LIFE IS GOOD CHIROPRACTIC

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY – FRONT AND BACK

Health History: I am here for: Wellness Care A Health Concern	Name				S.S.#			Age	
Health History: I am here for: Wellness Care A Health Concern Problem area(s):	Street Ad	dress					Phor	e	
Health History: I am here for: Wellness Care A Health Concern Problem area(s):	City			StateZi	р		_Date of Bi	rth	
Problem area(s):	□ Male	☐ Female	☐ Right Handed	☐ Left Hand	led E	-Mail			
Marital Status: Spouse's name and health status: Children's names, ages and health status: 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? Wellness Commitment: At Life is Good Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. To bet help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a finance commitment, but we do ask for you cooperative commitment. Based on a scale of 10% to 100%, please circle you personal level of commitment toward obtaining and maintaining health and wellness.	Health	History:	I am here for: □	Wellness Ca	e 🗆 A F	lealth C	oncern		
Pattern of problem:	Problem a	area(s):					V	Vork Related? □ Yes □	⊒ No
Initiating Factors: What makes it better? What makes is worse? List any current medications: List any past surgeries & dates: List any past surgeries & dates: Personal & Family History: Occupation: Marital Status: Spouse's name and health status: Children's names, ages and health status: Children's names, ages and health status: Bate of last chiropractic visit Pate of last chiropractic visit Reason for care Date of last chiropractic warrays How long were you under care? Wellness Commitment: At Life is Good Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. To bet help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a finance commitment, but we do ask for you cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.	Date of o	nset:	 Su	dden ם Gradua	al Durati	on: ם mi	in 🗖 hours	☐ days ☐ months ☐ ye	ears
What makes it better? What makes is worse? List any current medications: List any past surgeries & dates: List any past accidents & dates: Personal & Family History: Occupation: Employer: Marital Status: Spouse's name and health status: Children's names, ages and health status: Children's names, ages and health status: Employer: Marital Status: Spouse's name and health status: Children's names, ages and health status: Children's names, ages and health status: Wellness Commitment: At Life is Good Chiropractic ware dedicated toward achieving the goal of total lasting health for our patients. To bet help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financ commitment, but we do ask for you cooperative commitment. Based on a scale of 10% to 100%, please circle your personal level of commitment toward obtaining and maintaining health and wellness.	Pattern of	problem: 🗖 (Constant 🗖 Intermitte	ent 🛭 Occasion	al 🛚				
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10% 20% 30% 40% 50% 60% 70% 80% 90% 100%	help you commitme	achieve this, vent, but we do	we need to understate ask for you cooperate toward obtaini	nd your commit ative commitme ng and maintain	ment tow nt. Based ing health	ard beind on a so and we	g healthy. V cale of 10% Illness.	le do not ask for a fina to 100%, please circle	ancial
		10% 20%	% 30% 40% 	% 50% 	60%	70%	80%	90% 100%	

PLEASE FILL IN BELOW

If you have had the following, or if you suffer from the following, *Please Check* ✔

Condition, Symptom Or Problem	Constantly or Frequently	Sometimes or Occasionally
Grating/Grinding Neck Neck Pain		
Shoulder Pain Arm/Hand Pain		
Mid Back Pain Low Back Pain	0	
Hip Pain Leg/Foot Pain	0	
Disc Problems Arthritis	0 0	
Other Joint Pain Numbness	0 0	
Cold Hands/Feet Pins and Needles	0	0
Headache Migraine	0	0
Dizziness Ringing in Ears	0	
Earaches Hearing Loss	0	
Sinus Trouble Frequent Colds	0	
Difficulty Breathing Allergies	0	
Asthma Chronic Cough	0	
Chest Pains Heart Problems	0	
High Blood Pressure Low Blood Pressure	0	
Digestive Problems Urinary Problems	0	
ADD/ADHD Diabetes	0	0
Cancer Loss of Sleep	0	
Faulty Posture Painful Menstrual Cycles	0	
Irregular Cycles Pregnant At This Time	0	
Other	_ □	

Circle the areas where you have any problems. Please also describe these problems.
Below, please fill in any other health information you feel we might need for your care.
Thank you for being complete and thorough.