Empowered Life, PC
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Practice Member Information_____ File#_____

Name: _____
Appointment Date: M ____ D ____ 20_____ Birth Date: M ____ D ____ Y_____
Home Address: _____
City: _____ State:_____ Zip: _____
Home Phone: _____ May we leave a message? __ Yes __ No
Cell Phone: _____ May we leave a message? __ Yes __ No
Work Phone: _____ May we leave a message? __ Yes __ No
Email: _____
May we add you to our email newsletter and calendar of events? ___ Yes ___ No (Your email will not be shared)
Spouse's Name: _____
Name(s) and age(s) of children: _____ _____ _____ _____
Occupation: _____
Do you primarily: ____ Sit ____ Stand ____ Perform repetitive tasks?
How did you hear about us? _____

Healthcare History

Have you had previous chiropractic care? __ No __ Yes
Who was your previous Chiropractor? _____
Where? _____ When? _____
Were X-rays taken in the last 6 months? __ Yes __ No
What was the primary reason for consulting that office?
___ Relief Care – Symptom relief of pain or discomfort.
___ Corrective Care – Correcting, relieving, and stabilizing spinal joint and postural issues.
___ Wellness Care – Maximizing the body's ability for optimal healing and function.
Do you feel your previous chiropractic care was effective? __ No __ Yes
Please Explain: _____
Are you wearing: ___ Heel lifts ___Custom Orthotics
Family Doctor: _____
Date and reason of last visit: _____
May we contact your family doctor regarding your care at our office if necessary? __ No __ Yes
Other Specialists and healthcare professionals:
Name: _____
Professional Designation: _____
Date and reason of last visit: _____
Name: _____
Professional Designation: _____
Date and reason of last visit: _____

Pregnancy Profile

How far along in your pregnancy are you? _____ When is your baby's due date? M_____ D_____ Y_____
Have you taken any medications during this pregnancy? __ No __ Yes:
OTC and Reason: _____
Prescription and Reason: _____
Vaccines and Reason: _____
Have you experienced any physical trauma during this pregnancy? __ No __ Yes _____
Have you had any evaluation procedures (ultrasound, amniocentesis, choronic villus sampling)? __ No __ Yes
Dates and Reasons: _____
_____
_____
Have there been any stressful events in your life during this pregnancy? __ No __ Yes _____
_____
_____
What type of birth care provider are you planning on using? __ Midwife __ OB/Gyn __ MD __ Other _____
Where are you planning on delivering? __ Home __ Birth Center __ Hospital __ Other
_____
Is this your first pregnancy? __ Yes __ No:
If not, how many pregnancies previously: _____
How many children do you have? _____
Miscarriages? __ No __ Yes: __ D&C __ Natural Miscarriage
How many vaginal deliveries? _____
How many caesarean sections? _____
Have there been any complications during your previous deliveries? __ No __ Yes _____
Was labor induced/use of Pitocin? __ No __ Yes __ Unknown
Did your care provider rupture your membranes? __ No __ Yes __ Unknown
Was there any back or hip pain during labor? __ No __ Yes
Was baby in a suboptimal position during the pushing phase of any labor? __ No __ Yes __ Unknown
Did you receive any epidural? __ No __ Yes
Were there any operative devices used? __ No __ Yes: __ Forceps __ Vacuum
Any postpartum complications or long term consequences? __ No __ Yes _____
_____

Have you experienced any of the following symptoms during this pregnancy or a previous pregnancy?

Current	Previous		Current	Previous	
__	__	Headaches	__	__	Carpal Tunnel (numbness in the hands/fingers)
__	__	Facial Paralysis	__	__	Low/Mid Back Pain
__	__	Chronic Fatigue	__	__	Breech or Side Lying Presentation
__	__	Nausea/"Morning Sickness"	__	__	Round Ligament Pain/Pulling (front of belly)
__	__	Heartburn/Indigestion	__	__	Pain in your Pubic Bone
__	__	Preeclampsia	__	__	Pins/Needles in the Front/Side of your leg
__	__	Gestational Diabetes	__	__	Pain in Posterior of Leg (Sciatica)
__	__	Constipation	__	__	Leg Cramps
__	__	Hemorrhoids	__	__	Swelling of Ankles, Legs and Feet

Wellness Profile

Do you have a specific concern that brings you in?

