Healthy for Life Chiropractic

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Case #____________

NEW PATIENT INFORMATION

Welcome! PLEASE PRINT CLEARLY.

Full Name:______________________________ E-mail:___________________ Gender: ❑ M ❑ F Age:_____

Birth date:___/___/___ Address:________________________ City:________________ State:___ Zip:________

Social Security #:____-____-_____ Pregnant? ❑ Y ❑ N

Marital Status: ❑ S ❑ M ❑ D ❑ W # of Children: _______ Work Status: ❑ Full time ❑ Part-time ❑ Retired

Home Phone (____)______________ Cell Phone: (____)______________ Work Phone: (____)______________

Employer:_____________________________________ Occupation: _________________________________

Employer Address:____

In case of emergency contact: ____________________________ Relationship:_________________________

Home Phone (____)______________ Cell Phone: (____)______________ Work Phone: (____)______________

Medical Doctor:____ Date of Last Visit: ___/___/___

Reason: ____

Previous Chiropractor: __________________________________ Date of Last Visit :___/___/___

Reason: ____

How did you hear about this clinic? Whom may I thank for referring you?

____

HEALTH CONCERNS: Please list your top health concerns in order of priority.

1.____

2.____

3.____

TREATMENT: What type of treatment are you looking for? (If unsure, please leave blank.)

❑ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem

❑ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem

❑ I am looking to take care of my problem and then go on to "achieve optimal health and wellness"

COMPLAINT/PROBLEM: In relation to your **primary** complaint:

When did you first seek treatment for this problem?____________________

Has another doctor(s) treated you for this condition? ❑ Y ❑ N

If yes, whom? ______________________________ Treatment(s):____

Have you had any intolerance or reactions to treatments? ❑ Y ❑ N Describe: ___________________________

If this is a reoccurrence, when was the first time you noticed this problem? ______________________________

How did it originally occur? ____

Has it become worse recently? ❑ Y ❑ N ❑ Same ❑ Better ❑ Gradually worse

How frequent is the condition? ❑ Constant ❑ Daily ❑ Intermittent ❑ Night only

How long does it last? ❑ All day ❑ Few hours ❑ Minutes

1) Does this cause **you:**

❑ Moodiness
❑ Irritability
❑ Interrupted Sleep
❑ Restricted Daily Activities

2) Does this affect your **WORK:**

❑ Decision Making
❑ Poor Attitude
❑ Decreased Productivity
❑ Unable to work long hours
❑ Exhausted at end of day

3) Does this affect your **LIFE:**

❑ Lose patience with spouse/children
❑ Restricted household duties
❑ Hinders ability to exercise/participate in sports
❑ Interferes with ability to participate in hobbies or other desired activities

How long has it been since you felt good? ❑ Days ❑ Weeks ❑ Months ❑ Years ❑ >10years

Describe the pain: ❑ Sharp ❑ Dull ❑ Numbness ❑ Tingling ❑ Aching ❑ Burning ❑ Stabbing

❑ Other:_______________________

What makes the problem worse? ❑ Standing ❑ Sitting ❑ Lying ❑ Bending ❑ Lifting ❑ Twisting

❑ Other:_____________________

Is there anything that you can do to relieve the problem? ❑ Y ❑ N If yes, describe: _____________________

If no, what have you tried to do that has not helped? ____

What do you believe is wrong with you? ____

Are there any other conditions or symptoms that may be related to your major symptom? ❑ Y ❑ N

If yes, what? ___________________________________

Subluxations are caused by physical traumas, chemical toxicities and mental/emotional stresses. Please answer the following:

List all recent accidents or injuries within the last 6 months (physical traumas):

	Date:	Describe:
1)	________________	____
2)	________________	____
3)	________________	____
4)	________________	____
5)	________________	____
6)	________________	____

List accidents or injuries prior to 6 months ago (physical traumas):

	Date:	Describe:
1)	________________	____
2)	________________	____
3)	________________	____
4)	________________	____
5)	________________	____
6)	________________	____

Please check all of the symptoms that apply. (**P**=Past/**C**=Current)

P/ C

- ❑ ❑ High Blood Pressure
- ❑ ❑ Low Blood Pressure
- ❑ ❑ Eye Pain
- ❑ ❑ Blurred Vision
- ❑ ❑ Dizziness
- ❑ ❑ Earache
- ❑ ❑ Forgetfulness
- ❑ ❑ Confusion
- ❑ ❑ Sinusitis
- ❑ ❑ Teeth Grinding
- ❑ ❑ Acid Reflux
- ❑ ❑ Excessive Thirst
- ❑ ❑ Unpleasant Taste
- ❑ ❑ Neck Pain
- ❑ ❑ Sore Throat
- ❑ ❑ Persistent Coughing
- ❑ ❑ Lump in Throat
- ❑ ❑ Swallowing Pain
- ❑ ❑ Knee Pain
- ❑ ❑ Shoulder Pain

P/ C

- ❑ ❑ Headache
- ❑ ❑ Walking Problems
- ❑ ❑ Abdominal Pains
- ❑ ❑ Nausea/Vomiting
- ❑ ❑ Poor Appetite
- ❑ ❑ Joint Stiffness
- ❑ ❑ Urination Difficulty
- ❑ ❑ Frequent Urination
- ❑ ❑ Constipation
- ❑ ❑ Hemorrhoids
- ❑ ❑ Irritability
- ❑ ❑ Menstrual Irregularities
- ❑ ❑ Elbow/Hand Pain
- ❑ ❑ Tingling in Hands
- ❑ ❑ Clammy Hands
- ❑ ❑ Swollen Joints
- ❑ ❑ Low Back Pain
- ❑ ❑ Hip Pain
- ❑ ❑ Ankle/Foot Pain
- ❑ ❑ Poor Circulation

