HEALTHY LIVING
Family Chiropractic

Patient# _____

WELCOME...

Today's Date ____/____/_____

Please fill out this form as completely as possible. Please print.

PERSONAL INFORMATION

Name_____ What you prefer to be called_____

Age_____ Date of Birth____/____/_____ Sex___ SS#_____ E-Mail_____

Home Address_____ City_____ State_____ Zip_____

Contact Numbers: Cell (_____) _____ Home (_____) _____ Work (_____) _____

Preferred method of being reminded of appointments: □ Phone Call □ Text Message (no charge to you) □ E-mail

If text message reminders, we also need your cell phone carrier in order to send text: _____

Occupation_____ Employer_____ City_____ State_____ Zip_____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living With

Spouse/Partner_____

Emergency Contact_____ Relationship_____ Phone (_____) _____

Whom may we thank for referring you to our office? _____

REASONS FOR SEEKING CHIROPRACTIC CARE

At Healthy Living Family Chiropractic, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Please briefly describe the main concern that you would like Healthy Living Family Chiropractic to address for you.

_____

_____

Are these concerns affecting your quality of life? (Please check those applicable to you)

□ Work □ School □ Exercise/Sports □ Driving □ Walking □ Eating

□ Sleep □ Sitting □ Love Life □ Hobby – please list_____

When did the issue start? _____ What brought it on? _____

Have you had this problem before? □ No □ Yes – please explain _____

If you are experiencing pain, where is it located? _____

Describe the symptoms □ Sharp □ Dull □ Achy □ Numb □ Tingling □ Stabbing □ Throbbing

Does the pain travel/radiate anywhere? □ No □ Yes – please describe_____

Since the problem started, it is? □ About the same □ Getting better □ Getting worse

What makes it worse? □ Standing □ Walking □ Sitting □ Lying

□ Bending □ Lifting □ Twisting □ Coughing □ Other _____

What have you done for this condition that has helped you feel better? _____

What have you done for this condition that was of no help? _____

Are you currently wearing □ Heel lift R/L □ Arch Supports □ Neither

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for ***this condition***: □ Chiropractor □ Medical Doctor □ Other – please list_____

Name_____ City_____ Date_____

X-rays taken □ No □ Yes _____ Special tests done □ No □ Yes _____

Diagnosis_____ What was done_____

Have you ever had ***chiropractic care***? □ No □ Yes Name of D.C._____

How long under care? □ _____days □ _____weeks □ _____months □ _____years

Date of last visit_____ Why did you stop care? _____

Are you satisfied with the care you received there? □ No □ Yes

FAMILY HISTORY

Mother: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems
□ Kidney □ Stroke □ Cancer _____ □ Other _____

Father: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems
□ Kidney □ Stroke □ Cancer _____ □ Other _____

Siblings: □ In good health □ Heart □ Diabetes □ High Blood Pressure □ Respiratory Problems
□ Kidney □ Stroke □ Cancer _____ □ Other _____

YOUR HEALTH PROFILE

The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

GENERAL HISTORY

Please mark all symptoms you have ever had, even if they do not seem related to your current problem.

□ Dizziness	□ Shortness of breath	□ Depression	□ Ulcers
□ Loss of balance	□ Pain in ribs/chest	□ Nervousness	□ Menstrual irregularity
□ Fainting	□ Neck pain/stiffness	□ Tension	□ Menstrual pain
□ Headache	□ Back pain (mid/low)	□ Fever	□ Urinary problems
□ Seizures	□ Pins/Needles in arms/legs	□ Allergies	□ Sinus problems
□ Stroke	□ Numbness in fingers/toes	□ Hot flashes	□ Skin issues
□ Visual disturbances	□ Cold hands/feet	□ Cold sweats	□ Recurrent Colds/Flu
□ Loss of smell	□ Fatigue/Low energy	□ Heart burn	□ Fibromyalgia
□ Buzz/Ring in ears	□ Sleeping problems	□ Heart attack	□ Diabetes
□ Loss of taste	□ Irritability	□ Stomach upset	□ Cancer _____
□ Nausea	□ Mood swings	□ Diarrhea/Constipation	□ Other _____

Please list any other ***serious medical condition(s)*** you currently have or ever had:

_____

_____

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor and often ignored repetitive physical traumas that we have endured are often too numerous to list.
Please list the major traumas that you remember from your childhood up to the present.

Have you had any ***accidents or injuries in your life*** related to any of the following? (check all that apply)

□ Automobile □ Motorcycle □ Bicycle □ Sports □ Playground □ Abuse □ None

If yes, state type of injury and date: _____

_____

Have you ever ***hurt/injured*** your spine, head, neck, ribs, chest, upper and lower back, pelvis or hips? □ No □ Yes

If yes, state type of injury and date: _____

_____

Have you ever been ***hospitalized*** or had any ***surgeries***? □ No □ Yes

If yes, state reason and dates: _____

_____

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed in, injected, taken by mouth or placed on the skin (I.e. food allergies, drug reactions, exposure to chemicals in the air, etc.).

