

Touch of Life Chiropractic Center

General Information

Today's Date: ____/____/____

Name: _____ Birth Date: ____/____/____

Address: _____ City: _____ State: _____ Zip: _____

Social Security: ____-____-____ Home#: () _____ Work#: () _____

Fax#: _____ Cellular#: () _____ E-Mail: _____

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Male/Female Single/Married/Divorced/Widowed Spouse Name: _____

of Kids: _____ Names/Ages: _____

Main reason for consulting our office today: Wellness Care/ Specific Problem _____

Referred By: _____

**Please check if you are here for any of the following: Car 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's 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 assess your current status and more accurately determine what course of care will best help you reach your true health potential.

The Beginning Years—Many of the health challenges that people face later in life have their origins in stresses from 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 during pregnancy ____ Epidural/Meds in labor ____ Breech
____ Vaginal Delivery
____ Forceps Delivery ____ Vacuum Extractor used ____ Labor Induced
____ C-Section ____ Premature/Overdue ____
____ Very short labor ____ Complications ____ Very Long labor ____ Mom on Antibiotics
____ Other

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

<input type="checkbox"/> Recurrent Childhood Illness	<input type="checkbox"/> Serious Falls	<input type="checkbox"/> Active in Sports
<input type="checkbox"/> Car Accident(s)	<input type="checkbox"/> Surgery/Stitches	<input type="checkbox"/> Alcohol/Drug Abuse
<input type="checkbox"/> Smoker	<input type="checkbox"/> Antibiotics/other meds	<input type="checkbox"/> Vaccinated
<input type="checkbox"/> Broken Bones	<input type="checkbox"/> Severe Emotional Stress	<input type="checkbox"/> Under Chiropractic Care
<input type="checkbox"/> Other		

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

<input type="checkbox"/> Present Smoker	<input type="checkbox"/> Former Smoker	<input type="checkbox"/> OTC/Prescription
<input type="checkbox"/> Alcohol Use	<input type="checkbox"/> Surgery/Stitches	<input type="checkbox"/> Play Sports
<input type="checkbox"/> High Personal Stress	<input type="checkbox"/> Work Injury	<input type="checkbox"/> High Job Stress
<input type="checkbox"/> Poor Sleep	<input type="checkbox"/> Sit a Lot	<input type="checkbox"/> Drive a Lot
<input type="checkbox"/> No Exercise	<input type="checkbox"/> Not Enough Sleep	<input type="checkbox"/>
<input type="checkbox"/> Poor/Inadequate Diet		<input type="checkbox"/> Wear Orthotics/Lifts
<input type="checkbox"/> Severe Health Problems		
<input type="checkbox"/> Other Injuries		

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

Check any of the following diseases you have had:

<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Mumps	<input type="checkbox"/> Influenza	INTAKE
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Small Pox	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Coffee
<input type="checkbox"/> Polio	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Tea
<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Alcohol
<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Cancer	<input type="checkbox"/> Mental Disorders	<input type="checkbox"/> Cigarettes
<input type="checkbox"/> Anemia	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Lumbago	<input type="checkbox"/> White Sugar
<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Eczema	

Have you been tested HIV positive? YES / NO

Check any of the following you have had the past 6 months:

MUSCULO-SKELETAL CODE

<input type="checkbox"/> Low Back Pain	<input type="checkbox"/> Gas/Bloating After meals
<input type="checkbox"/> Pain Between Shoulders	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Black/Bloody Stool
<input type="checkbox"/> Arm Pain	<input type="checkbox"/> Colitis
<input type="checkbox"/> Joint Pain/Stiffness	
<input type="checkbox"/> Walking Problems	GENITO-URINARY CODE
<input type="checkbox"/> Difficult Chewing/Click Jaw	<input type="checkbox"/> Bladder Trouble
<input type="checkbox"/> General Stiffness	<input type="checkbox"/> Painful / Excessive Urination

FEMALE ONLY:

When was your last period?

GENERAL CODE:

<input type="checkbox"/> Fatigue
<input type="checkbox"/> Allergies
<input type="checkbox"/> Loss of Sleep
<input type="checkbox"/> Fever
<input type="checkbox"/> Headaches

NERVOUS SYSTEM CODE

<input type="checkbox"/> Nervous
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Forgetfulness

C-V-R CODE

<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Short Breath
<input type="checkbox"/> Blood Pressure Problems
<input type="checkbox"/> Irregular Heartbeat
<input type="checkbox"/> Heart Problems

EENT CODE

<input type="checkbox"/> Vision Problems
<input type="checkbox"/> Dental Problems
<input type="checkbox"/> Sore Throat
<input type="checkbox"/> Ear Aches
<input type="checkbox"/> Hearing Difficulty

- Confusion/Depression
- Fainting
- Convulsions
- Cold/Tingling Extremities
- Stress

- Lung Problems/Congestion
- Varicose Veins
- Ankle Swelling
- Stroke

- Stuffed Nose

GASTRO-INTSTESTINAL CODE

MALE/FEMALE CODE

FAMILY

- Poor/Excessive Appetite same
- Excessive Thirst
- Frequent Nausea
- Vomiting
- Diarrhea
- Constipation
- Hemorrhoids
- Liver Problems
- Gall Bladder Problems
- Weight Trouble
- Abdominal Cramps

- Menstrual Irregularity
- Menstrual Cramps
- Vaginal Pain/Infection
- Breast Pain/Lump
- Prostate/Sexual Dysfunction
- Other Problems
- _____
- _____
- _____

HISTORY

- The following member have a or similar problem as I do:
- Mother
 - Father
 - Brother
 - Sister
 - Spouse
 - Child

Clarifying your Health Objectives:

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

Are you healthy (or healthier) today as you were 5 years ago? YES / NO / Don't know

If yes, what strategies have you used?

Will you be as healthy (or healthier) as you are today, 5 years from now? YES / NO / Don't know

If yes, what strategies will you implement to get there?

If no, or don't know, what strategies could you implement to get there?

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 allow this office to perform an assessment on me in order to make as complete an evaluation as possible. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

Signed: _____

Date ____ / ____ / ____