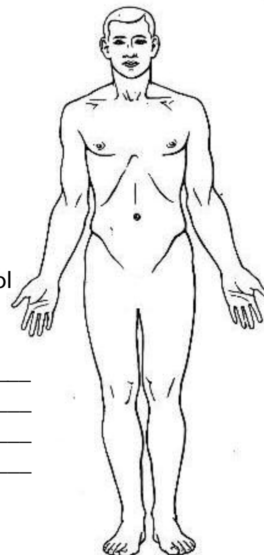
P/ C

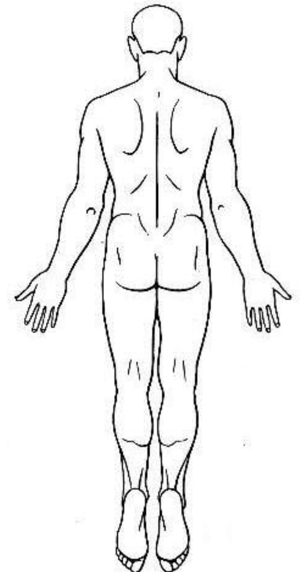
- ❑ ❑ Tingling in Feet
- ❑ ❑ Rapid Heart Rate
- ❑ ❑ Slow Heart Rate
- ❑ ❑ Weak Muscles
- ❑ ❑ Paralysis
- ❑ ❑ Shakiness
- ❑ ❑ Sweating
- ❑ ❑ Insomnia
- ❑ ❑ Fainting
- ❑ ❑ Dry Mouth
- ❑ ❑ Sore Muscles
- ❑ ❑ Impatience
- ❑ ❑ Fatigue
- ❑ ❑ Feel Loss of Control
- ❑ ❑ Swollen Ankles
- ❑ ❑ Chest Pressure
- ❑ ❑ Other:____________

____
____
____

Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Achy – AAA	Pins & Needles – PPP
Stabbing – SSS	Numbness – NNN
Burning – BBB	Cramping – CCC





ALLERGIES: Please check and list all allergies/sensitivities

❑ Food:____

❑ Medications: ____

❑ Seasonal/Other: _______________________________________

Do you have an iodine sensitivity? ❑ Y ❑ N

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started
❑ Antacids		
❑ Antibiotics		
❑ Antidepressants		
❑ Anti-Diabetics		
❑ Anti-Inflammatory		
❑ Blood Pressure Lowering Meds.		
❑ Cholesterol Lowering Meds.		
❑ Hormone Replacements (HRT)		
❑ Oral Contraceptives		
❑ Other		

SURGICAL PROCEDURES: List all surgical procedures you have had:

____

____

SUPPLEMENTS: Do you take vitamins/supplements or herbs? ❑ Y ❑ N
If yes, which ones and who recommended them? ______________________________

HABITS:	Heavy	Moderate	Light	None
Alcohol	❑	❑	❑	❑
Coffee	❑	❑	❑	❑
Soda/Diet Soda	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Drugs	❑	❑	❑	❑
Stress Level	❑	❑	❑	❑

	5-7x/wk	3-5x/wk	1-3x/wk	None	Type	Time
Exercise	❑	❑	❑	❑	❑	❑
	8+hrs	7-8 hrs	6-7 hrs	5-6 hrs	<5 hrs	
Sleep	❑	❑	❑	❑	❑	
	5+	4	3	2		
Meals/day	❑	❑	❑	❑		
	64+ oz	32-64 oz	16-32 oz	<8oz		
Water/day	❑	❑	❑	❑	❑	❑

Are you vegetarian/vegan? ❑ Y ❑ N Lacto-Ovo? ❑ Y ❑ N

WORK ACTIVITY: ❑ Heavy Labor ❑ Light Labor ❑ Mostly Sitting ❑ Mostly Standing
❑ Driving ❑ Walking/Moving

FAMILY HISTORY: Identify any conditions that you/family members have now or have had in the past:
(G=Grandparents, M=Mother, F=Father, S=Siblings, X=Self)

___	Alcoholism	___	Eczema	___	Miscarriage(s)	___	Tumor(s)
___	Anemia	___	Emphysema	___	Mumps	___	Ulcer(s)
___	Cancer	___	Epilepsy	___	Stroke	___	Other: ______________________
___	Cold Sores	___	Goiter	___	Pneumonia		______________________
___	Diabetes	___	Gout	___	Polio		______________________
___	Depression	___	Heart Disease	___	HIV/AIDS		______________________
___	Deep vein thrombosis						______________________

Wellness Checklist —The other 4 factors of health in addition to a healthy nervous system.

Please circle things that you do for you health.

Nutrition:
Eat Healthy
Drink bottled water
Are you on any special diet? If yes, what? ______________________________
Receive chiropractic care

Rest & Relaxation:
Engage in activities to destress your body
Get 8 hours good quality sleep regularly
Use a special pillow
Use a special mattress
Receive chiropractic care

Exercise:
Stretching
Small motor movements train
Weight train
Wear orthotics
Floss your teeth
Receive chiropractic care

Mental Wellbeing:
Actively try to think positively
Meditate
Pray
Receive chiropractic care

I understand the information contained within this form and guarantee this form was completed correctly and to the best of my knowledge.

____ ______________________________

Patient's signature Date