INNATE LIFE
CHIROPRACTIC

VITAL INFORMATION

Date_____

All information is strictly confidential and is only available for Innate Life Chiropractic staff to serve you best.

First Name:_____ Middle Name:_____

Last Name:_____ Nickname:_____

Mailing Address:_____

City:_____State:_____Zip:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Age:_____ Date of Birth: _____/_____/_____ Email:_____

Marital Status (check): ☐Married ☐Single ☐Partnership ☐Widowed ☐Divorced

Name of Spouse:_____ Do you have children? ☐Yes ☐No

# of children:_____ Ages of Children:_____

Emergency Contact:_____Relationship:_____Phone:(____)_____

How were you referred to Innate Life Chiropractic?_____

Reason(s) for seeking services at Innate Life Chiropractic:_____

_____

☐I have Medicare ☐The reason for this visit is from a recent auto accident.

How many Medical Doctor office visits did you have last year?☐None ☐Less than 5 ☐6 – 10 ☐10+

Medications you currently take:

☐NSAID'S (Advil, etc.) ☐Statins ☐Blood Pressure ☐Painkillers

☐Muscle Relaxers ☐Allergy ☐Anti-Depressants ☐Cold Medications

☐Hormones ☐Other: _____

DEDICATION TO HEALING

Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life. "...a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

- The World Health Organization

Please mark the scale with the following indicators:

'X' = current level of health ***'O'* = your *desired* level.**

What is your current level of dedication to yourself, your life and well-being? (circle)

None 1 2 3 4 5 6 7 8 9 10

What change(s) would you most like to experience with care in this office?

□Symptom Relief/Temporary Relief □Restore Health □ Maintain Health
□Wellness & Prevention □ Improved Performance □ Expand Level of Well-Being
□ Other:_____

Since the nervous system controls EVERYTHING in your body it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. What other specific goal(s) might you have?

□ Better sleep □ More energy □ Keep up with children/grandchildren
□ More joy and ease □ Cease medication □ Reach full potential

Are there any other goals do you have for your life :_____

_____

PLEASE DESCRIBE YOUR REASONS FOR SEEKING CARE IN THIS OFFICE.

Primary Complaint_____

When did you first experience this problem? _____

How did this problem first begin? _____

_____

What aggravates this problem? _____

What have you tried to relieve this problem? (interventions, treatments, medications, surgery, etc.)

_____

_____

How would you describe the symptoms of this problem?

□Burning □Stabbing □Aching □Sharp □Tingling □Numb □Dull □Constant □Other_____

Please describe the location of the pain or symptom. _____

If there is pain, does it travel to other areas of the body? YES – NO

If so, where? _____

Please rate the severity of this problem overall: Low – 1 2 3 4 5 6 7 8 9 10 – High

Today: Low – 1 2 3 4 5 6 7 8 9 10 – High

Since this started is it: □getting better □staying the same □getting worse

How often do you experience this problem?

□less than 25% (Interment) □26-50% (Occasionally) □51-75% (Frequent) □76-100% (Constant)

Is there a time of day it feels worse? □Yes □No If yes, when:_____

Have you seen any other doctors for this problem? □Yes □No Who and what were their recommendations?_____

This impacts your: □Work □Family time □Leisure □Sleep □Athletics □Other:_____

Secondary Complaint_____

When did you first experience this problem? _____

How did this problem first begin? _____

_____

What aggravates this problem? _____

What have you tried to relieve this problem? (interventions, treatments, medications, surgery, etc.)

_____

_____

How would you describe the symptoms of this problem?

□Burning □Stabbing □Aching □Sharp □Tingling □Numb □Dull □Constant □Other _____
Please describe the location of the pain or symptom. _____
If there is pain, does it travel to other areas of the body? YES – NO
If so, where? _____
Please rate the severity of this problem: Low – 1 2 3 4 5 6 7 8 9 10 – High
Today: Low – 1 2 3 4 5 6 7 8 9 10 – High
Since this started is it: □getting better □staying the same □getting worse
Is there a time of day it feels worse? □Yes □No If yes, when:_____
How often do you experience this problem?
□less than 25% (Interment) □26-50% (Occasionally) □51-75% (Frequent) □76-100% (Constant)
Have you seen any other doctors for this problem? □Yes □No Who and what were their recommendations?

_____
This impacts your: □Work □Family time □Leisure □Sleep □Athletics □Other:_____

HISTORY OF INJURY/REPETITIVE STRESSES

How many auto accidents (including fender benders) have you had? □+5 □3-4 □1-2 □None
What sports are/were you involved in? _____
Have you ever: □Fallen down the stairs □Slipped and Fell □Stress/Strain at work
□ Had a sports injury –If so, please describe:_____
□ Broken a bone -- If so, which ones?_____
□ Other Injuries: _____
Do you: □Sit 4+ hours/day □Drive 2+ hours/day □Perform Repetitive Tasks (Typing/Lifting)
Have you had:
□ Surgery -- if so, when & for what condition(s)? _____
_____
_____
□ Hospitalizations -- if so, when & for what condition(s):_____
_____
_____
□ Chronic Illness(es) -- Explain: _____
_____

WORK & FAMILY HISTORY

Your Occupation:_____ Number of Hours/Week_____
Duties:_____
Job Satisfaction: Low – 1 2 3 4 5 6 7 8 9 10 – High
Daily Stress Level: Low – 1 2 3 4 5 6 7 8 9 10 – High
Does your work negatively impact your health? □Yes □No
If so why_____
Are you satisfied with your home life? □Yes □No Do you have a clear purpose in life? □Yes □No
If you care to share more:_____
_____
_____

Health Status of:

Spouse:	□Poor	□Fair	□Good	□Excellent
Children:	□Poor	□Fair	□Good	□Excellent
Parents:	□Poor	□Fair	□Good	□Excellent
Siblings:	□Poor	□Fair	□Good	□Excellent

HEALING HISTORY

What activities other than Chiropractic care do you do to support your health and well-being?

