Healthy for Life Chiropractic
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864.313-0210

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 **<u>you</u>:**
- ❑ Moodiness
- ❑ Irritability
- ❑ Interrupted Sleep
- ❑ Restricted Daily Activities

2) Does this affect your **<u>WORK</u>:**
- ❑ Decision Making
- ❑ Poor Attitude
- ❑ Decreased Productivity
- ❑ Unable to work long hours
- ❑ Exhausted at end of day

3) Does this affect your **<u>LIFE</u>:**
- ❑ 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 <u>within the last 6 months</u> (physical traumas):

	Date:	Describe:
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

List accidents or injuries <u>prior to 6 months ago</u> (physical traumas):

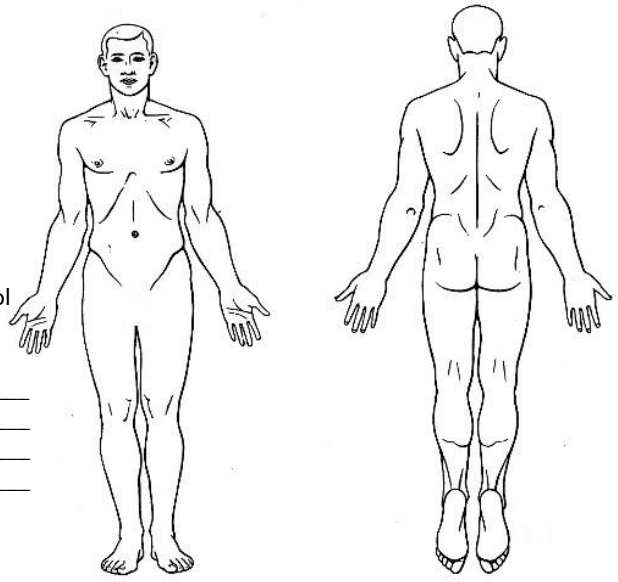
	Date:	Describe:
1)	_____	_____
2)	_____	_____
3)	_____	_____
4)	_____	_____
5)	_____	_____
6)	_____	_____

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

P/ C	P/ C	P/ C
❑ ❑ High Blood Pressure	❑ ❑ Headache	❑ ❑ Tingling in Feet
❑ ❑ Low Blood Pressure	❑ ❑ Walking Problems	❑ ❑ Rapid Heart Rate
❑ ❑ Eye Pain	❑ ❑ Abdominal Pains	❑ ❑ Slow Heart Rate
❑ ❑ Blurred Vision	❑ ❑ Nausea/Vomiting	❑ ❑ Weak Muscles
❑ ❑ Dizziness	❑ ❑ Poor Appetite	❑ ❑ Paralysis
❑ ❑ Earache	❑ ❑ Joint Stiffness	❑ ❑ Shakiness
❑ ❑ Forgetfulness	❑ ❑ Urination Difficulty	❑ ❑ Sweating
❑ ❑ Confusion	❑ ❑ Frequent Urination	❑ ❑ Insomnia
❑ ❑ Sinusitis	❑ ❑ Constipation	❑ ❑ Fainting
❑ ❑ Teeth Grinding	❑ ❑ Hemorrhoids	❑ ❑ Dry Mouth
❑ ❑ Acid Reflux	❑ ❑ Irritability	❑ ❑ Sore Muscles
❑ ❑ Excessive Thirst	❑ ❑ Menstrual Irregularities	❑ ❑ Impatience
❑ ❑ Unpleasant Taste	❑ ❑ Elbow/Hand Pain	❑ ❑ Fatigue
❑ ❑ Neck Pain	❑ ❑ Tingling in Hands	❑ ❑ Feel Loss of Control
❑ ❑ Sore Throat	❑ ❑ Clammy Hands	❑ ❑ Swollen Ankles
❑ ❑ Persistent Coughing	❑ ❑ Swollen Joints	❑ ❑ Chest Pressure
❑ ❑ Lump in Throat	❑ ❑ Low Back Pain	❑ ❑ Other:_____
❑ ❑ Swallowing Pain	❑ ❑ Hip Pain	_____
❑ ❑ Knee Pain	❑ ❑ Ankle/Foot Pain	_____
❑ ❑ Shoulder Pain	❑ ❑ Poor Circulation	_____

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

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