

# LIFE IS GOOD CHIROPRACTIC

PLEASE PRINT CLEARLY AND FILL IN COMPLETELY – FRONT AND BACK

Name \_\_\_\_\_ S.S.# \_\_\_\_\_ Age \_\_\_\_\_

Street Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female  Right Handed  Left Handed E-Mail \_\_\_\_\_

## **Health History:** I am here for: Wellness Care A Health Concern

Problem area(s): \_\_\_\_\_ Work Related?  Yes  No

Date of onset: \_\_\_\_\_  Sudden  Gradual Duration:  min  hours  days  months  years

Pattern of problem:  Constant  Intermittent  Occasional  \_\_\_\_\_

Initiating Factors: \_\_\_\_\_

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: \_\_\_\_\_

## **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 better help you achieve this, we need to understand your commitment toward being healthy. We do not ask for a financial 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.

10%    20%    30%    40%    50%    60%    70%    80%    90%    100%

Where did you hear about our office or who referred you?  Friend \_\_\_\_\_

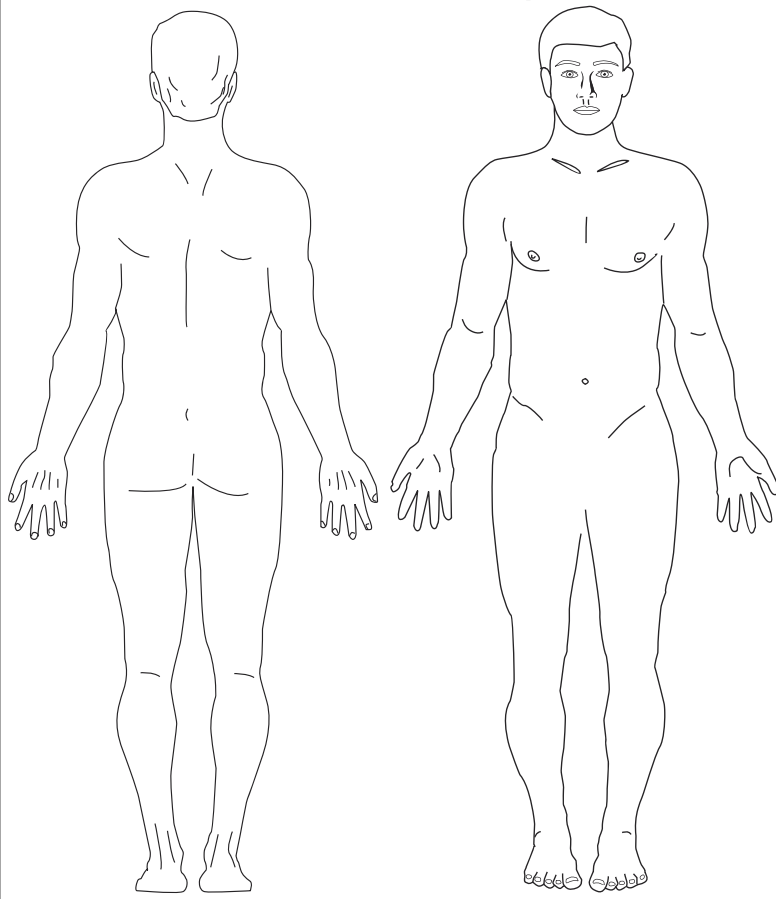
Flyer  Newspaper  Radio  Sign  Other \_\_\_\_\_

**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	<input type="checkbox"/>	<input type="checkbox"/>
Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>
Arm/Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>
Mid Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>
Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>
Leg/Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>
Disc Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Other Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>
Numbness	<input type="checkbox"/>	<input type="checkbox"/>
Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>
Pins and Needles	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in Ears	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Digestive Problems	<input type="checkbox"/>	<input type="checkbox"/>
Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Loss of Sleep	<input type="checkbox"/>	<input type="checkbox"/>
Faulty Posture	<input type="checkbox"/>	<input type="checkbox"/>
Painful Menstrual Cycles	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Cycles	<input type="checkbox"/>	<input type="checkbox"/>
Pregnant At This Time	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

**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.**

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*Thank you for being complete and thorough.*