

**Welcome to Life Chiropractic Center**

It is our purpose and desire to provide you with the best care available in North Idaho. If for some reason we feel we cannot help you, we will be happy to make a referral to someone who can.

***“From infants to the elderly, restoring Health and Wellness to sick and hurting people.”***

***About You***

Name \_\_\_\_\_ Today's date \_\_\_\_\_  
What do you prefer to be called? \_\_\_\_\_ Male Female SS# \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Zip code \_\_\_\_\_ Home phone # \_\_\_\_\_ Other phone # \_\_\_\_\_  
E-mail address \_\_\_\_\_ Birth date \_\_\_\_\_  
Marital Status \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ How long? \_\_\_\_\_ Employer's phone # \_\_\_\_\_  
Employer's address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Spouses name \_\_\_\_\_ # of Children \_\_\_\_\_ Ages \_\_\_\_\_

***Account Info***

Is this a: wellness evaluation specific condition auto accident work injury other \_\_\_\_\_  
Desired method of payment: cash check credit card  
Insurance carrier \_\_\_\_\_ phone # \_\_\_\_\_  
Policy # \_\_\_\_\_ Claim # \_\_\_\_\_  
Secondary insurance \_\_\_\_\_ Policy # \_\_\_\_\_  
Please provide your insurance card to the front desk person so a copy can be made.

***Reason for my visit***

Have you ever seen a chiropractor before? Yes No  
The reason for my visit: Wellness Specific condition other \_\_\_\_\_  
Please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
If you are here for a specific condition, when did it begin? \_\_\_\_\_  
Is this condition getting worse? Yes No Constant Comes and goes  
Is this condition interfering with your: work sleep daily routine  
If so, please explain: \_\_\_\_\_  
\_\_\_\_\_  
Have you been treated by a medical physician for this condition? Yes No  
If so, where? \_\_\_\_\_

***Explanation of History***

The nervous system controls and regulates every cell, tissue, and organ in the body. Physical, chemical, and emotional stress can alter the shape, position, tone, and tension of the nervous system. This may be contributing to your altered state of health. Your case history will help uncover events which may have been stressful to your nervous system.

***Past medical conditions***

**Have you ever had any of the following medical conditions?**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Heart Attack               | <input type="checkbox"/> Heart Surg/Pacemaker    | <input type="checkbox"/> Heart Murmur      |
| <input type="checkbox"/> Congenital Heart Defect    | <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Artificial valves |
| <input type="checkbox"/> Alcohol/Drug Abuse         | <input type="checkbox"/> Venereal Disease        | <input type="checkbox"/> Hepatitis         |
| <input type="checkbox"/> HIV+/AIDS                  | <input type="checkbox"/> Shingles                | <input type="checkbox"/> Cancer            |
| <input type="checkbox"/> Frequent neck pain         | <input type="checkbox"/> Emphysema/Glaucoma      | <input type="checkbox"/> Anemia            |
| <input type="checkbox"/> High/Low Blood Pressure    | <input type="checkbox"/> Psychiatric Problems    | <input type="checkbox"/> Rheumatic Fever   |
| <input type="checkbox"/> Severe/ Frequent Headaches | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Ulcers/Colitis    |
| <input type="checkbox"/> Fainting/Seizures/Epilepsy | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Asthma            |
| <input type="checkbox"/> Diabetes/Tuberculosis      | <input type="checkbox"/> Difficulty Breathing    | <input type="checkbox"/> Chemotherapy      |
| <input type="checkbox"/> Lower Back Problems        | <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Arthritis         |

Please list any other serious medical conditions: \_\_\_\_\_  
 \_\_\_\_\_

***Birth History***

**Please provide us with any information you have about your own birth.**

1. Did your mother have any difficulties during her pregnancy with you? - - - - -  Yes  No
2. Any falls or accidents? - - - - -  Yes  No
3. Was your delivery traumatic? - - - - -  Yes  No
4. Was your mother taking any drug during her pregnancy with you? - - - - -  Yes  No
5. Was her labor chemically induced or altered? - - - - -  Yes  No
6. Were you incubated or isolated after birth? - - - - -  Yes  No
7. My birth was:  at home  in a birthing center  in a hospital
8. Were you:  nursed  bottle fed formula  bottle fed mothers milk  nursed and bottle fed

***General Physical Trauma***

**Have you experienced any of the following?**

1. Falls from crib? - - - - -  Yes  No
2. Falls on ice? - - - - -  Yes  No
3. Falls up or down steps? - - - - -  Yes  No
4. Sports injuries? - - - - -  Yes  No
5. Broken bones? - - - - -  Yes  No
6. Knocked unconscious? - - - - -  Yes  No
7. Auto accidents? - - - - -  Yes  No
8. Hospitalizations? - - - - -  Yes  No

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9. Other falls, jolts, or impacts that could have injured your spine? -----  Yes  No  
 Please explain: \_\_\_\_\_

During the week I:  sit  stand  walk  do desk work  drive  do mechanical work  do lifting  
 Do you:  read for prolonged periods  play an instrument  watch TV for prolonged periods

***Chemical Stress***

Please list any medications you are taking: \_\_\_\_\_  
 Do you smoke?  Yes  No If Yes, how much? \_\_\_\_\_ how long? \_\_\_\_\_  
 Do you work around any chemicals, dust or fumes?  Yes  No Please list: \_\_\_\_\_  
 Please grade dietary selection with the following scale: **O**-often **S**-sometimes **R**-rarely **N**-never

___ Alcohol	___ Eggs	___ Beef
___ Coffee	___ Cooked, canned vegetables	___ Poultry
___ Tobacco	___ Raw vegetables	___ Fish
___ Artificial sweeteners	___ Fruit	___ Seafood
___ Soda	___ Whole grains	___ Weight loss foods
___ Diet food	___ Dairy(milk products)	___ Fasting
___ Refined sugar	___ Fried foods	___ Organic foods

***Emotional Stress***

Mark "P" for past and "C" for current

	P	C		P	C		P	C
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	School stress	<input type="checkbox"/>	<input type="checkbox"/>	Family stress	<input type="checkbox"/>	<input type="checkbox"/>
Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	Personal relationship	<input type="checkbox"/>	<input type="checkbox"/>	Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>
Work stress	<input type="checkbox"/>	<input type="checkbox"/>	Change in lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>

***Other***

Please list any nutritional supplements you are taking: \_\_\_\_\_  
 Are you wearing:  Heel lifts  Insoles  Arch supports  
 What is the age of your mattress? \_\_\_\_ Is it comfortable?  Yes  No  
 How would you rate your physical health?  Excellent  Good  Fair  Poor  Getting better/ worse  
 Your emotional health?  Excellent  Good  Fair  Poor  Getting better  Getting worse  
 For women: Are you taking birth control?  Yes  No /how long? \_\_\_\_\_  
 Are you pregnant?  Yes  No /how long \_\_\_\_\_ Are you nursing?  Yes  No  
 Is there anything else you would like me to know? \_\_\_\_\_  
 What do you hope to receive from Chiropractic care? \_\_\_\_\_

The best health services are based on a friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services at the time of visit, unless other arrangements have been made with the business manager. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes in my health status.

Signature \_\_\_\_\_ Date \_\_\_\_\_