CONFIDENTIAL CHIROPRACTIC NEW CLIENT HISTORY FORM

Todays Date: ___________________________

Legal Name: ____ Nick name: _____________________

Address: __________________________________City:______________________State:______ Zip:__________

Home Phone: ____________________ Cell Phone: _____________________Work Phone: __________________

Email: _____________________________________ Best way to contact you if needed: Text Phone Email

Age: _________ Birth Date: ____________________ Sex: *Female Male* Blood Type: ________________

Occupation: ______________________________ Marital Status: S M D W other: _________________________

Spouse Name: ____________________________ Spouse Occupation: ____________________________________

Spouse health status: Excellent Good Average Poor Other: ____________________ # of children: ___________

Emergency Contact Name: ___________________________ Emergency Phone: ______________________________

Who can we thank for your referral to our office?____

Reason you are seeking care?

What is your primary reason for seeking chiropractic care today?

____
____
____

How has this (reason for coming) affected your life? (family time, occupation, social, future health status)

____
____
____

If you don't know already, chiropractic focuses on the <u>function</u> of your nervous system; did you know that pain makes up <u>less than 10%</u> of the total nervous system? To be healthy, restoration of the nerve system is necessary.

You are here for: __ General health __Preventative/Wellness care ___ Prenatal/Pregnancy/Postnatal care

__ Symptom relief __Work related/personal injury __Auto accident __Slip/fall __Sport injury / Rehab

__Other (please explain):____

If you are here *other* than preventative/wellness and keeping your nervous system functioning at 100%, you may have had a recent or past injury/incident you would like to be addressed. (please tell us more information below)

Date injury began (if known) ___________________ Was it (circle): Sudden Gradual Progressive over time
Date body expressions first appeared: ____
Have you ever had this same concern/expression? If so, When: ____

Have you ever been under chiropractic care for this ***specific*** concern? Yes No

(please describe in detail this concern; including frequency, severity, duration and if it ***keeps you up at night***:)

____
____
____

Is there anything/activities/movements that makes this body expression BETTER or WORSE? Yes No ; Describe:

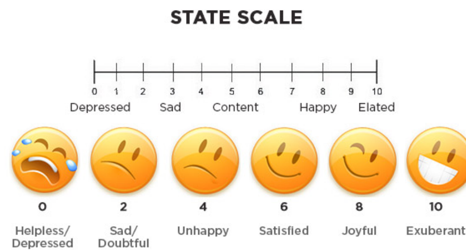
____
____
____
____

Type of *body expression*: Sharp Dull Ache Burn Throb Spasm Numb Tingling Shooting NONE

Does it radiate: Yes No Into arm(s) or leg(s)? ____

How often do you experience these *messages* during the day? 100% 75% 50% 25% Only with activity

PLEASE CIRCLE THE FACE OF YOUR CURRENT STATE YOU ARE FEELING IN YOUR LIFE:



Are you currently under the supervision of another Health Care Provider? Y N For this concern? Y N
Or for any other complaints not listed above? Y N Please list: _________________________________

If yes, Please write name, address, phone and area (s) and/or reasons for being treated if you want us to co-manage:

____
____

Other alternative practitioners you use currently for healing? For these current concerns? Y N Explain:

____
____

Chiropractic History

Your Birth History: *(birth is the first trauma every child experiences in life)*

Do you know how *you* were delivered? Home birth Water birth Natural C-Section Forceps Vacuum Other

Any details you know that would be helpful about your birth or your mom's labor (long, pulling, twisting, induced):
____
____

Have you ever been under chiropractic care? Yes No If Yes, How many months/years? __________________

Reason why you decided to get care? ____

How many times did you receive adjustments? __NONE __ 1-15 __16-20 __20+ __ Other: _________

How did you respond and what was the outcome: ______________________________________

Date of last chiropractic visit: _______________ Focus of care: wellness, car accident, pain, condition, Other

Have you had an X-Rays/MRI taken? Yes No When? ______________Do you have copies I can view? Yes No

Do you have any recent COREscore results detecting silent nervous system imbalances? Yes No; Date: _________

Have you had a posture analysis? Yes No Are you aware of any of your poor posture habits? Yes No
Explain: ____

Are you aware of any poor posture habits in your spouse, partner or children? Yes No

The most common postural weakness today is Forward Head Syndrome, aka "Text Neck" (head and neck starting to bend forward and progressively moving downward weakening your whole body). Even less severe forms of this posture can cause many adverse effects on your overall state of health as well as creating symptoms.

