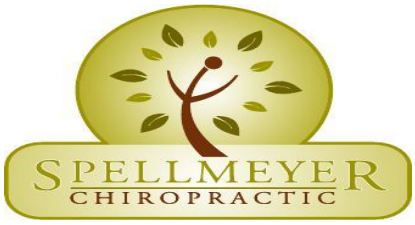


PERSONAL INFORAMTION

Name:_____ Date:_____
Birthday:_____ Age:_____
Address:_____
City:_____ Zip Code:_____
Home #_____Cell #:_____Work#:_____
E-mail Address:_____
Occupation:_____ Employer:_____
Marital Status: Single ☐Married ☐Divorce ☐Widow ☐
Spouse/Partner's Name:_____
Children
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F
Name:_____ Age:_____ Gender ☐M☐F

Who may we thank for referring you to out office? or how did you choose us?
☐Family/ Friend (name)_____☐Health Practitioner:_____
☐Website ☐Facebook ☐Walk-in ☐Other:_____

CHIROPRACTIC HISTORY

Have you been to a chiropractor before? ☐No ☐Yes, Date of last visit _____
Has a family member previously seen a chiropractor? ☐No ☐Yes, Spouse_____Child_____
Name of Chiropractor:_____
Reason for seeing them:_____
Describe your experience:_____
How frequently did you go for adjustment?_____
What made you decide not to return to see them?_____

IMPORTANT NOTE:

Today's visit will be focusing on assessing the health of your spine and nerves system. Your central nervous system (brain and spinal cord) is the master controller of your body. Everything in your life is processed and controlled by your nervous system, therefore your health and overall quality of life is depended on proper function and communication. Due to the close relationship with your spine, if your spine is misaligned and degenerating, it can interfere and alter the function of your nervous system (SUBLUXATION). The results of this miscommunication between your brain and body in some cases is pain or discomfort but it can have broader, more serious effects such as energy loss, fatigue, depression, immune problems, digestive problems, high blood pressure and many more. Many times subluxations are affecting your health long before symptoms show up. By continuing to fill out this form, we will understand how subluxations may already be affecting your health and quality of life.

CURRNET PREGNANCY- Are you pregnant? ☐No ☐Yes; if yes fill out the gray section below

Due Date:_____ Current # of weeks pregnant_____
Please list, the names of practitioners you see: OBGYN/Hospital?_____
Midwife:_____ Doula:_____ Naturopath:_____
Are/will you be attending a prenatal class with or without your spouse? ☐No ☐Yes If yes, which?_____
Do you currently participate in a prenatal exercising/yoga program? ☐No ☐Yes
Are you taking dietary supplements? ☐No ☐Yes If yes; which ones?_____
Food Intake (describe your diet):_____
_____
Sleep quality: How many hours?_____ Continuous? ☐No ☐Yes
What position?_____ Use pillows (body)? ☐No ☐Yes
How many times a night do you wake up to use the restroom?_____
Job details: what type of work do you do? ☐Office work (sedentary)☐Physical ☐Homemaker
Office- Hours seated?_____ Commuting time?_____ Drive/transit?_____
Opportunity to move/stretch? ☐No ☐Yes
Physical- Hours on feet?_____ Commuting time?_____ Drive/transit?_____
Opportunity to rest/stretch? ☐No ☐Yes
Intensity of physical activity? ☐Light ☐Moderate ☐Heavy

PREVIOUS PREGNANCY & BIRTH HISTORY

How many pregnancies have you had?_____ If this is your first pregnancy mark N/A
Have you had any miscarriages? ☐No ☐Yes How many?_____
During any pregnancy did you:
Smoke? ☐No ☐Yes How much?_____
Drink? ☐No ☐Yes How many?_____
Any ultrasounds or other radiation? ☐No ☐Yes If so, how many and for what reason:_____
_____
Were there any invasive procedures during the pregnancy (amniocentesis, CVS, etc.)? ☐No ☐Yes
Please explain:_____
Trauma/ illness during pregnancy?_____
Please describe any emotional stress the mother experienced during the pregnancy:_____
_____
Position during labour: ☐On back ☐Side ☐Sitting ☐Standing
Did the mother have an episiotomy? ☐No ☐Yes
Was monitoring used? ☐Internal ☐External
Location of birth? ☐Home ☐Hospital ☐Birthing center
Birth assistants? ☐Midwife ☐Doula ☐Medical doctor ☐None

