# 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 _____

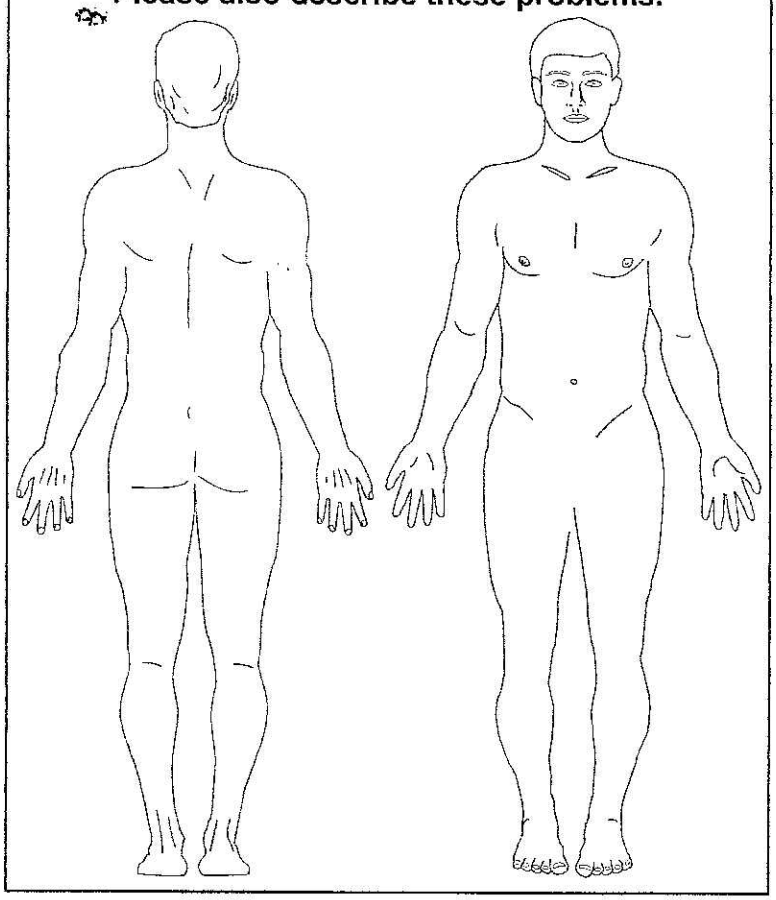
❑ Flyer ❑ Newspaper ❑ Radio ❑ Sign ❑ Other _____

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