Have you ever been told you carry your head forward, look down too much and have your noticed a rounding of your shoulders or developing a puffy "hump" at the base of your neck? Yes No

Were you satisfied with your past chiropractic care plan/recommendations/adjustments? Yes No
Explain:____
____

Reason you discontinued care or changed Chiropractors?
____
____

Previous Chiropractor(s) names, address, phone (if known and allowing us to share medical information with):
____
____
____

Did you know? *Abnormal postural habits or distortions are the result of traumas/stress (emotional, chemical and/ or physical) to the body and have misaligned the vertebrae in your spine in response to protect you. When these vertebrae are moved from their normal balanced position, they will cause stress to the spinal cord and the delicate nerves that pass between each of the 24 moveable vertebrae in your spine. These misalignments are called:* ***subluxations.*** *It has been extensively documented that subluxations causing stress to your nerves, will weaken and distort the overall structure of your spine. This results in many things creating stress in your nervous system and a weakened or distorted posture effecting all your organs, tissues and glands lowering immune system functioning. This is why it is important to get checked often to detect any imbalances so you can express a healthy life at 100%!*

Medical History

Have you ever experienced any: **Please CIRCLE *all current symptoms* and place a check mark past symptoms (you have had before)

anxiety, abnormal stool, acid reflux/ hiatal hernia, alcoholism, allergies, anemia, arteriosclerosis, arthritis, asthma, autoimmune dx, back pain, breast lump, bronchitis, bruise easily, cancer, chest pain/conditions, cold extremities, constipation, coughing up blood, cramps, depression, dermatitis/ skin issues, diabetes, diarrhea, digestion problems, dementia, dizziness, ears ring, excessive menstruation, eye pain/difficulties/ issues, fatigue, food intolerance, frequent urination, gallbladder issues/ surgery, gout, headache, hemorrhoids, hepatitis, hernia, high blood pressure, HPV, hot flashes, IBS, incontinence, irregular heart beat, irregular menstrual cycle, kidney infection, kidney stones, kidney issues, leaky gut, loss of appetite, loss of memory, loss of balance, loss of smell, loss of taste, lyme disease, mood change, multiple sclerosis, neck pain, neck stiffness, nervousness, nosebleeds, pacemaker, painful periods, polio, poor posture, prostate issues, psoriasis, rash, sciatica (pain below knee), scoliosis, shortness of breath, seizures, shortness of breath with activity, sinus issues/infections, sleep problems/insomnia, spinal curvatures, stroke, swelling of ankles/feet, swollen joints, thyroid condition, tuberculosis, ulcers, varicose veins, venereal disease, vertigo, weight gain, weight loss

Other (s) NOT listed above in list (please list/explain):

____

____

-OR- "I deny **ALL** of above"; if none apply to me: ____________________________ (initial)

****FEMALES**: Are you pregnant currently? Yes No Due Date: __________Complications?__________

Is there a chance you may be pregnant? Yes No Last period/menstruation: ____________________

Date of last physical exam: ______________ Primary Physician: ________________________

Have you had any medical X-Rays taken for diagnosis of an injury or disease condition in the *last year*? Yes No
If Yes, why, when and are (s) taken?____

Please list all past surgeries (date and type): ______________________________________

Please list all minor and major auto accidents (date and details):

____

____

Any slips or falls? Yes No Were they treated with any type of practitioner or healing modality? (list)
____

Severe Illness (s) or Hospitalization (s) or ANY Medical Interventions with (date and details):
____

Have you been treated for ANY health/medical conditions in the last year? Yes No

If Yes, Please describe: ____

It is very important to know the history of your family so you know what your ***genetic weakness*** are. Please fill in any illness or health conditions below:

Family History

FAMILY MEMBER (s) **(list parent, child, etc. with name, age, deceased or alive with any CURRENT conditions)**	**Present and Past health conditions (LIST)** **Example: heart dx, cancer, diabetes, high BP, arthritis, dementia, etc…**

Medications

Medications you are ***currently*** taking (prescription and over the counter meds) please list below:

Type of Medication:	Dosage:	How Long on Med.?	Why taking Med.?

Where you on any medications ***temporarily*** at any time? Yes No Explain:
____

Any other medications or drugs given/taken in the last year for ***anything***, please explain:
____

Diet & Lifestyle Choices

How important is your health to you? __Very ___Somewhat __Need Guidance ___Not Important
How would you rate your current health? Excellent Good Average Fair Poor
How would you rate your family's current health? Excellent Good Average Fair Poor

Please place an "X" in the associated column below:

HABITS	None	Light	Moderate	Heavy
Alcohol				
Coffee				
Tobacco				
Drugs				
Sodas				
Water				
Salty Foods				
Sugary Foods				
Artificial Sweetners				

Stressors:

The following can contribute to vertebral subluxation complexes (please circle all that apply):

Physical stress:
Birth trauma Slip/Fall Car Accidents Sports Injuries Physical abuse Heavy labor Poor Posture
Heavy Computer Use or Cell Phone Use Repetitive Movements Prolonged Driving Prolonged Sitting

Emotional stress:
Relationships Career Family Financial Pace of Life Quick Temper/Anger Holding in Feelings
Perfectionism Procrastination Depression Anxiety PTSD Other: __________________________

Chemical stress:
Environmental Smoke 2nd Hand Smoke Caffeine Alcohol Diet/Sugar Free drinks/foods Soda Intake
Prescription Drugs Allergy Medications Recreational Drugs Junk Foods Fast Foods Toxic Cleaners

***What do you feel is the **primary stress** in your life today? ______________________________

What are the 3 ***healthiest habits*** you choose currently in your life?