How many hours did labour last? _____Active labour?_____ Pushing Time?_____
Was labour induced? ☐No ☐Yes Reason?_____
Was the mother administered any drugs? ☐Epidural ☐Morphine ☐Other:_____
Was there any intervention used during birth? ☐No ☐Yes ☐Forceps ☐C-section ☐Vacuum
Was there any evidence of birth trauma to the infant? Check all that apply:

☐Bruising ☐Stuck in birth canal ☐Respiratory depression
☐Odd shaped head ☐Fast or excessively long birth ☐Cord around neck

Were there any other complications during birth or Congenital anomalies/ defects present?
☐No ☐Yes; If yes, Please explain:_____

REPRODUCTIVE HEALTH HISTORY

Age of 1st menstruation:_____ How heavy? ☐Light ☐Moderate ☐Heavy
Pain? ☐No ☐Yes If yes, do you use medication? ☐No ☐Yes, _____
Cramps? ☐No ☐Yes If yes, do you use medication? ☐No ☐Yes, _____
Headaches? ☐No ☐Yes If yes, do you use medication? ☐No ☐Yes, _____
Contraception? ☐No ☐Yes If yes, Age of start? _____ Duration?_____

HISTORY OF SPINAL TRAUMA

Sports activities you participated in as a child:_____
How active is your lifestyle? ☐Slightly active ☐Moderately active ☐Very active
List any injuries (i.e, falls, sprains, broken bones):_____

HEALTH CONCERNS- FILL IN ALL AREAS Please check ☑ all that you have experienced in the last 12 months and indicate if you were experiencing them before, during or after pregnancy

	Before	Pregnancy	After		Before	Pregnancy	After
ADD/ADHD	☐	☐	☐	Hand/Wrist Pain	☐	☐	☐
Allergies	☐	☐	☐	Headaches	☐	☐	☐
Anxiety	☐	☐	☐	Heart Disease	☐	☐	☐
Asthma	☐	☐	☐	Hernias	☐	☐	☐
Back Pain	☐	☐	☐	High Blood Pressure	☐	☐	☐
☐Upper ☐Mid ☐Low	☐	☐	☐	Hip Pain	☐	☐	☐
Balance/Coordination	☐	☐	☐	Insomnia	☐	☐	☐
Bladder	☐	☐	☐	Irregular Cycles	☐	☐	☐
___Experiencing leaking	☐	☐	☐	Jaundice	☐	☐	☐
Cancer	☐	☐	☐	Kidney issues	☐	☐	☐
Chest Pain	☐	☐	☐	Knee/Ankle/Foot Pain	☐	☐	☐
Chronic Cough	☐	☐	☐	Menstrual Cramps	☐	☐	☐
Chronic Fatigue	☐	☐	☐	Metabolism issues	☐	☐	☐
Colds	☐	☐	☐	Migraines	☐	☐	☐
Congestion	☐	☐	☐	Neck/Shoulder Pain	☐	☐	☐
Constipation	☐	☐	☐	Pneumonia/Bronchitis	☐	☐	☐
Cramps	☐	☐	☐	Poor Circulation	☐	☐	☐

Depression	☐	☐	☐	Heartburn/Reflux	☐	☐	☐
Diabetes	☐	☐	☐	Reproductive issues	☐	☐	☐
Diarrhea	☐	☐	☐	Spectrum Disorder	☐	☐	☐
Dizziness	☐	☐	☐	Skin issues	☐	☐	☐
Nausea	☐	☐	☐	Sleep issues	☐	☐	☐
Ear Infection/Aches	☐	☐	☐	Speech issues	☐	☐	☐
Eczema	☐	☐	☐	Sensory Disorder	☐	☐	☐
Epilepsy/Seizure	☐	☐	☐	Throat issues	☐	☐	☐
Eye Pain	☐	☐	☐	Thyroid issues	☐	☐	☐
Food Sensitivities	☐	☐	☐	Tinnitus/Ringing Ears	☐	☐	☐
Focus/Memory issues	☐	☐	☐	Vertigo	☐	☐	☐
Gallbladder issues	☐	☐	☐	Other_____	☐	☐	☐
G.I issues	☐	☐	☐	Other_____	☐	☐	☐

