

PERSONAL DATA

Today's Date _____

Legal Name _____ Age _____ Date of Birth _____

Preferred Name _____ Parent's Names (if under 18) _____

Home Address _____ City _____ State _____ Zip _____

Home phone (____) _____ Cell Phone (____) _____

E-mail address _____

Occupation _____ Employer _____

 Marital Status S M D W Spouse/Partner _____

Names and Ages of Children _____

Whom may we thank for referring you to our office? _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel WellSpine KC can address for you? _____

How bad (10 being the worst) does this problem seem to be to you? 0 1 2 3 4 5 6 7 8 9 10

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N	Love life:	Y	N

On a scale from 0-10, how committed to fixing this problem are you? _____/10

WHAT ARE YOUR HEALTH GOALS?

IMMEDIATE: _____

SHORT TERM: _____

LONG TERM: _____

CHIROPRACTIC HISTORY

 Have you ever received Chiropractic care? Y N Name of D.C. _____

 How long under care? _____ Days _____ Weeks _____ Months _____ Years

Date of last visit: _____ Why did you stop care? _____

FOR WOMEN:

Are you pregnant? Y N Date of last menstrual period: _____

 If x-rays are recommended, your signature is required (below) to verify that you are not pregnant.

Signature: _____ Date: _____

If pregnant, Due Date: _____ Name of OBGYN or Midwife _____

 Where will you be birthing your baby? Hospital Home Birthing Center Other _____

The primary system in the body, which coordinates health, is the NERVE SYSTEM. The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment. Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused Vertebral Subluxations to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

- Home
 Natural
 Hospital
 Caesarian section
 Forceps
 Breech
 Cord around neck
 Prolonged labor
 Drug induced labor
 Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. With regard to the major traumas that you remember from your childhood up to the present, have you had any accidents due to any of the following? (Check all that apply)

- Automobile
 Motorcycle
 Bicycle
 Sports
 Playground
 Abuse

If yes, state type of injury and date: _____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? Y N

If yes, list body parts injured and dates of injuries: _____

Have you ever been hospitalized or had surgery? Y N

If yes, state reason and dates: _____

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate which of the below events, you are currently experiencing, or you remember experiencing:

Childhood Trauma	Y	N	Loss of loved one	Y	N	Abuse	Y	N
Work/School Stress	Y	N	Divorce/separation	Y	N	Financial Stress	Y	N
Lifestyle change	Y	N	Parents' divorce	Y	N	Illness	Y	N

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? Y N If yes, did you have a reaction? Y N Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Toxic chemicals | <input type="checkbox"/> Second hand smoke | <input type="checkbox"/> Drug therapy |
| <input type="checkbox"/> Radiation | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Other |

If yes, please list: _____

Do you have allergies or sensitivities to any foods? Y N If yes, please list: _____

Do you presently consume any of the following?

- Coffee/caffeine Alcohol Tobacco Over the counter drugs Prescribed drugs

Amount _____/day _____/day _____/day

Please list all medications (prescribed and over the counter): It is most helpful that you list all medications as they often impact your care. _____

QUALITY OF LIFE (presently)

How do you grade your physical health? Good Fair Poor

How do you grade your emotional/mental health? Good Fair Poor

How do you rate your overall "quality of life"? Good Fair Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

Do you follow a special dietary regime? _____

YOUR EXPECTATIONS FROM CHIROPRACTIC CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

- Relief of a symptom or problem ___ Relief and Prevention of a symptom or problem
- Healthier spine and nerve system ___ Optimal health on all levels
- OTHER _____

Are there any other concerns or questions you have for us?