__ No, I'm interested in having my nervous system assessed to achieve optimal health and functioning.

__ Yes: _____

If yes, please answer the following questions:

What type of complaint? ___ Acute ___ Sub-acute ___ chronic ___ Recurring

Where is the pain located? _____

When did the pain begin? _____

What is the origin of the injury or condition?

__Not sure __ After a fall __ After a long drive
__ After a long flight __ After a poor night's sleep __ After a slip
__ After lifting an object __ After over-arching or reaching __ After performing household chores
__After performing yardwork __ After sitting in one place too long __ Associated with prolonged or chronic illness

What is the frequency of pain?

__ Constant __ Frequent __ Intermittent __ On and Off __ Random

How would you describe the discomfort? (mark all that apply)

__ Aching __ Annoying __ Burning __ Deep __ Diffuse __Dull __Heavy __ Intolerable __Pulling __Sharp
__Shock like __Stabbing __Stiffness __ Throbbing __ Tightness __ Tingling

If the discomfort radiates, where does it travel to? (mark all that apply) __ Non-radiating

__ front of left chest	__ front of right chest	__ left abdomen/groin	__right abdomen/groin
__ front of left thigh	__ front of right thigh	__ back of left thigh	__ back of right thigh
__ front of left lower leg	__ front of right lower leg	__ back of left lower leg	__ back of right lower leg
__ top of left foot	__ top of right foot	__ bottom of left foot	__ bottom of right foot
__ front of left shoulder	__ front of right shoulder	__ back of left shoulder	__ back of right shoulder
__ front of left upper arm	__ front of right upper arm	__ back of left upper arm	__ back of right upper arm
__ front of left lower arm	__ front of right lower arm	__ back of left lower arm	__ back of right lower arm
__ front of left hand	__ front of right hand	__ back of left hand	__ back of right hand
__ front of left face	__ front of left face	__ back of left side of head	__ back of right side of head

Is it getting better, worse or staying the same?

__ Getting better __ Getting worse __ Staying the same __ Relief which lasted for awhile

Rate the pain on a scale of 1 to 10, with 10 being the worst pain: _____

What makes the symptoms better? (mark all that apply):

__ Chiropractic adjustment __ Massage __ Prescription Medications __ Work
__ Cold packs __ Nothing __ Re-direct attention
__ Exercise __ Over the counter Medications __ Rest
__ Heat packs __ Physical Therapy __ Stretching

What makes the symptoms worse? (mark all that apply):

__ Almost any movement	__ Coughing and sneezing	__ Household chores	__ Sitting
__ Bathing	__ Daily child or pet care	__ Lifting	__ Squatting
__ Bending	__ Driving	__ Looking over shoulder	__ Standing
__ Caring for family	__ Eating	__ Lying down	__ Stress
__ Carrying	__ Falling or staying asleep	__ Pulling	__ Stretching
__ Changing positions	__ Getting out of bed	__ Pushing	__ Talking on the phone
__ Climbing stairs	__ Getting out of car	__ Reaching	__ Turning
__ Computer use	__ Getting up from lying down	__ Reading	__ Twisting
__ Concentrating	__ Getting up from sitting	__ Repetitive motions	__ Walking
__ Cooking	__ Grocery shopping	__ Resting	__ Working
		__ Running	__ Yard work

Has this condition occurred before? __ Yes __ No

Have you received any past care for this complaint? (mark all that apply)

__ Nothing
__ Acupuncture
__ Chiropractic Care
__Craniosacral therapy
__ Homeopathic medicine
__ Hypnosis
__ Injection therapy
__ Medical care
__ Naturopathic therapy
__ Nutritional supplements
__ Occupational therapy
__ Osteopathic therapy
__ Over-the-counter medications
__ Prescribed medications
__ Physical therapy
__ Psychotherapy
__ Reiki
__ Surgery

Have any recent diagnostic images or tests been performed? __ Yes __ No _____

Which daily living activities are most affected? (mark all that apply)