Please answer the following which will reveal exposures you may have had.

Have you been ***exposed to any of the following*** on a regular basis (past or present)?

□ Toxic chemicals □ Second hand smoke □ Drug therapy □ Radiation □ Chemotherapy □ Other_____

Do you have ***allergies*** to any foods? □ No □ Yes If yes, please list_____

Do you ***consume*** any of the following? □ Caffeine □ Alcohol □ Tobacco □ Over the counter drugs □ Prescribed drugs

Please list all ***medications*** you are taking and why: (prescription and non-prescription)

_____

_____

Please list all ***supplements or vitamins*** you are taking and why:

_____

_____

Note: it is imperative that you list all medications as they may have an influence on your care.

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.
Please indicate if you have experienced any of the emotional stresses below. (check all that apply)

□ Loss of loved one □ Work or School □ Divorce/Separation □ Financial □ Lifestyle change □ Self-esteem

QUALITY OF LIFE

How do you grade your ***physical health***? □ Good □ Fair □ Poor

How do you grade your ***emotional/mental health***? □ Good □ Fair □ Poor

How do you rate your overall ***"quality of life"***? □ Good □ Fair □ Poor

Do you ***exercise*** regularly? □ Yes □ No If yes, how often? _____

Do you follow a ***special dietary regime***? □ Yes □ No If yes, what? _____

ADDITIONAL QUESTIONS

If there is a need for ***dietary changes or nutrients***, would you like to be informed? □ Yes □ No

If there is a need for ***specific exercises***, would you like to be informed? □ Yes □ No

If there is a need for support in the ***emotional/stress area of health***, would you like to be informed? □ Yes □ No

Is there any ***specific health topic*** you would like more information on? _____

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (check all that apply)

□ Relief of a symptom or problem

□ Relief and Prevention of a symptom or problem

□ Healthier spine and nerve system

□ Best possible health on all levels

COMMUNICATION INFORMATION

So we may meet your expectations, please answer this last question.
Out of the four following options, how would your ***best friend*** or ***significant other*** best describe you?

□ Straight to the point □ Social & Outgoing □ Steady & Dependable □ Cautious & Perfectly Accurate

PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give the doctors of Healthy Living Family Chiropractic permission to render care to me today. The initial visit includes a professional and complete health history/consultation and chiropractic examination/evaluation.

Signature _____ Date ____/____/_____

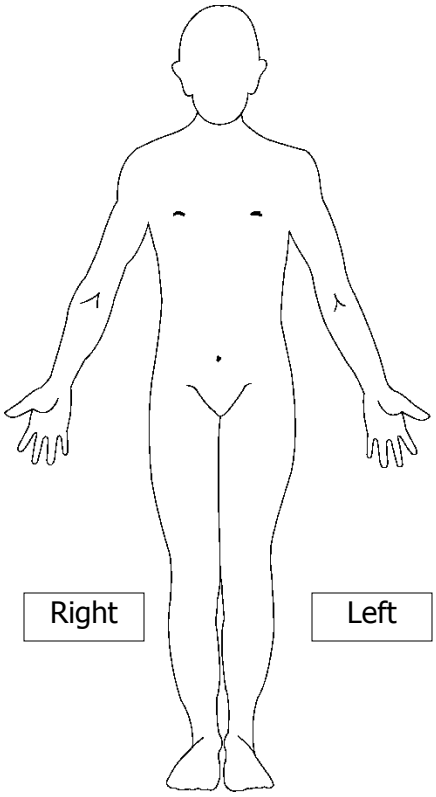
Thank you for choosing our practice! We look forward to helping you.

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

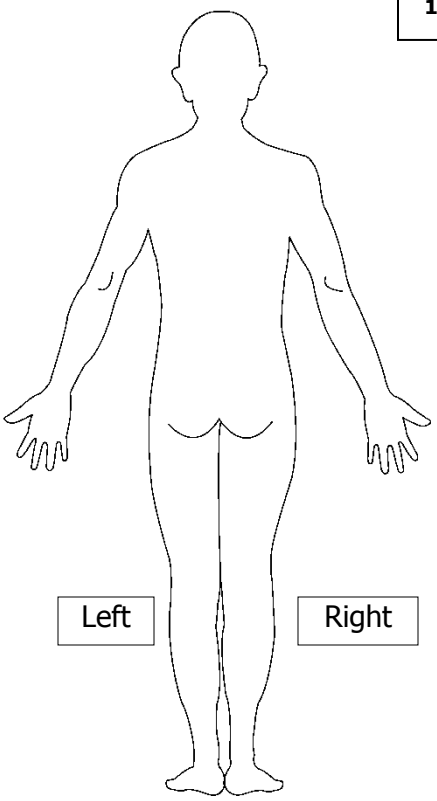
PAIN CHART

Front



Right Left

Back



Left Right

PAIN SCALE

Please mark on the pain scale (below) from Zero to 10 the pain you feel with this condition.
10 = the worst pain you have felt with this condition.

Neck-Shoulder-Arm Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(_____)
0 10
no pain severe pain

Signature _____ Date _____