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:_____ Last Name:_____

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

Mailing Address:_____

City:_____State:_____Zip:_____

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

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:_____

_____

Please mark the scale with the following indicators: 'X' = current level of health *'O'* = your *desired* level.

VERY CHALLENGED CHALLENGED TRANSITION GOOD EXCELLENT

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 :_____

PREGNANCY INFORMATION

PREVIOUS BIRTH EXPERIENCE

Is this your first pregnancy? ☐Yes ☐No

If not, please tell us about your previous pregnancy and/or birth experience(s).

_____

Do you plan to follow the same plan as your previous delivery? □Yes □No - If no, what would you like to change? _____

CONCEPTION & EARLY PREGNANCY

When is your expected or calculated due date? _____

Did you have any difficulty conceiving? □Yes □No - If yes, please explain: _____

_____

Have you ever used any form of hormonal or oral contraceptives? □Yes □No - If yes, which ones, and for how long? _____

Have you experienced morning sickness? □Yes □No - If yes, please explain: _____

_____

CURRENT HEALTH

What type of exercise(s) are you currently performing? _____

Please tell us about your current diet, and any dietary restrictions:_____

_____

Have you taken any medications or supplements during your pregnancy? □Yes □No - If yes, please explain:

_____

Have you had any slips, falls, or other physical traumas during the pregnancy? □Yes □No - If yes, please explain: _____

Have you had any major emotional stressors during your pregnancy? □Yes □No - If yes, please explain:

_____

YOUR BIRTH PLAN

You top three goals for this pregnancy:

1. _____

2. _____

3. _____

Do you currently have a birth plan? □Yes □No - If yes, please explain: _____

_____

Who is your OB/GYN or midwife? _____

Will they be present for delivery? □Yes □No Do you intend to have a doula or birth coach? □Yes □No

Are you taking any pre-natal or birthing classes? □Yes □No

Do you wish to have a natural vaginal labor and delivery? □Yes □No - If not, what concerns do you have?

_____

Do you plan on breastfeeding your child? □Yes □No

What do you intend to do for vaccines? _____

What would you like to gain from chiropractic care during your pregnancy?

_____

Do you have any health conditions or challenges?_____

If so, when did it begin? _____ How did the condition start? ▢ Suddenly ▢ Gradually ▢ Post-Injury

Is the condition: ▢ Getting Worse ▢ Improving ▢ Constant ▢ Intermittent ▢ Unsure

What makes the condition better?_____

What makes the condition worse? _____

Is the condition worse during certain times of the day? ▢ No ▢ Morning ▢ Afternoon ▢ Evening ▢ Night

How often do you experience this problem? □ Occasionally □ Intermittent □Frequent □ Constant

Is this condition interfering with: ▢ Work ▢ Sleep ▢ Hobbies ▢ Exercise ▢ Daily Routine

Have you ever had a similar condition? ▢ Yes ▢ No Please Explain_____

Please rate the severity of this problem on average: 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

HISTORY OF PHYSICAL STRESSES (BIRTH TO PRESENT)

Throughout life, stresses and traumatic events can damage the spine and nerve system. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature. Understanding the PHYSICAL, CHEMICAL, or EMOTIONAL stresses that have acted upon your spine and nerve system assists us in serving you. Please answer the following questions as accurately and completely as possible.

Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Was **YOUR** birth: (check all that apply)

□ drug induced □ C section □ breech □ natural □ forceps

□ prolonged □ cord around neck □ at home □ in hospital □ suction

Have you ever injured your spine (neck, head, back, hips)? □ Yes □ No

If yes, please explain how and when:_____

How many auto collisions (including fender benders) have you had? □+5 □3-4 □1-2 □None

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)

What sports are/were you involved in? _____

Have you had:

□ Surgery -- if so, when & for what condition(s)? _____

_____

_____

□ Hospitalizations -- if so, when & for what condition(s):_____

_____

□ Chronic Illness(es) -- Explain: _____

HISTORY OF CHEMICAL STRESSES

Chemical stresses occur during life due to any substance that is breathed, injected, taken by mouth, or placed in the skin that is toxic to the body, (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.

Have you been vaccinated?	□ Yes	□ No		
Do you or have you ever taken?	□ Prescription drugs	□ Over the counter drugs	□ Recreational drugs	
Have you been exposed to?	□ Chemicals	□ Fumes	□ Dust	□ Smoke
Do you consume?	□ Alcohol	□ Coffee/caffeine	□ Tobacco	

Medications you currently take:

□NSAID'S (Advil, etc.)	□Statins	□Blood Pressure	□Painkillers
□Muscle Relaxers	□Allergy	□Anti-Depressants	□Cold Medications
□Hormones	□Other: _____		

HISTORY OF EMOTIONAL STRESSES

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below. (Please circle)

Childhood trauma	Yes No	Loss of loved one	Yes No	Relationships	Yes No	Family	Yes No
Work or School	Yes No	Divorce/separation	Yes No	Financial	Yes No	Abuse	Yes No
Lifestyle change	Yes No	Parents' divorce	Yes No	Illness	Yes No	Other	Yes No

QUALITY OF LIFE

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

How many Medical Doctor office visits did you have last year? □0 □Less than 5 □6 – 10 □10+

WORK & FAMILY HISTORY

Your Occupation:_____ Number of Hours/Week_____

Job Satisfaction: 1 2 3 4 5 6 7 8 9 10 Daily Stress Level: 1 2 3 4 5 6 7 8 9 10

Does your work negatively impact your health? □Yes □No If so, how_____

Please mark **P** for *had in the past* and **C** for *currently have*.

GENERAL
___Unintended Weight Loss
___Fever
___Chills
___Night sweats
___Fatigue
___Night Pain
___Irritability
___Trouble sleeping

SKIN
___Rashes
___Lumps
___Sores
___Dryness
___Changes in hair
___Changes to nails
___Changes in moles

HEAD & NECK
___Head injuries
___Concussions
___Lumps
___Swollen Glands
___Stiffness
___Thyroid problems
___Neck problems
___Jaw pain, TMJ

EYE, EAR, NOSE, THROAT
___Vision Changes
___Redness
___Double Vision
___Blurred Vision
___Hearing Loss
___Discharge
___Ringing in ears
___Frequent colds/flue
___Hay fever
___Nose bleeds
___Sinus/drainage problems
___Allergies
___Frequent sore throat
___Hoarseness of voice
___Swollen/Sore 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/Black/Tarry stool
___Incontinence
___Change in bowel habits
___Prolonged bloating
___Ulcers
___Digesting 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
___Vertigo

VASCULAR
___Leg cramps
___Leg swelling
___Blood clots
___Anemia
___Easy bruising
___Wounds take excessive time to heal

MUSCULAR/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

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

PLEASE CONTINUE TO THE NEXT PAGE.

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 practice 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 that 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.

Health

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

Adjustment

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

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.

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

Patient Signature _____ Date _____