Welcome to New Life Chiropractic

Please Print Clearly and Fill in Completely.

Print Name ____ Email _________________________@_________________

Street Address ____ Date of Birth _______________________ Age ________

City ____ State _____ Zip __________

Home Phone ______________________ Work Phone _______________________ Cell Phone ____________________

Social Security Number: ____

Who may we thank for referring you / how did you hear of our office? ____

Were you injured in an automobile accident? YES ❑ NO ❑ Were you injured at work? YES ❑ NO ❑

Please Check ✓

Sex: Male ❑ Female ❑ Right Handed ❑ Left Handed ❑ Married ❑ Single ❑ Divorced ❑ Partner ❑ Widowed ❑

Health History:

Reason for seeking Chiropractic Care: ____

Describe any health problems, including how long you've had them: ____

____

Have you seen any other doctor for this problem? YES ❑ NO ❑ Name: ____

Were you referred by any doctor? YES ❑ NO ❑ Name: ____

Name, Phone# & Address of PCP: ____

List any medications: ____

Family History:

At our office we are not only interested in your health and well-being, but also the health and well-being of you family and loved ones.

Spouse's Name:____

Children Names/Ages:____

Parents Health History:____

Siblings Health History:____

Chiropractic History:

Have you ever been to a chiropractor before? YES ❑ NO ❑ If yes Doctor's Name: ______________________________

Date of last Chiropractic visit ___________ Reason for care ____

Date of last Chiropractic X-rays __________ How long were you under care? __________________________________

Are other family members under Chiropractic Care? YES ❑ NO ❑ Who?

Current Complaint: ____

I would describe the pain as: sharp ❑ dull ❑ achy ❑ comes & goes ❑ travels ❑ constant ❑

Since the problem started, it is: about the same ❑ getting better ❑ getting worse ❑

What makes it worse? ____

It interferes with: work ❑ sleep ❑ walking ❑ sitting ❑ hobbies ❑ leisure ❑

Please Fill in Below

If you have had, or have the following Please ✓

Condition, Symptom Or problem	Constantly or Frequently	Sometimes or Occasionally
Headaches	❑	❑
Migraines	❑	❑
Neck Pain	❑	❑
Shoulder Pain	❑	❑
Arm/Hand Pain	❑	❑
Mid Back Pain	❑	❑
Low Back Pain	❑	❑
Hip Pain	❑	❑
Leg/Foot Pain	❑	❑
Disc Problems	❑	❑
Arthritis	❑	❑
Other Joint Pain	❑	❑
Numbness/Tingling	❑	❑
Joint Swelling	❑	❑
Dizziness	❑	❑
Heartburn/Ulcers	❑	❑
Weakness	❑	❑
Fatigue	❑	❑
Nervousness	❑	❑
Insomnia	❑	❑
Anxiety	❑	❑
Depression	❑	❑
Heart Problems	❑	❑
Frequent Colds	❑	❑
Ringing in Hears	❑	❑
Hearing Loss	❑	❑
Cough	❑	❑
Chest Pain	❑	❑
Female Problems	❑	❑
Allergies	❑	❑
Asthma	❑	❑
Cancer	❑	❑
Male Problems	❑	❑
Osteoporosis	❑	❑
Diabetes	❑	❑
Hypoglycemia	❑	❑
Constipation	❑	❑
Diarrhea	❑	❑
Skin Conditions	❑	❑

Circle the areas where you have any problems
Please also describe these problems.

L R R L R L

Mark as follows:
A - Ache B - Burning N - Numbness P - Pins & Needles
S - Stabbing O - Other - Describe ____________________

Below, please fill in any other health information you feel we might need for your care.

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Childhood History (prior to age 18)

Research is showing that many of the health challenges that occur later in life have their origins during our developmental years, some starting at birth. Please answer these questions to the best of your ability.

