

# Well Beings Chiropractic Family Health

1990 Wadsworth Blvd. Ste #2, Lakewood, CO 80214  
Phone (303) 238-6500 www.WellBeingsChiropractic.com

Please fill out this form as completely and accurately as possible.

Today's Date \_\_\_\_\_ Patient File # \_\_\_\_\_

## PERSONAL DATA

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parents' names (if you are under 18) \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital Status  S  M  D  W Spouse/Partner's Name: \_\_\_\_\_

Names and ages of children \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Corrective Care Chiropractic can address for you?

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work Y N

Driving Y N

Sleep Y N

School Y N

Walking Y N

Sitting Y N

Exercise/sports Y N

Eating Y N

Other Y N

## HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care?  Y  N Name of D.C. \_\_\_\_\_

How long under care?  \_\_\_\_\_ days  \_\_\_\_\_ weeks  \_\_\_\_\_ months  \_\_\_\_\_ years

Date of last visit: \_\_\_\_\_ Why did you stop? \_\_\_\_\_

How was your experience? \_\_\_\_\_

Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

Medical Physician  Naturopath  Acupuncturist  Homeopath

Massage Therapist  Psychotherapist  Energy Healer  Dentist

Reason why: \_\_\_\_\_

## FOR WOMEN ONLY

Are you pregnant?  Y  N  Possible/Unknown

If pregnant due date? \_\_\_\_\_ Name of OBGYN or Midwife: \_\_\_\_\_

If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in “early detection” of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have experienced and **how they may relate to your present spinal, nerve and health status.**

## CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

Does your job require regular airline travel and hotel stays? Y N If yes, how often? \_\_\_\_\_

How long is your daily commute? \_\_\_\_\_ How many hours do you typically work in a week? \_\_\_\_\_

How many hours per week do you watch T.V.? \_\_\_\_ Are you sitting or lying on a couch? \_\_\_\_\_

Please describe your exercise/sports program including type and frequency:

How many hours of sleep do you typically get each night? \_\_\_\_\_ Do you sleep well? Y N

Do you ever sleep on your stomach? Y N How old is your mattress? \_\_\_\_\_

Do you wear orthotics (foot supports) or a heel lift? Y N If yes, for how many years? \_\_\_\_\_

Do you use a cervical pillow? Y N

## PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? Y N C-section? Y N Forceps/vacuum ? Y N

Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: \_\_\_\_\_

Have you had any **significant adult injuries**? Please list dates, injury and treatment: \_\_\_\_\_

Have you had any **automobile accidents or work-related injuries**?

Date: \_\_\_\_\_ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: \_\_\_\_\_ Care received: \_\_\_\_\_

Date: \_\_\_\_\_ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N

Injuries: \_\_\_\_\_ Care received: \_\_\_\_\_

## EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma Y N

Loss of loved one Y N

Abuse Y N

Work or school Y N

Divorce/separation Y N

Financial Y N

Lifestyle change Y N

Parents divorce Y N

Illness Y N

## CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.)

The following will reveal exposures you may have had.

Were you **vaccinated**? Y N If yes, did you have a **reaction**? Y N

Have you been **exposed to** any of the following on a regular basis, past or present?

Toxic chemicals  Radiation  Second hand smoke  Chemotherapy  Drug therapy  Other

If yes, please explain: \_\_\_\_\_

Do you have any **food allergies**? Y N If yes, please list: \_\_\_\_\_

How many **fast food meals** do you eat per week? \_\_\_\_\_

How many **alcoholic beverages** do you drink per week? \_\_\_\_\_

Do you smoke **tobacco products**? Y N If yes, how many packs per day? \_\_\_\_\_

How many glasses of **water** do you drink per day? \_\_\_\_\_

How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? \_\_\_\_\_

Are you currently on **prescription** or **over-the counter medication**? Y N Please list, indicating dose & frequency \_\_\_\_\_

Please list any **nutritional supplements** you are taking: \_\_\_\_\_

How do you rate your **physical health**? Excellent Good Fair Poor

## QUALITY OF LIFE

How do you rate your **emotional/mental health**? Excellent Good Fair Poor

How do you rate your overall "**quality of life**"? Excellent Good Fair Poor

## EXPECTATIONS

I would like to have the following benefits from **Chiropractic Care**: (Check all that apply)

- Relief of a symptom or problem
- Relief and prevention of a symptom or problem
- Healthier spine and nerve system
- Optimal health on all levels

What are your top three health goals?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

*I hereby certify that the information provided is true and accurate.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

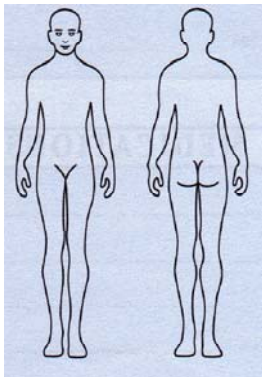
# CHIROPRACTIC CLINICAL OBJECTIVE

Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression.

Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

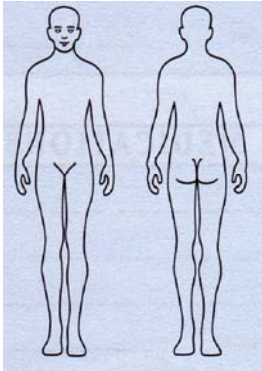
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Arthritis                                    | <input type="checkbox"/> Headache                   | <input type="checkbox"/> Asthma                                   |
| <input type="checkbox"/> Back Curvature                               | <input type="checkbox"/> Migraine Headache          | <input type="checkbox"/> Chest Pain                               |
| <input type="checkbox"/> Mental / Emotional Disorders                 | <input type="checkbox"/> Neck Pain R/L              | <input type="checkbox"/> Difficult Breathing                      |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Shoulder Pain R/L          | <input type="checkbox"/> Heart Problems                           |
| <input type="checkbox"/> Swollen or Painful Joints                    | <input type="checkbox"/> Numbness or Tingling       | <input type="checkbox"/> Heart Attack                             |
| <input type="checkbox"/> Convulsions / Epilepsy in arms, or hands R/L | <input type="checkbox"/> Carpal Tunnel Syndrome R/L | <input type="checkbox"/> Stroke                                   |
| <input type="checkbox"/> Skin Problems                                | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Bruit                                    |
| <input type="checkbox"/> Bruise Easily                                | <input type="checkbox"/> Ringing in Ears            | <input type="checkbox"/> High / Low Blood Pressure                |
| <input type="checkbox"/> Cancer                                       | <input type="checkbox"/> Hearing Loss               | <input type="checkbox"/> Varicose Veins                           |
| <input type="checkbox"/> Allergies                                    | <input type="checkbox"/> Loss of Balance            | <input type="checkbox"/> Liver Trouble                            |
| <input type="checkbox"/> Frequent Colds                               | <input type="checkbox"/> Digestive Problems         | <input type="checkbox"/> Gall Bladder Trouble                     |
| <input type="checkbox"/> Upper Back Pain / Stiffness                  | <input type="checkbox"/> Depression                 | <input type="checkbox"/> Mid Back Pain / Stiffness                |
| <input type="checkbox"/> Excessive Gas                                | <input type="checkbox"/> Attention Disorder         | <input type="checkbox"/> Pain with cough, or strain               |
| <input type="checkbox"/> Constipation / Diarrhea                      | <input type="checkbox"/> Anxiety Disorder           | <input type="checkbox"/> Hip Pain                                 |
| <input type="checkbox"/> Prostate Problems                            | <input type="checkbox"/> Eating Disorder            | <input type="checkbox"/> Low Back Pain / Stiffness                |
| <input type="checkbox"/> Impotence                                    | <input type="checkbox"/> Trouble Concentrating      | <input type="checkbox"/> Sciatica                                 |
| <input type="checkbox"/> Kidney Problems                              | <input type="checkbox"/> Loss of memory             | <input type="checkbox"/> Numbness or Tingling in legs or feet R/L |
| <input type="checkbox"/> Frequent Urination                           | <input type="checkbox"/> Ear Infection              | <input type="checkbox"/> Muscle Tightness                         |
| <input type="checkbox"/> Menstrual Problems / PMS                     | <input type="checkbox"/> Learning Disability        | <input type="checkbox"/> Trouble sleeping                         |
| <input type="checkbox"/> Menopausal problems                          |   |   |

## Primary Health Concern:



- o Please indicate the location of your pain or discomfort on the diagram
- o When did this problem start? \_\_\_\_\_
- o Have you ever had this problem before?  No  Yes If yes, when \_\_\_\_\_
- o Please indicate quality of the pain:
  - | Dull | Burning | Numb | Stabbing | Tingling | Cramping
- o Does this pain radiate or travel?  No  Yes If yes, please indicate on diagram
- o Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- o What makes this pain or condition better? \_\_\_\_\_ Worse? \_\_\_\_\_
- o What have you done to treat this problem? \_\_\_\_\_

## Secondary Health Concern:



- o Please indicate the location of your pain or discomfort on the diagram
- o When did this problem start? \_\_\_\_\_
- o Have you ever had this problem before?  No  Yes If yes, when \_\_\_\_\_
- o Please indicate quality of the pain:
  - | Dull | Burning | Numb | Stabbing | Tingling | Cramping
- o Does this pain radiate or travel?  No  Yes If yes, please indicate on diagram
- o Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2-----3-----4-----5-----6-----7-----8-----9-----10
- o What makes this pain or condition better? \_\_\_\_\_ Worse? \_\_\_\_\_
- o What have you done to treat this problem? \_\_\_\_\_