Special Note: Have you taken any medication within the last 24 hours? No☐ Yes☐

Please list:_____

Which one of the above is your **MAIN** concern that brought you to our office?_____

On a scale of 1-10 (10 being severe), how bad is the problem? _____/10

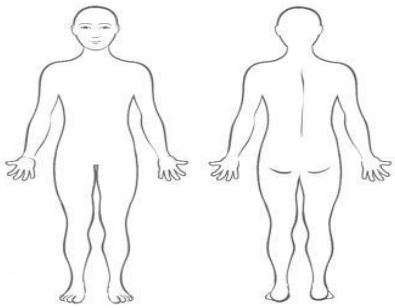
When did it start?_____ How? _____

Is it? ☐Getting better ☐Getting worse ☐Staying the same

How would you describe the problem?_____

Are you taking medication for this condition? No☐ Yes☐ Please list:_____

Where is the problem? Please circle or draw on the illustration and explain or describe your present condition in the lines below (i.e. sharp, dull, burning, tight, throbbing…)



Front:_____

_____

_____

Back:_____

_____

_____

What makes it worse? _____

What makes it better? _____

What else have you tried and what were the results?_____

What parts of your life is this condition interfering with: ☐Work ☐Sleep ☐Exercise ☐Family ☐Social ☐Positive mental attitude ☐Hobbies ☐Others:_____

_____

Which part of your life is most important for you to get back to ASAP?_____

Beyond feeling better, what are 3 reasons you want to be healthier?

1. _____
2. _____
3. _____

Fill out ALL details below for the NEXT 3 most concerning conditions that you checked off:

1. _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____/10

When did it start?_____ How ?_____

Is it? ☐Getting better ☐Getting worse ☐Staying the same

How would you describe the problem?_____

Are you taking medications for this condition? No☐ Yes☐ Please list:_____

2. _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____/10

When did it start?_____ How ?_____

Is it? ☐Getting better ☐Getting worse ☐Staying the same

How would you describe the problem?_____

Are you taking medications for this condition? No☐ Yes☐ Please list:_____

3. _____

On a scale of 1-10 (10 being severe), how bad is the problem? _____/10

When did it start?_____ How ?_____

Is it? ☐Getting better ☐Getting worse ☐Staying the same

How would you describe the problem?_____

Are you taking medications for this condition? No☐ Yes☐ Please list:_____

Please list ALL OTHER medications you are currently taking and for what reason:_____

_____

YOUR INJURY/SURGERY HISTORY

Have you had any surgery?

1. Type:_____ Date:_____ Hospitalized ☐No ☐Yes
2. Type:_____ Date:_____ Hospitalized ☐No ☐Yes

Accidents and/or injuries: Auto, Work related or other (especially those related to your present problems)

1. Type:_____ Date:_____ Hospitalized ☐No ☐Yes
2. Type:_____ Date:_____ Hospitalized ☐No ☐Yes

Informed Consent

Chiropractic care has been proven to be safe, both clinically and scientifically. The risk of injuries and complication is so small that Chiropractors carry the lowest malpractice insurance premiums of all the health care professions in the world. Although Chiropractic is reported to be the safest health care system in the world, there are a few "side effects" associated with it and we feel that it is responsible to let you know:

1. Research show that the most common unpleasant effect following chiropractic care is temporary muscle soreness associated with the adaptive changes after the adjustment. This however is only temporary and generally not severe soreness.
2. While extremely rare, there have been reports of ligament sprains and rib fractures.

☐ I have read and understand the above consent. If I have nay questions or concerns, I will discuss them with my Chiropractor.

☐ I understand that research and training is an important aspect for all health care disciplines. For this reason, I consent to my information being used for research data purposes and understand that audio or video recordings may occur from time to time. (Your personal privacy is very important to us. We will not release any personal information).

☐ I consent to the care recommended by my Chiropractor and extend this consent to include all other Chiropractors in this office

Your name: _____ Signature:_____Date:_____

Witness:_____