocked unconscious? ☐ Yes ☐ No _____

Have you ever used crutches, a walker, or cane? ☐ Yes ☐ No _____

Have you had any broken bones? ☐ Yes ☐ No _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? ☐ Yes ☐ No _____

_____

Have you had extensive dental or orthodontist work performed? ☐ Yes ☐ No _____

Sprains, strains, dislocations? ☐ Yes ☐ No _____

Surgical operations? ☐ Yes ☐ No _____

Have you ever been hospitalized? ☐ Yes ☐ No _____

FAMILY HEALTH HISTORY:

Is there a family history of conditions / disease? (heart, cancer, thyroid, etc.) _____

_____

Medications I am presently taking (name)

- ☐ Painkillers _____
- ☐ Anti-inflammatories _____
- ☐ Muscle relaxants _____
- ☐ Blood Pressure _____
- ☐ Anti-depressants / stimulants _____
- ☐ Tranquilizers, Anti-anxiety _____
- ☐ Blood thinners _____
- ☐ Birth control pills _____
- ☐ Other _____

_____

_____

Lifestyle Habits

	Heavy	Mod	Light	None
Tobacco	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Prescription Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐

Personal Stress Levels

Past	☐	☐	☐	☐
Present	☐	☐	☐	☐

I hereby authorize the doctors in this clinic to a perform a neuro-structural chiropractic analysis to determine any care deemed necessary to address my concern(s). In the event that X-rays are necessary in my case, I understand and agree that X-rays taken are part of my personal health history and will remain in this clinic where they can be reviewed for me by the doctors unless otherwise requested.

I have listed below an emergency/alternate contact with whom this office may communicate. Primarily in the event of an emergency. Under such circumstances, this office has my consent to identify me as a patient to the contacts named below.

I understand and agree that all services rendered are charged directly to me and that I am personally responsible for payment. I understand that fees for professional services are due when rendered. I understand that if I suspend or terminate my care, any fees for professional services rendered will become due and payable at standard professional fee rate.

I clearly understand that all 3rd party coverage is an arrangement between my 3rd party carrier and me. If this office chooses to assist you in billing your insurance company, this service is solely done as a convenience to me. Well Within Chiropractic, pc will provide the necessary information for my 3rd party carrier to determine whether or not they will reimburse me or not for care I receive in this office. I understand that 3rd party carriers may deny any claim and that I am ultimately held responsible for any unpaid balances.

MEDICARE INFORMATION: This office does NOT participate with Medicare and does not accept patients who are enrolled in Medicare. Understanding this, I am refusing to authorize Well Within Chiropractic, pc to file claims with Medicare effective today's date. Additionally, I agree to NOT submit any account statements to Medicare on my own for reimbursement.

I hereby state that all information that I have given to Well Within Chiropractic, pc is complete and truthful. I did/will not misrepresent the presence, nature, severity or cause of my health concern. I further state that I have disclosed my full health history and authorize the release of all past medical/chiropractic records to WWC,PC. I present myself for health concerns only and it is not my intent to mislead, defraud or coerce this office or any third party or misrepresent myself in any manner.

_____ _____ _____

Patient Printed Name | Signature / Authorized Guardian | Date

ALTERNATE/EMERGENCY CONTACT INFORMATION:

(Name of a spouse/partner/relative or close friend designated as Alernate/Emergency contact:)

Name _____ Relationship _____

Address _____ City / State _____ Zip _____