Life in Motion Chiropractic

Date: ____________

Confidential Health Information

Please allow our staff to photocopy your driver's license and insurance cards. All information you supply is confidential. We comply with Federal privacy standards.

Please fill in the following information and circle the appropriate answers where needed:

Last Name ____

First Name ____________________ Middle Name ______________

Address ____

City ____________________ State ______ Zip Code ____________

Home Phone __________________________

Cell Phone __________________________

Email Address ____

Gender ☐ Male ☐ Female Age ________ Birthdate ______________

Occupation __________________ Employer __________________

City ________________ Work Phone ______________________

Typical workday spent: ☐ Sitting ☐ Standing ☐ Manual Labor ☐ Driving ☐ Walking ☐ Otherwise Active

Whom may we thank for **referring** you? __________________________

Have you ever consulted a chiropractor before? ☐ No ☐ Yes

If yes, When? ______________ Doctor ____________________

Primary Care Physician ________________________________

City: __________________ Phone Number: ________________

☐ *I agree to allow Life in Motion Chiropractic to contact the doctor listed above for the purpose of co-management of care.*

Emergency Contact __________________ Phone ______________

Preferred Language:

____

Marital Status:

☐ Single
☐ Married
☐ Divorced
☐ Separated
☐ Widowed

Preferred Method of Contact:

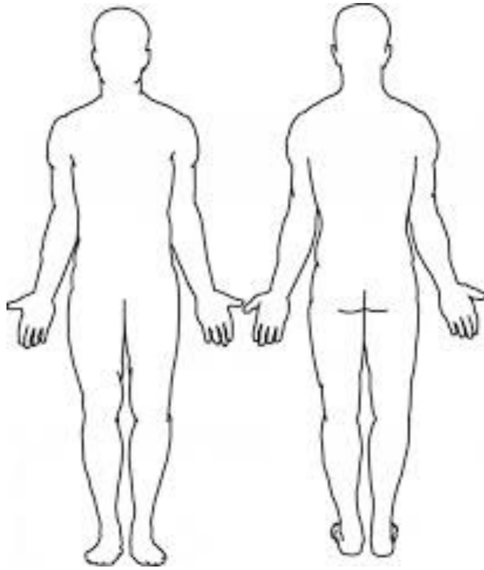
☐ Home Phone
☐ Cell Phone
  ☐ Can Text
☐ Work Phone
☐ E-mail

Cellphone Provider

☐ Verizon
☐ ATT
☐ T-Mobile
☐ Sprint
☐ Other

____

Draw your complaints on the figure below:



Date: ____________

Social History: *Please input number and indicate if this is per day or per week.*

Alcohol use: ____ drinks per DAY / WEEK
Coffee use: ____cups per DAY / WEEK
Tobacco use: ____ packs per DAY / WEEK
Exercise:: ____ mins per DAY / WEEK
Soda: ____ cups per DAY / WEEK
Water: ____ cups per DAY / WEEK
Pain relievers: ____ per DAY / WEEK
Recreational drugs? Y / N

Primary Complaint:

____

____

When did it begin? ________________________

How did it begin? ________________________

Average pain intensity? (0 - 10) ______________

What have you tried to relieve symptoms?
(check all that apply)

- ☐ Prescription medication
- ☐ Chiropractic
- ☐ Over-the-counter drugs
- ☐ Acupuncture
- ☐ Homeopathic remedies
- ☐ Massage
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Ice
- ☐ Heat

Other: ________________________________

Have your symptoms been getting:

☐ Better ☐ Worse ☐ No Change

How does this problem affect your life?

____

Secondary Complaint:

____

____

When did it begin? ________________________

How did it begin? ________________________

Average pain intensity? (0 - 10) ______________

What have you tried to relieve symptoms?
(check all that apply)

- ☐ Prescription medication
- ☐ Chiropractic
- ☐ Over-the-counter drugs
- ☐ Acupuncture
- ☐ Homeopathic remedies
- ☐ Massage
- ☐ Physical Therapy
- ☐ Surgery
- ☐ Ice
- ☐ Heat

Other: ________________________________

Have your symptoms been getting:

☐ Better ☐ Worse ☐ No Change

How does this problem affect your life?

____

In addition to the complaints listed above, what additional health goals do you have?