__ None
__ Employment
__ Homemaking
__ Lifting
__ Personal care (washing, dressing, etc.)
__ Sitting
__ Sleeping
__ Social life
__ Standing
__ Traveling and/or driving
__ Walking

What do you have difficulty performing due to this specific condition? (Mark all that apply)

__ Bending over
__ Caring for family
__ Climbing stairs
__ Concentrating
__ Dressing Self
__ Driving Car
__ Exercising
__ Getting in/out of car
__ Getting to sleep
__ Grocery shopping
__ Performing household chores
__ Lifting objects
__ Looking over shoulders
__ Making love
__ Lying down
__ Reaching overhead
__ Rising out of chair or bed
__ Showering or bathing
__ Sitting
__ Standing
__ Staying asleep
__ Using a computer
__ Walking
__ Participating in yard work

How long can you perform the above tasks before difficulty sets in? (Give a duration of time, circle what's appropriate)

_____ minutes / hours / days / weeks

What are your specific therapeutic goals? (mark all that apply)

__ To have no functional limitations
__ To sleep throughout the night w/o pain
__ To decrease swelling
__ To improve all ranges of motion w/o pain
__ To be able to lift w/o pain
__ To improve strength
__ To improve overall flexibility
__ To decrease stiffness
__ To relieve pain
__ To walk on all terrain w/o limitation
__ To hunt w/o limitation
__ To return to sport activity w/o limitation
__ To return to work w/o limitation
__ To walk w/o assistive device
__ Ability to transfer lying down to sitting w/o pain
__ Ability to transfer from bed to device w/o pain
__ Ability to transfer from device to bed w/o pain
__ Ability to transfer sitting to standing w/o pain
__ Ability to transfer sitting to lying w/o pain
__ Ability to transfer standing to sitting w/o pain

Do you have any additional complaints? __ No __ Yes

Explain:_____

_____

_____

_____

_____

_____

_____

Review of Symptoms

Do you have any **Musculoskeletal** issues? (mark all that apply)

__ No additional musculoskeletal complaints
__ Arthritis
__ Back problems
__ Cramping
__ Elbow/wrist pain
__ Foot/ankle pain
__ fracture
__ Gout
__ Hip disorders
__ Implants or plates
__ Joint or muscle pains/stiffness
__ Denies the following: implants, pins or screws
__ Knee injuries
__ Neck pain
__ Osteoporosis
__ Pins or screws
__ Poor posture
__ Scoliosis
__ Shoulder problems
__ Swelling, redness, deformity of joint(s)
__ TMJ issues

Do you have any **Neurological** complaints? (mark all that apply)

__ No additional neurological complaints
__ Denies: temporary loss of smell, vision or hearing
__ ADHD/ADD
__ Anxiety and/or panic
__ Depression
__ Difficulty concentrating
__ Dizziness
__ Epilepsy or seizures
__ Headache
__ Loss of smell or taste
__ Memory issues
__ Numbness
__ Pins and needles
__ Sleeping issues
__ Stroke
__ Temporary loss of vision, smell or hearing
__ Weak muscles

Do you have any **Head or ENT** (Ear, Nose, Throat) complaints? (mark all that apply)

__ No head an ENT complaints
__ Blurred or double vision
__ Cataracts
__ Changes in head dimensions
__ Chronic ear infections
__ Dental problems
__ Difficulty swallowing
__ Ear or hearing problems
__Earache
__ Eye or vision problems
__ Eye surgery
__ Eyeglasses or contact lenses
__ Glaucoma
__ Gum problems
__ Headaches or migraines
__ Hoarseness
__ Nose congestion or sinus trouble
__ Postnasal drip
__ Recent hearing loss
__ Ringing in the ears
__ Sore throat
__ Swollen lymph nodes
__ TMJ problems
__ Insomnia

Do you have any **Cardiovascular** complaints? (mark all that apply)

__ No cardiovascular complaints
__ Blood clots
__ Chest pain or tightness
__ Congenital heart defects
__ Coronary artery disease
__ Dizziness
__Dyspnea (difficult breathing)
__ Excessive bruising
__ Heart attack
__ Heart Murmur
__ High blood pressure
__ High cholesterol or triglycerides
__ Leg pain upon walking
__ Low blood pressure
__ Lower extremity edema
__ Palpitations
__ Rheumatic fever
__ Swollen legs or feet
__ Varicose veins