____

____

What are the 3 ***worst habits*** you choose currently in your life?

____

____

Vitamins:

Do you ***currently*** take vitamins/supplements/herbs? (please list below): Yes Sometimes Never

Vitamin / Supplement / Herb: Dosage: Reason: How long:

____

____

____

____

Water Intake / Diet:

What type of water do you drink (filtered, spring, reversed osmosis, alkaline, tap)? ______________

How many glasses of water do you currently drink? __________ # of ounces ______________

Do you feel you eat healthy and have great habits eating local organic foods? Yes No

Explain:

____

____

Exercise:

Do you exercise? Yes No How often per week? 1x 2x 3x 4x 5x 6x 7x Other: ______________

What activities do you do? Running Swimming Weight Training Yoga Pilates Cycling Jogging Hiking Dance

Please explain your daily exercise regimen: ______________________________

Do you partake in any monthly/quarterly/yearly triathlons or the like? Yes No

Explain: ______________________________

Sleep:

Hours of sleep at night: ________ Wake up at night? Y N Why:______________________

Do you feel you need more sleep than you are getting? Yes No Ideal # of hours: ______________

Do you sleep on your back? Y N Side Sleep? Y N Stomach Sleep? Y N

Type of pillow you use: (soft, flat, hard, feather, foam) ______________________________

Type of mattress you use: Soft Firm Pillow Top Tempur-Pedic Organic Latex/Foam Futon Other

Other: ______________________________ Age of mattress: ______________

Job related posture and repeated activities:

Do you sit for a prolonged amount of time? Y N At your job? Y N How many hours: ___________________

Do you lift heavy objects daily? Explain:

____

____

Is there anything you do in a repetitive manor of movement daily? (lifting, twisting, typing, sitting, etc.)

____

____

Do you have a lot of pressure or stress at home/ work?	Yes	Sometimes	Never
Do you experience pain daily?	Yes	Sometimes	Never
Do your symptoms interfere with daily life?	Yes	Sometimes	Never
Are your symptoms worse at certain times during they day?	Yes	Sometimes	Never
Do changes in weather affect your symptoms?	Yes	Sometimes	Never
Do you wear orthotic foot inserts in your shoes?	Yes	Sometimes	Never

Please explain if YES:

____

____

____

Health Goals/ Wellness Management:

My health goals for this year are: (list your top 3) (Ex: To be happy again, loose weight, get healthy)

1.____

2.____

3.____

Do you do any daily activities for stress management? (Please List)

____

____

Is there anything else that I need to know to best serve you? (Please List):

____

____

____

____

In our office we are not only interested in your health and wellbeing, but also in the health and wellbeing of your family and loved ones. Current research indicates that ***family health patterns*** often emerge throughout life that can offer useful information about the health of the individuals. Please mention any members of your family that aren't under regular chiropractic preventative care that you would like to express 100% health today:

Spouse/Partner:____
Children:____
Parent's:____
Siblings: ____

We would like to offer you a one time FREE offer for a nervous system scan ($55 value) to each one of these listed loved ones! Would you be interested in learning how? ***Yes*** ***No***

I, ______________________________, have answered the above questions co to the best of my knowledge based on the information provided. I will let Dr. Jodi Hodges know of any left out information or updates when available.

Intention:

What is your intent for receiving chiropractic care? Please circle **ALL** type (s) of care desired so that we may best understand the care you wish to participate in and if you are a fit for this office (we may refer you to another office):

1- Relief (for the relief of my current body expressing symptoms only)
2- Wellness & Health Supportive Programs (non-symptom based)
3- Nutrition & Supplementation and/or Cleanse/Detox Systems
4- Exercises, Stretches and/or Weight Loss Assistance
5- I prefer Dr. Jodi to select the type of care she feels is best for me.

Patient's Signature ____ Date: __________

*NOTE: PAYMENT IS DUE TIME OF SERVICE **

Other/Promotions/Emails/Newsletters:

We want you and your family to be in continued contact with us having the latest health information and specials in our monthly blogs, newsletters or emails. Are you OK with us keeping in touch with you? **Yes** **No**

What is the best email for this type of contact? _____________________________________

***Note: you can unsubscribe at any time!*

Fill out for Children and Medicare ONLY:

— —

Minors and Children ONLY:

Authorization for treatment and care of a minor (if applicable):

I hereby authorize this wellness center and its doctor to administer care as they deem necessary to my son/daughter/ward.

Name of Minor: ____________________ Parent/Guardian Signature: _________________Date:___________

Witness:____ Date:___________________

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Medicare Patients ONLY:

I understand that this office does **NOT** participate in the Medicare Program at this time. I am willing to move forward with the exam and treatment protocols to see if I want to move forward with care and to see if this office is a fit for me. The price will be determined by your current Medicare coverage and you will be paying at time of service in cash, check or credit card. We will NOT bill your Medicare Company.

Name of Medicare patient: _________________________ Signature: ________________________________

Witness: ____ Date: ________________