____

Date: ____________

Review of Systems:

*Please CHECK any conditions you **HAVE HAD** or **CURRENTLY HAVE**?*

PAST	Musculoskeletal	CURRENT
☐	Arthritis	☐
☐	Back Problem	☐
☐	Elbow/Wrist Pain	☐
☐	Foot/Ankle Pain	☐
☐	Hip Pain	☐
☐	Knee Injuries	☐
☐	Osteoporosis	☐
☐	Scoliosis	☐
☐	Shoulder Problems	☐
☐	TMJ Problems	☐
	Neurological	
☐	Dizziness	☐
☐	Headache	☐
☐	Muscle Weakness	☐
☐	Numbness	☐
☐	Pins & Needles	☐
	Cardiovascular	
☐	Angina	☐
☐	High blood pressure	☐
☐	Low blood pressure	☐
☐	Poor circulation	☐
☐	Varicose veins	☐
	Respiratory	
☐	Apnea	☐
☐	Asthma	☐
☐	Emphysema	☐
☐	Hay fever	☐
☐	Pneumonia	☐
☐	Shortness of breath	☐
	Digestive	
☐	Anorexia/Bulimia	☐
☐	Constipation	☐
☐	Diarrhea	☐
☐	Food sensitivity	☐
☐	Heartburn	☐
☐	Ulcer	☐

PAST	Sensory	CURRENT
☐	Blurred vision	☐
☐	Chronic ear infections	☐
☐	Hearing loss	☐
☐	Loss of smell	☐
☐	Ringing in ears	☐
	Skin	
☐	Acne	☐
☐	Eczema	☐
☐	Hair loss	☐
☐	Psoriasis	☐
☐	Rash	☐
☐	Skin cancer	☐
	Endocrine	
☐	Frequent infection	☐
☐	Hypoglycemia	☐
☐	Immune system	☐
☐	Low energy	☐
☐	Thyroid issues	☐
	Genitourinary	
☐	Bedwetting	☐
☐	Infertility	☐
☐	Kidney stones	☐
☐	PMS	☐
☐	Prostate	☐
	Constitutional	
☐	Fainting	☐
☐	Fatigue	☐
☐	Low libido	☐
☐	Poor appetite	☐
☐	Sudden weight change	☐
☐	Weakness	☐

Date: ____________

Family History:

	Diabetes	Heart	Cancer	Back
Mother	☐	☐	☐	☐
Father	☐	☐	☐	☐
Brother(s), # of ____	☐	☐	☐	☐
Sister(s), # of ____	☐	☐	☐	☐

Allergies:

Do you have any known allergies? Y / N

If yes:____________________________________

Are you allergic to any medications? Y / N

If yes: ____________________________________

General Lifestyle:

Answer the following questions with brief details if applicable.

Have you ever been in a car accident or fall? Y / N

If yes, explain______________________________

Have you ever fractured/dislocated a bone? Y / N

If yes, explain______________________________

Have you ever been knocked unconscious? Y / N

Do you wear orthotics? _____ Brand: ___________

How many hours of sleep do you average/night? ___

What is your preferred sleeping position?

☐ Side ☐ Back ☐ Stomach

How long have you had your mattress? __________

How long have you had your pillow? ____________

Do you utilize prayer or mediation? Y / N

Do you have Mercury fillings? Y / N

Surgeries:

☐ Appendectomy
☐ Cancer
☐ Eye
☐ Pacemaker
☐ Tonsillectomy
☐ Bypass
☐ Cosmetic
☐ Hysterectomy
☐ Spine
☐ Vasectomy

Other: ____________________________

If yes:____________________________________

Illnesses:

***Mark** the illnesses you have **HAD** in the past or **HAVE** now:*

PAST		CURRENT
☐	AIDS	☐
☐	Alcoholism	☐
☐	Allergies	☐
☐	Atherosclerosis	☐
☐	Cancer	☐
☐	Chicken pox	☐
☐	Epilepsy	☐
☐	Diabetes	☐
☐	Glaucoma	☐
☐	Goiter	☐
☐	Gout	☐
☐	Heart disease	☐
☐	Hepatitis	☐
☐	HIV positive	☐
☐	IBS	☐
☐	Malaria	☐
☐	Measles	☐
☐	Multiple Sclerosis	☐
☐	Mumps	☐
☐	Polio	☐
☐	Rheumatic fever	☐
☐	Scarlet fever	☐
☐	STD	☐
☐	Stroke	☐
☐	___________	☐

I hereby attest that the information I provided above is accurate to the best of my knowledge.

Patient's/Guardian's Signature: ______________________________ **Date:** _______________