Do you have any **Respiratory** complaints? (mark all that apply)

__ No respiratory complaints
__ Apnea (breathing disruptions with sleep)
__ Asthma
__ Blood in saliva
__ Emphysema
__ Hay fever
__ Persistent cough
__ Pneumonia
__Shortness of breath
__ Snoring issues
__ Tuberculosis
__ Wheezing

Do you have any **Gastrointestinal** complaints? (mark all that apply)

__ No gastrointestinal complaints
__ Abdominal pain
__ Black or bloody stool
__ Bloating
__ Changes in bowel habits
__ Colitis
__ Colon cancer or colon polyps
__ Constipation
__ Crohn's disease
__ Difficulty swallowing
__ Food sensitivities
__ Gastric reflux
__ Heartburn
__ Hemorrhoids
__ Irritable bowel syndrome
__ Jaundice
__ Liver disease
__ Nausea
__ Pancreatitis
__ Severe diarrhea
__ Ulcer
__ Vomiting

Do you have any **Genitourinary** complaints? (mark all that apply)

__ No genitourinary complaints
__ Blood in the urine
__ Incontinence
__ Kidney stones
__ Painful or frequent urination
__ Sexual dysfunction
__ Urgency
__ Urinary infections

Do you have any **Endocrine** complaints? (mark all that apply)

__ No endocrine complaints
__ Cushing's syndrome
__ Diabetes
__ Excessive thirst
__ Feeling hot or cold all the time
__ Heat or cold intolerance
__ Hyperparathyroidism
__ Hyperthyroidism
__ Hypothyroidism
__ Increase size of hands or feet
__ Increase urination
__ Pancreatic conditions
__ Polydipsia (frequent thirst)
__ Polyuria (frequent urination)
__ Purple striae (stretch marks)
__ Steroid treatments
__ Testosterone deficiency
__ Thyroid problems

Do you have any **Dermatological** (skin) or **Hematopoietic** (blood) complaints? (mark all that apply)

__ No dermatology or hematopoietic complaints
__ Blood in stool
__ Changed in hair or nails
__ Easy bruising
__ Eczema
__ Excessive acne
__ Excessive hair loss
__ Flushing
__ Gum bleeding
__ Hyper/hypo pigmentation
__ Psoriasis
__ Skin cancer
__ Skin pigmentation issues
__ Skin trouble or rashes
__ Varicose veins

Do you have any known **Allergies or Sensitivities**? (mark all that apply)

__ Other_____
__ No known allergy
__ Animal dander/fur
__ Dairy
__ Dust
__ Latex
__ Nuts
__ Pollen
__ Seafood
__ Tape or Adhesive
__ Therapeutic cold sensitivity
__ Therapeutic heat sensitivity
__ Wheat
__ Anti-Seizure medication
__ Cephalosporins
__ General anesthesia
__ IV contrast dye
__ Local anesthesia
__ NSAID
__ Penicillin
__ Sulfonamides

Do you have any **Surgical History**? (mark all that apply)

__ Other _____
__ None reported
__ Abdominal Aortic Aneurysm repair
__ Appendectomy
__ Bunionectomy
__ C-Section
__ Cardiac bypass
__ Cardiac valve replacement
__ Carpal tunnel – Left / Right
__ Cataract – Left / Right
__ Cosmetic – breast reduction/enlargement
__ Cosmetic – face lift
__ Cosmetic – nose
__ Cosmetic – other _____
__ Cosmetic – tummy tuck
__ Discectomy level _____
__ Ear tubes
__ Gall bladder removed
__ Ganglion cyst
__ Gastric bypass
__ Hysterectomy – complete
__ Hysterectomy – partial
__ Implants
__ Knee – Left / Right
__ Lasik
__Mastectomy
__ Shoulder – Left / Right
__ Spinal fusion
__ Thyroidectomy
__ Tonsils
__ Tonsils & Adenoids
__ Transplant
__ Wisdom Teeth

Do you take any **Drugs** and/or **Medication(s)**? (mark all that apply)

