Welcome to our Office

Name:		**Home Phone: ( ) -**
Cell Phone: ( ) -		**Work phone: ( ) -**
Address:		
Birthdate:	**Age:**	**Marital status: M W D S**
Spouse Name:	**How many children do you have?**	
Occupation:	**Employer:**	
Ins. Company:	**Policy #:**	

1. **Most patients are referred by a caring Friend or Family member. We really appreciate referrals. Who encouraged you to visit our office?**

   ☐ Website ☐ Yellow pages ☐ Sign ☐ Company Talk ☐ Telephone Call
   ☐ YouTube ☐ Other_____

2. **Research shows that your spine should be checked regularly. How many times have you been adjusted in your lifetime?** _____ **.**

3. **When was your last complete Spinal Exam including x-rays?** _____ **.**

4. **Have you been told that you have a Spinal Curvature or Spinal Arthritis?**

   ☐ Yes ☐ No

5. **Unhealthy spines cause decay which eventually results in cracking or grinding. Do you ever hear noises or feel grinding when you move your neck or lower back?**

   ☐ Yes ☐ No

6. **Do you have difficulty turning your head to back up a car or turning your head to see traffic while merging on to a highway?** ☐ Yes ☐ No

7. **Poor posture leads to poor health and often indicates spinal problems. How would you rate your overall posture?** Poor 1 2 3 4 5 6 7 8 9 10 Excellent

8. **Stress can cause or accelerate Spinal Damage. Rate your stress levels.**

   ☐ Low ☐ Medium ☐ High

9. **During pregnancy the stresses on your spine and pelvis are increased significantly. Is there any chance that you are pregnant?** ☐ Yes ☐ No

10. **When was your last Car Accident or Work Injury?** _____**.**

Current Health Habits

Patient Name: _____ **Date:** 4/8/2013

(Please take several minutes to answer these questions so that we can understand your past health habits.)

1. How are you currently taking care of your health?

☐ Medications ☐ Exercise ☐ Vitamins ☐ Emergency Room ☐ Nutrition/Diet

☐ Chiropractic ☐ Routine Medical Care ☐ Holistic Care ☐ Other _____

2. How are those health habits working out for you?

☐ Bad results ☐ Nothing Changed ☐ Still Trying ☐ Some Results ☐ Didn't Get Worse

☐ Great Results ☐ Didn't Work at All ☐ Too Early to Tell ☐ Other_____

2. **How have others around you been affected by your health condition?**

☐ No One is Affected ☐ They Tell Me to do Something ☐ People Avoid Me

4. What are you concerned that this might be (or beginning) to affect? (or will affect)

☐ My Job ☐ Marriage ☐ Time with My Children ☐ My Self Esteem ☐ Finances

☐ My Future Ability to Work ☐ Sleep ☐ My Freedom to Do What I Want ☐ My Hobbies

5. Are there other health conditions your concerned that this might turn into in the future?

☐ Family Health Problems ☐ Diabetes ☐ Depression ☐ Heart Disease ☐ Arthritis

☐ Chronic Fatigue ☐ Scoliosis ☐ Cancer ☐ Fibromyalgia ☐ I May Need Surgery

6. How do you sleep?

☐ Side ☐ Stomach ☐ Back ☐ Very Peacefully ☐ Restless ☐ Hours Per Night _____

7. Do you drink alcohol?

☐ No ☐ Social Drinker ☐ Light Drinker ☐ Moderate Drinker ☐ Heavy Drinker

☐ Alcoholic ☐ Abstaining Alcoholic

8. Do you smoke cigarettes?

☐ No ☐ Social Smoker ☐ Light Smoker ☐ Moderate Smoker ☐ Heavy Smoker

9. Do you drink any caffeine?

☐ No ☐ 1 Cup In The Morning ☐ 2-4 Cups A Day ☐ 5 Or More Cups A Day

List any serious condition the Doctor should be aware of.

_____

What prompted you to come in?

_____

What caused your symptoms?

_____

How long has this been going on?

_____

What are your current weekly exercise habits?

_____

Is your Mom still alive? Yes or No. Is Dad still alive? Yes or No.

Please describe the reason for their passing, if applicable, or their current health status if they are living.

_____

Have you ever fractured any bones in your body at any time, ever?
(Please explain each with dates.)

_____

What are your favorite hobbies and activities? How often do you participate in them?
(Times per week/hours per time)

_____

When this problem is at it's worst, in what ways does it interfere (reduce your productivity or effectiveness) with your daily activities?

_____

How would you rate your energy level overall, prior to your present findings, on a scale of 0 to 10 (10 being the best)

_____

Height: _____ Weight: _____ Blood Pressure:_____/_____

Social Security #: _____

The above information is true to the best of my knowledge. Initial: _____ Date: _____

Thank you for helping us understand your past health habits. We really appreciate your time.

Family Posture Evaluation

Name: ______________

Age: ______________

Relation: ______________

☐ Foward head lean

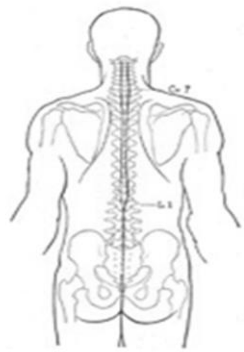
☐ Forward shoulders

☐ Forward lean

Left head tilt ☐

Left high ☐
shoulder

Left lean ☐



☐ Right head tilt

☐ Right high
shoulder

☐ Right lean

Name: ______________

Age: ______________

Relation: ______________

☐ Foward head lean

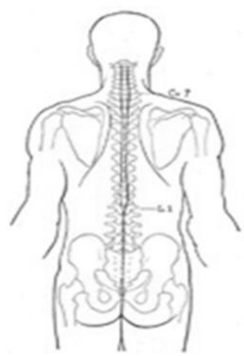
☐ Forward shoulders

☐ Forward lean

Left head tilt ☐

Left high ☐
shoulder

Left lean ☐



☐ Right head tilt

☐ Right high
shoulder

☐ Right lean

Name: ______________

Age: ______________

Relation: ______________

☐ Foward head lean

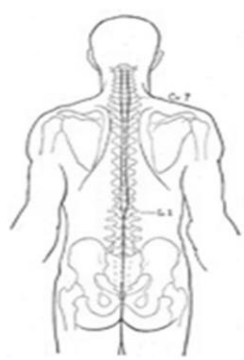
☐ Forward shoulders

☐ Forward lean

Left head tilt ☐

Left high ☐
shoulder

Left lean ☐



☐ Right head tilt

☐ Right high
shoulder

☐ Right lean

Name: ______________

Age: ______________

Relation: ______________

☐ Foward head lean

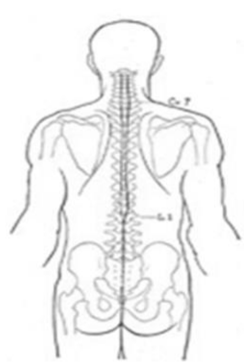
☐ Forward shoulders

☐ Forward lean

Left head tilt ☐

Left high ☐
shoulder

Left lean ☐



☐ Right head tilt

☐ Right high
shoulder

☐ Right lean