			Details
1. Did you have any childhood illnesses?	1.YES ❑	NO ❑	____________________
2. Did you have any serious falls as a child?	2.YES ❑	NO ❑	____________________
3. Did you play any youth sports?	3.YES ❑	NO ❑	____________________
4. Did you have any surgery?	4.YES ❑	NO ❑	____________________
5. Prolonged us of medications? (i.e. antibiotics, inhalers, etc.)	5.YES ❑	NO ❑	____________________
6. Any car accidents?	6.YES ❑	NO ❑	____________________
7. Any major falls? (i.e. tree, seesaw, crib etc.)	7.YES ❑	NO ❑	____________________
8. Were you vaccinated?	8.YES ❑	NO ❑	____________________
9. Were you under regular Chiropractic care?	9.YES ❑	NO ❑	____________________

Adult History (age 18 to present)

10. Do/did you smoke?	10.YES ❑	NO ❑	____________________
11. Do/did you drink alcohol?	11.YES ❑	NO ❑	____________________
12. Do/did you play adult sports?	12.YES ❑	NO ❑	____________________
13. Did you have any surgery?	13.YES ❑	NO ❑	____________________
14. Any car accidents?	14.YES ❑	NO ❑	____________________
15. Any work injuries?	15.YES ❑	NO ❑	____________________
16. Prolonged us of medications? (i.e. antibiotics, inhalers, etc.)	16.YES ❑	NO ❑	____________________

17. On a scale of 1=none to 10=severe, rate your level of stress at home ____ work ____

18. On a scale of Poor, Good, Excellent: Describe your:

Diet __________ Exercise __________ Sleep ___________ General Health __________

19. Have you ever:

Bought bottled water?	YES ❑	NO ❑	____________________
Belonged to a health club?	YES ❑	NO ❑	____________________
Consumed vitamins or supplements?	YES ❑	NO ❑	____________________

Wellness Commitment

At New Life Chiropractic we are dedicated toward achieving the goal of total lasting health for our members. To better help you achieve this; we need to understand your commitment toward being healthy. We do *not* ask for a *financial commitment,* but we ask for your *cooperative commitment.* Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness:

10% 20% 30% 30% 40% 50% 60% 70% 80% 90% 100%

Insurance Information (if applicable)

Name of insured: ________________________________ Date of Birth: ____________________

Insurance Company: ______________________________ Phone#: ________________________

ID# ____ Policy #: ________________________

I understand and agree that health and accident policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic Office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid to New Life Chiropractic will be credited to my account upon receipt. However, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient Name: ________________________ Signature: ______________________ Date: ________

Guardian's Name: ______________________ Signature: ______________________ Date: ________

Consent to Initiate Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same health objective. Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: An adjustment is the specific application of forces to facilitate the body's correction of subluxation. Our Chiropractic method of correction is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being and not merely the absence of disease or infirmity. (from the World Health Organization)

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to eliminate subluxation which interferes with the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, ______________________________________ have read and fully understand the above statements.
(print name)

All the questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

I hereby authorize the Doctor to provide any and all forms of evaluation, x-rays and care that may be indicated in connection with the patient above, and further authorize and consent that the Doctor chooses and employs such assistance as he or she sees fit. I also understand that prior to care, a full explanation of the procedure(s) involved will be given. I agree to pay for all services rendered in this office.

____ ________________________________

Signature Date

CHILDREN

Birth Weight __________ Birth Height __________ Current Weight __________ Current Height __________

Siblings: # __________ Age(s): _________________ Sex: _________________

Type of Birth: Normal/Vaginal ❑ Forceps ❑ Breech ❑ Caesarean ❑ Suction ❑

Home Birthing Center ❑ Hospital ❑ Problems During Pregnancy ❑ _______________________________

____

Apgar Scores __________ Jaundice (yellow) YES ❑ NO ❑ Cyanosis (blue) YES ❑ NO ❑

Congenital Anomalies / Defects ____

Infant Feeding: Breast ❑ Bottle ❑ Formula ❑ Quality of sleep: Good ❑ Fair ❑ Poor ❑

# of hours of sleep per night: ____

Obstetrician / Midwife: ______________________________ Pediatrician / Family MD: ___________________________

Last Visit Date: _________________________ Purpose: ____

Immunization History: ____

Any treatment on an emergency basis? YES ❑ NO ❑ If yes, explain: ______________________________

____

Childhood Diseases: Chickenpox ❑ Mumps ❑ Measles ❑ Rubella ❑ Rubeola ❑ Whooping Cough ❑

Other: ____

Parent / Guardian's names (please print):

Mother: ____ Father: ____

I hereby authorize New Life Chiropractic and those employed by same to administer chiropractic care as deemed

necessary to my child, ____.
Child's name

Parent / Guardian Signature: ____ Date: _______________________