__ Other _____
__ Over-the-counter _____
__ Prescription _____
__ Anti-depressant
__ Muscle relaxer
__ NSAID
__ Pain reliever
__ Steroidal anti-inflammatory
__ Anti-acid
__ Anti-viral
__ Aspirin
__ Chemotherapy
__ Codeine
__ Hallucinogenic
__ Marijuana
__ Mood elevator
__ Sleeping pill
__ Stimulant

Do you have any **Past Illnesses**? (mark all that apply)

__ Denies history of diabetes, cancer, and hypertension

__ AIDS/HIV
__ Alcoholism
__ Alzheimer's
__ Anemia
__ Anorexia
__ Arthritis
__ Asthma
__ Bleeding disorders
__ Breast lump
__ Bronchitis
__ Bulimia
__ Cancer _____
__ Extremity issues _____
__ Hereditary disorder _____
__ Neuromuscular issues _____
__ Other_____
__ Chemical dependency
__ Depression
__ Diabetes
__ Emphysema
__ Epilepsy
__ Heart disease
__ Hepatitis
__ Hernia
__ Herniated disc
__ High blood pressure
__ High cholesterol
__ Kidney disease
__ Liver disease
__ Migraine headaches
__ Miscarriage
__ Multiple Sclerosis
__ Natural labor
__ Osteoarthritis
__ Osteoporosis
__ Pacemaker
__ Parkinson's disease
__ Pinched nerve
__ Congenital Anomaly _____
__ Fracture _____
__ Hospitalization _____
__ Trauma/injury _____
__ Psychiatric care
__ Rheumatoid arthritis
__ Stroke
__ Suicide Attempt
__ Thyroid problems
__ Tumor
__ Ulcers
__ Vaginal infection

Do you have any history of **Accidents or Trauma**? (mark all that apply)

__ No previous trauma reported
__ Single automobile accident
__ Multiple automobile accidents
__ Slip and fall
__ Multiple slips and falls
__ Single motorcycle accident
__ Multiple motorcycle accidents
__ Single boating accident
__ Multiple boating accidents
__ Resulting in NO significant injury or loss
__ resulting in loss of consciousness
__ Resulting in sprains/strains
__ Resulting in fracture(s) _____
__ Resulting in hospitalization(s) _____
__ Resulting in permanent injury or disability _____
__ Other _____

Any **Immediate Family Health History** issues? (mark all that apply)

__ Denies family history of diabetes, cancer, or hypertension

__ Congenital anomaly
__ Extremity issues
__ Fracture
__ Hereditary disorder
__ Hospitalization
__ Neuromuscular issues
__ Trauma/injury
__ AIDS/HIV
__ Alcoholism
__ Alzheimer's
__ Anemia
__ Anorexia
__ Arthritis
__ Asthma
__ Cancer: _____
__Other:_____
__ Bleeding disorders
__ Breast lump
__ Bronchitis
__ Bulimia
__ Chemical dependency
__ Depression
__ Diabetes
__ Emphysema
__ Epilepsy
__ Heart disease
__ Hepatitis
__ Hernia
__ Herniated Disc
__ High blood pressure
__ High cholesterol
__ Kidney disease
__ Liver disease
__ Migraine headaches
__ Miscarriage
__ Multiple Sclerosis
__ Natural labor
__ Osteoarthritis
__ Osteoporosis
__ Pacemaker
__ Parkinson's Disease
__ Pinched Nerve
__ Pneumonia
__ Polio
__ Previous chiropractic care
__ Prostate problems
__ Psychiatric care
__ Rheumatoid arthritis
__ Stroke
__ Suicide attempt
__ Thyroid problems
__ Tumor
__ Ulcers
__ Vaginal infection
__ Venereal disease

Type of **Work**? (mark all that apply)

__ Cannot work due to presenting condition
__ Permanently fully disabled
__ Permanently partially disabled
__ Full-time
__ Part-time
__ Homemaker
__ Retired
__ Student
__ Unemployed
__ Up to 20 hrs per week
__ 20-40 hrs per week
__ 40-50 hrs per week
__ 50-60 hrs per week
__ 60-70 hrs per week
__ Over 70 hrs per week
__ Mostly sitting
__ Mostly standing
__ Mostly walking
__ Light labor
__ Moderate labor
__ Heavy labor
__ Sedentary
__ Computer
__ Repetitive
__ Telephone
__ Difficult
__ Enjoyable
__ Relaxed
__ Stressful

