PATIENT INFORMATION

Patient's last name:	First:	DOB (MM/DD/YY)	Sex: M / F

Phone:	Email:

Address (Street, City, Postal code):

Employer:	Job Title: How Long:
Name of Emergency Contact:	Phone: Relationship:
Spouse's Name:	Children's' Names& Ages

Whom can we thank for referring you to us?

Name of previous Chiropractor:

When was your last Adjustment?

HISTORY OF COMPLAINT

What is your present health concern?

How long have you had this condition?

Have you had similar conditions in the past?

What aggravates your condition?

What relieves your condition?

Is your condition getting progressively worse? Yes / No	When is the problem at its worst?

How long does it last? Constant / On and off during the day / Comes and goes throughout the week

Pains are: Sharp / Dull / Achy / Burning / Stabbing / Other:

Pain severity (circle one): 1 -2 -3 -4 -5 -6 -7 -8 -9 -10	How does this condition interfere with your life? Work / Home / Family / Sleep/ Other:

How did the injury happen?

Condition(s) ever been treated by anyone in the past? Yes/No	If yes, when and by whom?
How long were you under care:	What were the results:

How has your condition affected your quality of life?

How had your condition affected you emotionally?

How has your condition affected your family life and/or relationships?

If left uncorrected, how do you see your condition affecting your life over the next 5 years?

If you are a candidate for spinal correction and if we were having this conversation 12 months from today, what has to happen over that time to make you feel happy with your progress?

What is your greatest motivation (other than pain) for seeking out a solution for your condition? (Mobility, quality of life, family, participation in sports, etc.)

Do you believe that this condition can improve?

DISEASE CASUATION ANALYSIS

Family Health History:

1. Does anyone in your family suffer from the same condition?
2. Are there any other hereditary conditions the doctor should be aware of?

Exercise:

Do you participate in aerobic exercise at least 30 minutes per day?

Not at all	1-2 days a week	3-4 days a week	5-7 days a week

Do you lift weights or do resistance training?

Not at all	HIIT/Bootcamp	Crossfit	Gym

How often do you stretch per week?

Not at all	1-2 days a week	3-4 days a week	5-7 days a week

Are you currently experiencing or have you ever experienced significant stress in the following areas:

Marriage	Kids	Finances	Work	Elderly Parents

Chemical Stress:

Do you feel that you make healthy food choices?	Yes	No	I Don't Know
Do you have a high intake of vegetables?	Yes	No	I Don't Know
Are you at your ideal body weight?	Yes	No	I Don't Know

PREVIOUS IMPACTS AND TRAUMAS

Motor Vehicle Accidents:

Year:	Impact: Front / Rear / Side	How fast were YOU going?	How fast were THEY going?	Seat Belt: Yes / No
Year:	Impact: Front / Rear / Side	How fast were YOU going?	How fast were THEY going?	Seat Belt: Yes / No
Year:	Impact: Front / Rear / Side	How fast were YOU going?	How fast were THEY going?	Seat Belt: Yes / No

Sports and recreation activities you participate in either now or in the past:

Childhood accidents (falls from trees/roof/playground/bicycle…)

Birth Trauma: Was YOUR delivery (circle all that apply): Easy / Difficult / Vaginal / C-Section / Forceps / Vacuum / Suction / Epidural

NERVOUS SYSTEM

Please circle any of the following signs of organ malfunction or dis-ease you have experiences:

Head Aches	Upper Back Pain	Low Back Pain
Allergies	Shoulder Pain	Neck Pain
Sinus Problems	Heart Problems	Menstrual Problems
Ear Infections	High/Low Blood Pressure	Menopausal Problems
TMJ	Heartburn	PMS
Dizziness/Vertigo	High Cholesterol	Prostate Problems
Loss of Balance/Fainting	Diabetes	Sexual Dysfunction/Impotence
Hearing Loss/Ringing in Ears	Numbness/Tingling	Infertility Problems
Double/Blurred Vision	Chest Pain	Spleen Problems
Anxiety/Depression	Breathing Difficulties/Asthma	Colon Problems
ADD/ADHD	Lung Problems	Bed Wetting
Learning Difficulties	Mid Back Pain	Hip Pain
Seizures/Tremors	Digestive Problems	Knee Pain
Stroke	Diarrhea/Constipation	Foot Pain
Irritable/Mood Changes	Gall Bladder Problems	Swollen/Painful Joints
Frequent Cold/Flu	Liver Problems	Scoliosis
Trouble Controlling Weight	Hepatitis (A / B / C)	Plantar Fasciitis
Trouble Sleeping	Kidney Problems	Are you Pregnant? Y / N

Other:

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INFORMED CONSENT TO CHIROPRACTIC ADJUSTMENTS AND CARE

I understand that any insurance coverage is an arrangement between the insurance company and myself. I understand that Vibrant Life Chiropractic will prepare any necessary reports and forms to assist submitting a claim to the insurance company. Furthermore, I understand and agree that all services rendered, are charged directly to me and that I am personally responsible for payment.

Our goal is to locate and correct vertebral subluxation, thereby restoring normal function to the spine, and removing any interference to nerve function, and maximizing the transmission of nerve impulses from brain to body. While we often see dramatic improvements in many diseases and conditions by restoring function to the spine and removing nerve interference, Chiropractic is not a treatment of any disease condition.

I understand and I am informed that, as in all health care, in the practice of Chiropractic there are some possible risks to care including, but not limited to, minor strains and sprains, and disc injuries. Physicians, Chiropractors, Osteopaths and Physiotherapists are required to advise patients with neck problems of the following – there have been very rare incidents of injury to the vertebral artery during the course of treatment. This has caused strokes, or stroke-like occurrences, which are usually of a temporary nature. The chances of this happening are less than 1 in 5.8 million. Tests with or without X-Rays have been performed on you to minimize this risk to yourself. Chiropractic is considered to be one of the safest, most effective forms of therapy for neck conditions. If you have any questions about this, please ask your Chiropractor. I have read the above statements and consent to treatment.

Signature_____ Date _____

Witness_____