

LIFESTYLE



CHIROPRACTIC

“DISCOVER THE WORLD OF WELLNESS”

GENERAL INFORMATION

Name: _____ Birthdate: _____ Age: _____
 Today's Date: _____
 Address: _____ City: _____ State: _____ Zip: _____
 SS #: _____ - _____ - _____ Driver's License Number: _____
 Home #: (____) _____ Work #: (____) _____ Ext: _____
 FAX #: (____) _____ E-Mail Address: _____
 Beeper / Cell #: (____) _____
 Occupation: _____ Employer: _____
 Employer's Address: _____ City: _____ State: _____ Zip: _____
 ___ Male ___ Female ___ # of Children ___ Single ___ Married ___ Divorced ___ Widowed
 Name of Spouse: _____ Names of Children: _____
 Reason for consulting our office: _____
 Referred By: _____
 Please check if you are here for any of the following: ___ Motor Vehicle Accident ___ Work Injury ___ Other Injury

YOUR HEALTH PROFILE

Why this form is important: As a family wellness oriented chiropractic office, we focus on helping you maximally express your health potential. Our first goal is to locate and eliminate any and all interference to the full outward expression of that potential and address the issues that brought you here. In addition, we hope to offer you and your family the opportunity for a lifetime of health, happiness and vitality. On a daily basis, we all experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are so gradual that they are not felt until they become serious and sometimes not until it is too late. Your answers to the following questions will give us a general view of the stresses you have faced in your lifetime, thus allowing us to better access your current status and more accurately determine your true health potential.

The Beginning Years: Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some even starting at birth. Please answer the following questions to the best of your ability.

Birth History: Please check those items that apply to you.

___ Mother smoked/drank/drugs in pregnancy ___ Epidural / Meds in Labor ___ Breech Vaginal Delivery
 ___ C-Section ___ Forceps Delivery ___ Vacuum Extractor Used
 ___ Labor Induced ___ Complications
 ___ Other: _____

Childhood Years: (Age 0-17 Years) - Please check those items that apply to you.

___ Childhood Illness ___ Serious Falls ___ Active in Sports ___ Very Inactive
 ___ Car Accident(s) ___ Surgery / Stitches ___ Alcohol Drug Abuse ___ Smoker
 ___ Antibiotics / Other Meds ___ Vaccinated ___ Under Chiropractic Care ___ Broken Bones
 ___ Severe Emotional Trauma(s): _____

Comments: _____

Adult Years: (Age 18 to present) - Please check those items that apply to you.

___ Present Smoker ___ Former Smoker ___ OTC / Prescription Meds ___ Alcohol Use
 ___ Surgery / Stitches ___ Play Sports ___ Car Accident(s) ___ Work Injury
 ___ High Job Stress ___ High Personal Stress ___ Sit a lot ___ Drive a lot
 ___ Poor Sleep ___ Not Enough Sleep ___ Poor / Inadequate Diet ___ No Exercise
 ___ Flat Feet ___ Wear Orthotics / Lifts ___ Severe Health Problems ___ Hard Falls
 ___ Broken Bones ___ Other Injuries: _____

___ Have been under chiropractic care in the past - How long ago was your last adjustment? _____

On a scale of 1-10, describe your stress level: (1=None / 10=Extreme) ___ Occupational ___ Personal

Females: Is there a possibility of you being pregnant? ___ Yes ___ No

ADDRESSING THE ISSUES THAT BROUGHT YOU TO OUR OFFICE

If you have no symptoms or complaints and you are here for wellness care, please check here . “Wish to have Chiropractic Wellness Services” and skip to “Family Health Profile” near the bottom of this form. Otherwise, please continue.
Chief Complaint(s):

How has this affected your life?

If you have pain, is it... Sharp Dull Constant Intermittent
 Traveling Radiating Mild Moderate
 Moderately / Severe Severe Intolerable
Since it began, is it... About the Same Getting Better Getting Worse Variable

What makes it worse? _____

What makes it better? _____

Does it interfere with... Work Sleep Walking Sitting Exercise Hobbies Leisure Activities

Did you have an injury? Yes No

If Yes, please explain: _____

How long have you had this problem? _____

Is there a time of day that it is worse typically? Yes No

If Yes, when? _____

Other doctors / treatments you've tried for this problem (Please list):

Chiropractic _____

Medical Doctor _____

Other _____

List any current medications: _____

Past Surgeries & Dates: _____

Past Accidents & Dates: _____

Please check all recurring or severe symptoms you have ever had, even if they do not seem related to your current problem(s):

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Pins & Needles in Legs / Feet | <input type="checkbox"/> Recurring Infection | <input type="checkbox"/> Infertility / Impotence / Miscarriage |
| <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Back Stiffness / Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness / Vertigo | <input type="checkbox"/> Buzzing / Ringing in Ears | <input type="checkbox"/> Sinus Problems / Allergies | <input type="checkbox"/> Nervousness / Anxiety |
| <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability / Mood Swings | <input type="checkbox"/> Tension / Stress |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Neck Stiffness / Pain | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Cold Feet |
| <input type="checkbox"/> Diarrhea / Constipation / Gas | <input type="checkbox"/> Foot Problems | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Light Bothers Eyes | <input type="checkbox"/> Problems Urinating | <input type="checkbox"/> Heartburn / Reflux |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pre-Menstrual Syndrome | <input type="checkbox"/> Menopause | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Jaw / TMJ Problems | <input type="checkbox"/> Other: _____ | | |

Family Health Profile: In our office, we are not only interested in your health & well being, but also in that of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children _____

Spouse _____

Parents _____

Siblings _____

Others _____

Wellness Commitment:

Please check. Are you open to looking at new ideas in health and wellness? Yes No

At Lifestyle Chiropractic, we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial commitment, but we do ask for your cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining your health and wellness. We can offer your two types of care in this office... relief care and wellness development care, the choice is always yours!

10%-----20%-----30%-----40%-----50%-----60%-----70%-----80%-----90%-----100%

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to all this office to examine me, for further evaluation.

Signature or Guardian

____/____/____
Date