Type of **Social Habits**? (mark all that apply)

__ Does not smoke, drink alcohol, or take recreational drugs
__ Does not drink alcohol
__ Is a social drinker
__ Is a light drinker
__ Is a moderate drinker
__ Is a heavy drinker
__ Is an alcoholic
__ Is a recovering alcoholic
__ Current every day smoker
__ Current some day smoker
__ Ex-smoker
__ Heavy tobacco smoker
__ Light tobacco smoker
__ Never smoked tobacco
__ Does not drink caffeine
__ Drinks 1 cup caffeine in am
__ Drinks 2-4 cups caffeine per day
__ Drinks 5 or more cups caffeine per day
__ Does not use recreational drugs
__ Light use of recreational drugs
__ Moderate use of recreational dugs
__ Heavy use of recreational drugs
__ Is drug addicted
__ Is a recovering drug addict

Type of **Exercise Routine**? (mark all that apply)

__ Daily
__ Every other day
__ Few times a week
__ Once a week
__ Almost nothing
__ Aerobic
__ Stretching
__ Strength
__ Baseball
__ Basketball
__ Blading
__ Boating
__ Climbing
__ Cycling
__ Football
__ Golf
__ Handball
__ Hang gliding
__ Hiking
__ Mountain Climbing
__ Ping-pong
__ Racquetball
__ Running
__ Skiing
__ Skydiving
__ Snowboarding
__ Soccer
__ Surfing
__ Tennis
__ Volleyball
__ Walking
__ Waterskiing
__ Weight training
__ Weight training with a personal trainer
__ Pilates
__ Spinning
__ Step
__ Yoga
__ Zumba

Type of **Diet and Nutrition**? (mark all that apply)

__ Controlled
__ Out-of-control
__ Restricted
__ Unrestricted
__ 1-2 meals a day
__ 2-3 meals a day
__ More than 3 meals a day
__ Eat too little
__ Eating too much
__ Binges
__ Purges
__ Balanced
__ High protein
__ Low carbohydrate
__ Low-fat
__ Low-cholesterol
__ No red meat
__ Atkins
__ Diabetic
__ Gluten Free
__ Ideal protein
__ Jenny Craig
__ Kosher
__ Macrobiotic
__ Paleo
__ Raw food
__ South Beach
__ Vegan
__ Vegetarian
__ Weight Watchers
__ Zone
__ Does not take daily supplements
__ Takes daily supplements
__ Other: _____

Lifestyle Information

The human body is designed to be healthy. The primary system in the body which coordinates health and function is the nervous system. Your nervous system is surrounded and protected by the bones of the spine, called vertebrae. Physical, emotional, and chemical stresses, common to our contemporary lifestyle, can result in misalignment to the spinal column as well as damage the delicate nervous system. The result is a condition called a Vertebral Subluxation. The remainder of the intake form addresses the possible factors which may contribute to vertebral subluxation in your spine which may be impeding your body's ability to heal.

Physical

Height_____ Weight _____
Are you happy with your current physical appearance and abilities? __ Yes __ No
Do you stretch after exercise or after activities of poor posture? __ Yes __ Sometimes __ No
Hours of sleep per night? __ >6 __ 7-9 __ 10+
Do you feel refreshed upon waking? __ Always __ Sometimes __ Rarely
Age of Mattress? _____ Do you feel your mattress is appropriate for your sleeping style? __ No __ Yes
Which position do you sleep? __ Back __ Belly Side: __ Right __ Left __ Both
Number of hours spent commuting/week? __ 0-2 __ 3-5 __ 6-8 __ 9-11 __ 12+
Number of hours spent at a desk or computer/week? __ 0 __ 1-5 __ 6-10 __ 11-20 __ 21-40 __ 41+
Number of hours spent on smart device/tablet/week? __ 0 __ 1-5 __ 6-10 __ 11-20 __ 21-40 __ 41+
Do you perform any repetitive tasks at home or at work? __ No __ Yes