□ Diet □Massage therapy □Counseling □Acupuncture □Community engagement

□Yoga □Meditation □Prayer/Spirituality □Nutritionist □Fasting

□Vitamins/supplements -- if so, what kind? _____

_____

□Exercise -- if so, what kind? _____

_____

□ Other: _____

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? □ Yes □ No

Date of last adjustment? _____ Name of previous chiropractor?_____

Reason for previous chiropractic care?_____

What care plan was given?_____

Did you follow the care plan? Yes □No If not, why? _____

_____

Are your family members under chiropractic care? ☐Yes ☐No If yes, who?_____

_____

HELP US SERVE YOU BETTER

Which best describes your reason for consulting our office?

☐ I have a specific concern and require your help with this concern

☐I want to ensure that my health concerns do not become an ongoing problem that will impact my future health.

☐ I want to be healthier five years from now than I am today

Anything else we should know so we can better serve you?

_____

_____

_____

_____

NAME: _____

Only mark "P" for had in the *Past* or "C" for *Currently* have.

GENERAL
___ Fever
___ Chills
___ Unintended weight loss
___ Night sweats
___ Fatigue
___ Night pain
___ Irritability
___ Trouble sleeping

SKIN
___ Rashes
___ Lumps
___ Sores
___ Dryness
___ Changes to hair
___ Changes to nails
___ Changes in moles

HEAD/NECK
___ Head injuries
___ Lumps
___ Swollen glands
___ Stiffness
___ Thyroid problems
___ Neck pain
___ Jaw pain, TMJ

EYE, EAR, NOSE, THROAT
___ Vision changes
___ Redness
___ Double vision
___ Blurred vision
___ Hearing loss
___ Discharge
___ Vertigo
___ Ringing in ears
___ Frequent colds/ flu
___ Hay fever
___ Nose bleeds
___ Sinus/ drainage problems
___ Allergies
___ Frequent sore throat
___ Hoarseness of voice
___ Sore tongue
___ Swollen tongue
___ Difficulty swallowing

HEART
___ Chest pain
___ Palpitations
___ Fainting
___ Shortness of breath

LUNGS
___ Prolonged Cough
___ Coughing up mucus/sputum
___ Coughing up blood
___ Sleep apnea
___ Difficulty breathing
___ Asthma

GI/BOWELS
___ Heartburn
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Bloody or Black or tarry stool
___ Incontinence
___ Change in bowel habits
___ Prolonged bloating
___ Ulcers
___ Digestive issues

BLADDER
___ Visible blood
___ Burning
___ Change in urinary habits
___ Difficulty passing urine
___ Urgency
___ Increase frequency
___ Kidney Stones
___ Up multiple times at night to urinate

NEUROLOGICAL
___ Headaches
___ Seizures
___ Numbness
___ Tingling
___ Paralysis
___ Tremors
___ Convulsions/ Epilepsy
___ Pain with cough/ sneeze
___ Dizziness
___ Loss of balance

VASCULAR
___ Leg cramps
___ Leg swelling
___ Blood clots
___ Anemia
___ Easy Bruising
___ Wounds take excessive time to hea

MUSCLUAR/ BONE
___ Muscle pain or cramps
___ Weakness
___ Scoliosis
___ Swollen or painful joints
___ Deformity of hands or feet

GLANDS
___ Intolerance to heat or cold
___ Appetite changes
___ Excessive thirst
___ Swollen or tender glands

PSYCHIATRIC
___ Nervousness
___ Depression
___ Insomnia
___ Mood changes
___ Eating Disorder

FEMALE ONLY
___ Pregnant
___ Irregular cycle
___ Irregular or excessive bleeding
___ Menopause
___ PMS
___ Fertility Issues
___ Sexual problems
___ Breast lumps
___ Nipple or skin changes
___ Nipple discharge

MALE ONLY
___ Prostate problems
___ Impotency/ Sexual Dysfunction
___ Discharge

THANK YOU FOR ANSWERING THESE QUESTIONS.
THIS IS YOUR FIRST STEP TOWARD WELLNESS WITH US!

PLEASE CONTINUE TO THE NEXT PAGE.

All information is strictly confidential and only available for Innate Life Chiropractic team to serve you best. **Doctor's Initials**_____

Agreement for Payment of Services

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account. HOWEVER, I CLEARLY UNDERSTAND AND AGREE THAT ALL SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT. It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made. If at any point, a patient must cancel the remaining of their care plan they are entitled to a refund of the remaining balance. A refund will not be given for services which have been previously rendered.

Patient Signature _____ Date _____

TERMS OF ACCEPTANCE

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

Adjustment

An adjustment is the specific application of forces to facilitate the body's clearing of vertebral subluxation.

Health

A state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

Subluxation

Subluxations are neurological tension patterns, which interfere with the proper functioning of the nervous system and its ability to transmit mental impulses. This results in a lessening of the body's innate ability to express its infinite potential.

We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, if during the course of a chiropractic 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 you seek the services of another healthcare provider.

We do not offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to clear major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to clear subluxations. However, we may use other procedures to help your body hold the adjustments.

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