

The Connection – Lifestyle Chiropractic Group, LLC

“Starting Where Others Have Failed”

General Information:

Name _____ Date _____
Address _____ City _____ Zip _____
Phone (H) _____ (C) _____ (W) _____
Birthdate _____ Male Female # Children Married Single Widowed
SS # _____ Driver's License # _____
Spouse's Name _____ Children's Names _____
Email Address _____ Employer _____
Employer's Address _____ Occupation _____
How were you referred to our office? _____
Are you currently pregnant? ____ Yes ____ No

About Your Health:

The human body is designed to be healthy. Throughout life, events occur which damage your health. This health profile is designed to identify the underlying layers of damage to your nervous system, which results in poor health, so that we may begin your journey of recovering your innate health potential.

Were you aware that....

- Doctors of Chiropractic work with the nervous system? Yes No
- The nervous system controls all bodily functions & systems? Yes No
- Chiropractic is the largest natural healing profession in the world? Yes No
- If Chiropractic care began at birth, you could achieve a higher level of health throughout life? Yes No

Please check if you are here for: Better Health Symptom Relief Auto/Work Injury Scoliosis Exam

Loss of Health:

Let's begin at birth, when you first damaged your nervous system, and began your journey to ill health.

Birth History: Please check all that apply

___ Mother smoked/drank/drugs during pregnancy ___ Epidural/Meds in Labor
___ Breech Vaginal Delivery ___ C-section ___ Forceps Delivery
___ Vacuum Extracted ___ Labor Induced ___ Complications
___ Other: _____

Childhood Years: (Age 0-17 years) Please check all that apply

___ Frequent Illness ___ Serious Falls ___ Active in Sports
___ Very Inactive ___ Car Accident(s) ___ Surgery/Stitches
___ Alcohol/Drug Use ___ Smoker ___ Antibiotics/Meds
___ Vaccinated ___ Chiropractic Care ___ Broken Bones
___ Severe Emotional Trauma(s): _____

Comments: _____

Next, lets take a look at your health habits and stresses that added on layers of damage resulting in symptoms and random bouts of sickness.

Adult Years: (Age 18 to present) Please check all that apply

- | | | |
|--|--|--|
| <input type="checkbox"/> Smoker | <input type="checkbox"/> OTC/Prescription Meds | <input type="checkbox"/> Alcohol Use |
| <input type="checkbox"/> Surgery/Stitches | <input type="checkbox"/> Play Sports | <input type="checkbox"/> Car Accident(s) |
| <input type="checkbox"/> Work Injury | <input type="checkbox"/> High Stress (Life/Job/etc) | <input type="checkbox"/> Sit alot |
| <input type="checkbox"/> Drive alot | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Poor Diet |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Lack of Exercise | <input type="checkbox"/> Flat Feet |
| <input type="checkbox"/> Orthotics/Lifts | <input type="checkbox"/> Severe Health Problems | <input type="checkbox"/> Hard Falls |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Chiropractic Care → Last Adjustment _____ | |
| <input type="checkbox"/> Other Injuries: _____ | | |

On a scale of 1 – 10, describe your stress level: (1=none/ 10=Extreme) Work Personal

Primary Reason For This Visit:

In Order of Severity list your Present Complaint(s):

1. _____
2. _____
3. _____

How does this affect your life? Irritable Loss of Energy Difficult Sleeping Work Loss

If you are having pain, is it..... Sharp Dull Constant Intermittent
 Traveling Radiating Mild Moderate Severe/Intolerable

Since it began, is it the..... Same Better Worse Variable
 Does it interfere with: Work Sleep Walking Sitting Exercise Hobbies Leisure

How long have you had this problem? _____

Is this related to an injury? Yes (Date of Injury: _____) No

If Yes, please explain: _____

Is there a time of day that it's worse? Morning Afternoon Evening During Sleep

Other Doctors seen for this condition: _____

List any current medications: _____

Are you using any home remedies? If so, please explain: _____

Past Accidents (Motor Vehicle/Work/Falls) & Dates: _____

Past Surgeries & Dates: _____

Other Symptoms: Please check each symptom that you have now or have had in the past. Even though they may seem unrelated to the purpose of this visit, they can have an affect on your overall health and care plan.

- | | | | | |
|---|--|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Neck Pain/Stiffness | <input type="checkbox"/> Back Pain/Stiffness | <input type="checkbox"/> Stress/Tension |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritability/Anger | <input type="checkbox"/> Anxiety/Nervousness | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Loss/Smell | <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Loss/Taste | <input type="checkbox"/> Loss/Balance |
| <input type="checkbox"/> Cold Sweats | <input type="checkbox"/> Cold Feet | <input type="checkbox"/> Cold Hands | <input type="checkbox"/> Diarrhea/Constipation | <input type="checkbox"/> Buzz/Ringing Ears |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> PMS | <input type="checkbox"/> Menopause | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diff Sleeping |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Hot Flashes | <input type="checkbox"/> Impotence/Infertility | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Diff Urinating |
| <input type="checkbox"/> Pins/Needles in Arms/Hands | <input type="checkbox"/> Pins/Needles in Legs/Feet | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Infections | |
| <input type="checkbox"/> Eyes Sensitivity | <input type="checkbox"/> Other: _____ | | | |

Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side	_____	_____	_____	_____	_____
Mother's Side	_____	_____	_____	_____	_____

I hereby certify that the statements and answers given on this form are accurate to the best of my recollection & knowledge.

Patient Signature _____ Dated _____

Guardian (If Minor) _____ Dated _____