Early Years

To your knowledge, was your delivery difficult? __ No __ Yes
If yes: __ Forceps __ Vacuum __ Caesarean __ Breech __Other: _____
Were you breast fed? __ No __ Yes For how long? _____
Did you experience emotional trauma as a child? __ No __ Yes _____
Were you ever given antibiotics as a child? __ No __ Yes _____
Did you ever have ear infections as a child? __ No __ Yes _____
Any major childhood illness? __ No __ Yes _____

Emotional

Rate your current level of ***personal stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Rate your current level of ***relationship stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Rate your current level of ***financial stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Rate your current level of ***health stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Rate your current level of ***family stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Rate your current level of ***career stress*** in your life: . . . . . __ None __ Low __ Moderate __ High
Do you feel you have a supportive network of friends and family? . . . . . __ Yes __ No
Do you feel you have healthy coping strategies for life stress? . . . . . __ Yes __ No

Chemical

Were you vaccinated as a child? . . . . . __ No __ Yes
Any adverse reactions to vaccines? . . . . . __ No __ Yes_____
Do you choose to have annual flu shots? . . . . . __ No __ Yes
Did you get the COVID vaccine? . . . . . __ No __ Yes
Any adverse reactions to COVID shot? . . . . . __ No __ Yes_____
Did you get any COVID booster shots/how many? . . . . . __ No __ Yes_____
Do you take antibiotics? . . . . . __ No __ Yes, how often? _____

How many glasses of water/day: . . . . . __ 0 __ 1-3 __4-6 __ 7-9 __ 10+
How many glasses of caffeinated beverages/day: . . . . . __ 0 __ 1-3 __4-6 __ 7-9 __ 10+
How any glasses of cow's milk and juice/day: . . . . . __ 0 __ 1-3 __4-6 __ 7-9 __ 10+
Do you eat gluten? . . . . . __ No __ Yes __ Trying to eliminate from diet
Do you eat dairy? . . . . . __ No __ Yes __ Trying to eliminate from diet
Do you eat refined sugars? (white sugar, white bread, and pasta) . . . . . __ No __ Yes __ Trying to eliminate from diet
Do you eat boxed/frozen foods? . . . . . __ No __ Yes __ Trying to eliminate from diet
Do you choose organic foods? . . . . . __ No __ Yes, which: __ Veggies __ Fruits __ Meats __ Grains __ All
Do you eat any artificial sweeteners? (Splenda, Aspartame, Diet Soda, etc) . __ No __ Yes
Any food/drink allergies, sensitivities, intolerances? . . . . . __ No __ Yes _____
Do you smoke? . . . . . __ No __ Yes __ I used to for ___ years/__ I wish I didn't
Are you or have you been exposed to secondhand smoke? . . __ No __ Yes
Do you drink alcohol? . . . . . __ No __ Yes __06-6/week __ 6-12/week __ 12+/week
Do you take a probiotic daily? . . . . . __ No __ Yes, _____ CFU's/day
Do you take vitamin D3 daily? . . . . . __ No __ Yes, _____ IU's/day
Do you take Omega 3 Fish oils daily? . . . . . __ No __ Yes, _____ mg/day
Other supplements or homeopathics?_____
Any other medication and their purpose? _____
_____
Do you have a plan with your medical doctor to wean yourself off of any long term medications? __ No __ Yes

Goals and Consent

Are you seeking chiropractic care today for:

__ Relief Care – Symptom relief of pain or discomfort
__ Corrective Care – Correcting, relieving and stabilizing spinal, joint and postural issues
__ Wellness Care – Maximizing the body's ability for optimal healing and function of the nervous system

What is your primary goal for consulting our clinic?_____
Our goals are to provide a detailed assessment of your current health status and provide to you the resources for a highly engaged and healthy body which is functioning at absolute peak potential. Essential to this is a healthy nervous system functioning free from interference called subluxation. You've taken an important step for your health through a chiropractic evaluation!

Consent to Evaluation

I _____ hereby grant permission to receive a chiropractic evaluation including history, spinal scan and examination. Any findings will be communicated before consenting to commencement of care, if appropriate.

_____ _____
Consenting Adult's Signature Date