NEW LIFE CHIROPRACTIC

Health Profile

T 1 2 3
C W S

Today's Date_____/_____/_____

Name_____ Date of Birth_____/_____/_____ Age_____ M / F

Address_____ City_____ State_____ Zip_____

Phone: Home_____ Cell_____ Carrier (i.e. AT&T) _____

Email Address_____

For reminders, do you like texts, email or a phone call? TEXT ME / EMAIL ME / CALL ME

Social Security #_____-_____-_____ If a minor, parents SS# _____-_____-_____

Occupation_____ Name of Employer_____

Single / Married / Divorced / Widowed Spouse's Name_____

Number of Children____ Names, Ages & Gender_____

Do you independently make your own financial decisions for your Health Care? Circle Y N

DO YOU HAVE INSURANCE ____YES ____NO NAME OF INSURANCE COMPANY_____

Who may we thank for referring you? _____

PLEASE LIST YOUR HEALTH CONCERNS BELOW

Health Concerns:	Rate severity 1=mild 10=unbearable	When did it start?	How did it happen?	Did the problem begin with an injury?	Are symptoms constant or on and off?
1._____	_____	_____	_____	_____	_____
2._____	_____	_____	_____	_____	_____
3._____	_____	_____	_____	_____	_____
4._____	_____	_____	_____	_____	_____

What health goals would you like to accomplish through Chiropractic care?

_____

_____

IF YOU ARE EXPERIENCING PAIN, IS IT _____SHARP or _____DULL?

DOES THE PAIN TRAVEL OR RADIATE ANYWHERE? ____YES ____ NO

IF IT DOES TRAVEL OR RADIATE, PLEASE DESCRIBE_____

SINCE YOUR PROBLEM STARTED, IS IT ____About the same ____ Getting better ____Getting worse?

WHAT MAKES IT WORSE?_____

WHAT HAVE YOU DONE THAT MAKES IT FEEL BETTER?_____

HAVE YOU SEEN OTHER DOCTORS FOR THIS CONDITION? _____Chiropractor _____Medical Doctor _____Other

LIST SURGICAL OPERATIONS AND YEARS_____

_____

LIST ALL MEDICATIONS YOU ARE ON_____

_____

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? _____YES _____NO

IF YOU HAVE, DOCTOR'S NAME & DATE_____

HAVE YOU EVER BEEN UNCONSCIOUS? ____YES ____NO FRACTURED A BONE? ____YES ____NO

IF YES, PLEASE DESCRIBE_____

ANY OTHER BODILY TRAUMA?_____

PLEASE CIRCLE ANY CONDITIONS YOU HAVE NOW / HAVE HAD:
STROKE CANCER HEART DISEASE SPINAL SURGERY SEIZURES SPINAL BONE FRACTURE SCOLIOSIS DIABETES
PLEASE CIRCLE ANY AND ALL CURRENT PROBLEMS YOU HAVE HAD IN THE LAST 2 YEARS

ASTHMA	ARTHRITIS	TMJ	CHRONIC FATIGUE
EPILEPSY	GASTRIC REFLUX	HEART DISORDERS	LUPUS
ULCERS	SCIATICA	IRRITABLE BOWEL	NAUSEA
DIZZINESS	NUMBNESS IN ARMS	DISC PROBLEMS	MENSTRUAL DISORDER
KIDNEY PROBLEMS	NUMBNESS IN LEGS	LIVER DISEASE	NECK PAIN
HEADACHES	NUMBNESS IN HANDS	LOW BACK PAIN	MIGRAINES
VERTIGO	NUMBNESS IN FEET	MID BACK PAIN	STIFFNESS IN NECK
CHEST PAINS	EAR INFECTIONS	STOMACH DISORDER	HIP PAIN
ARM PAINS	GRATING IN NECK	LEG PAINS	ANXIETY
NERVOUSNESS	SHOULDER PAIN	FAINTING	CHRONIC SINUS

OTHER_____

LIST SYMPTOMS/COMPLAINTS IN ORDER OF DISCOMFORT

1._____ 4._____
2._____ 5._____
3._____ 6._____

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

DATE _____

PLEASE PRINT YOUR NAME HERE _____

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

INFORMED CONSENT FOR CHIROPRACTIC CARE

Chiropractic care, like all forms of health care while offering considerable benefits may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases, injury has been associated with Chiropractic care. The types of complications that have been reported secondary to Chiropractic care include: sprain/strain injuries, irritation of disc condition, and rarely, fractures. One of the rarest complications associated with Chiropractic care occurring at a rate between one instance per one million to one per two million vertebral spine (neck) adjustments may be a vertebral injury that could lead to a stroke.

Prior to receiving Chiropractic care in this Chiropractic office, a health history and physical examination will be completed. Theses procedures are performed to assess your specific conditions, your overall health and in particular your spinal health. These procedures will assist us in determining if Chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

THE NATURE AND PURPOSE OF CHIROPRACTIC

Adjustments are made by chiropractors in order to correct spinal and extremity joint subluxations. One of the most common disturbances to the nerve system is the vertebral subluxation. This condition is where one or more vertebra in the spine is misaligned sufficiently to cause interference and/or irritation to the nerve system. The primary goal in Chiropractic health care is the removal of nerve interference caused by subluxation. The Chiropractic adjustment is the application of a precise, high velocity movement of the spine over a very short distance. There are a number of different methods or techniques by which the Chiropractic adjustment is delivered. Chiropractic adjustments at New Life Chiropractic are typically delivered via a gentle instrument or in some cases, by hand.

CONSENT FOR CHIROPRACTIC CARE

I understand and accept that there are risks associated with Chiropractic care and give consent to the examination that the Doctor deems necessary and the Chiropractic care, including spinal adjustments, as reported following my assessment.

_____	_____	_____
Patient Signature	Date	Witness Signature