`

LIFEWORKS CHIROPRACTIC

VITAL INFORMATION Date_____

All information is strictly confidential and is only available for Lifeworks staff to serve you best.

First Name:_____ Last Name:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Age:_____ Date of Birth: _____/_____/_____ Email:_____

Marital Status (check): ☐Married ☐Single ☐Partnership ☐Widowed ☐Divorced

Name of Spouse:_____ Do you have children? ☐ Yes ☐ No

# of children:_____ Ages of Children:_____

Emergency Contact: _____ Relationship:_____ Phone:(_____)_____

How were you referred to Lifeworks?_____

PERSONAL HEALTH HISTORY

Reason for seeking services at Lifeworks Chiropractic (Main concern):_____

_____

Is this due to an: ☐Auto accident ☐Worker's compensation case ☐Neither
Since this started it is: ☐the same ☐getting better ☐getting worse
This impacts your: ☐work ☐ family time ☐ leisure ☐sleep ☐athletics ☐other (please list): _____

_____

Are you currently seeing another doctor for this issue? ☐ Yes ☐ No

Name of Doctor(s):_____

Medications you currently take:
☐NSAID'S (Advil, etc.) ☐Statins ☐ Blood Pressure ☐Painkillers
☐Muscle Relaxers ☐ Allergy ☐ Anti-Depressants ☐ Cold Medications
☐Hormones Other: _____

COMMITMENT TO WELLNESS

Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life. "...a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

Please mark the scale with the following indicators
'X' = current level of overall health and life expression
'O' = your desired level

What is your current level of commitment to yourself, your life and well-being? (circle)

No Commitment 1 2 3 4 5 6 7 8 9 10

What change(s) would you most like to experience with care in this office?

□Symptom Relief/Temporary Relief □ Restore Health □ Maximum Correction
□Wellness & Prevention □ Improved Performance
□ Other:_____

Since the nervous system controls EVERYTHING in your body it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. What other specific goal(s) might you have?

□ Better sleep □ More energy □ Keep up with children/grandchildren
□ More joy and ease □ Cease medication □ Reach full potential
□ Other goals not listed:_____
_____

HISTORY OF INJURY/REPETITIVE STRESSES

How many auto accidents (including fender benders) have you had? □+5 □3-4 □1-2 □None
What sports are/were you involved in? _____
Have you ever: □Fallen down the stairs □Slipped and Fell □Had a sports injury □Stress/Strain at work □
Broken a bone -- If so, which ones?_____
□ Other Injuries: _____
Do you: □Sit > 4 hours/day □Drive > 2 hours/day □Perform Repetitive Tasks (Typing/Lifting)
Have you had:
□ Surgery -- if so, when & for what condition(s)? _____
_____
_____
□ Hospitalizations -- if so, when & for what condition(s):_____
_____
_____
□ Chronic Illness(es) -- Explain: _____
_____

WORK & FAMILY HISTORY

Your Occupation:_____Duties:_____

Do you find your profession stressful? □ Yes □ No

Health Status of:

Spouse:	□Poor	□Fair	□Good	□Excellent
Children:	□Poor	□Fair	□Good	□Excellent
Parents:	□Poor	□Fair	□Good	□Excellent
Siblings:	□Poor	□Fair	□Good	□Excellent

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? □ Yes □ No Approx. how long ago? _____

Approximately how many Chiropractic visits did you have? _____

Reason for previous chiropractic care?_____

Name of previous chiropractor?_____ City & State:_____

What care plan was given including at-home exercises?_____

_____

Did you follow the care plan? □ Yes □ No If not, why? _____

_____

Are your family members under chiropractic care? □ Yes □ No If yes, who?_____

_____

WELLNESS HISTORY

What activities other than Chiropractic care do you do to support your health and well-being?

□ Diet □Massage therapy □Counseling □Acupuncture

□Yoga □Meditation □Prayer/Spirituality □Nutritionist □Fasting

□Vitamins/supplements -- if so, what kind? _____

_____

□Exercise -- if so, what kind? _____

_____

□ Other: _____

Covid Vaccine: □ Yes □ No If yes, which type (i.e. Pfizer, J&J, Moderna)_____

Covid Booster: □ Yes □ No

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you?

_____

_____

_____

Great job so far! You are almost done!!!

We just need a quick review of your bodily systems.

Please continue to the next page.

NAME: _____

Only mark "P" for had in the *Past* or "C" for *Currently* have.

GENERAL
___ Fever
___ Chills
___ Unintended weight loss
___ Night sweats
___ Fatigue
___ Night pain
___ Irritability
___ Trouble sleeping

SKIN
___ Rashes
___ Lumps
___ Sores
___ Dryness
___ Changes to hair
___ Changes to nails
___ Changes in moles

HEAD/NECK
___ Head injuries
___ Lumps
___ Swollen glands
___ Stiffness
___ Thyroid problems
___ Neck pain
___ Jaw pain, TMJ

EYE, EAR, NOSE, THROAT
___ Vision changes
___ Redness
___ Double vision
___ Blurred vision
___ Hearing loss
___ Discharge
___ Vertigo
___ Ringing in ears
___ Frequent colds/ flu
___ Hay fever
___ Nose bleeds
___ Sinus/ drainage problems
___ Allergies
___ Frequent sore throat
___ Hoarseness of voice
___ Sore tongue
___ Swollen tongue
___ Difficulty swallowing

HEART
___ Chest pain
___ Palpitations
___ Fainting
___ Shortness of breath

LUNGS
___ Prolonged Cough
___ Coughing up mucus/sputum
___ Coughing up blood
___ Sleep apnea
___ Difficulty breathing
___ Asthma

GI/BOWELS
___ Heartburn
___ Abdominal pain
___ Diarrhea
___ Constipation
___ Bloody or Black or tarry stool
___ Incontinence
___ Change in bowel habits
___ Prolonged bloating
___ Ulcers
___ Digestive issues

BLADDER
___ Visible blood
___ Burning
___ Change in urinary habits
___ Difficulty passing urine
___ Urgency
___ Increase frequency
___ Kidney Stones
___ Up multiple times at night to urinate

NEUROLOGICAL
___ Headaches
___ Seizures
___ Numbness
___ Tingling
___ Paralysis
___ Tremors
___ Convulsions/ Epilepsy
___ Pain with cough/ sneeze
___ Dizziness
___ Loss of balance

VASCULAR
___ Leg cramps
___ Leg swelling
___ Blood clots
___ Anemia
___ Easy Bruising
___ Wounds take excessive time to hea

MUSCLUAR/ BONE
___ Muscle pain or cramps
___ Weakness
___ Scoliosis
___ Swollen or painful joints
___ Deformity of hands or feet

GLANDS
___ Intolerance to heat or cold
___ Appetite changes
___ Excessive thirst
___ Swollen or tender glands

PSYCHIATRIC
___ Nervousness
___ Depression
___ Insomnia
___ Mood changes
___ Eating Disorder

FEMALE ONLY
___ Pregnant
___ Irregular cycle
___ Irregular or excessive bleeding
___ Menopause
___ PMS
___ Fertility Issues
___ Sexual problems
___ Breast lumps
___ Nipple or skin changes
___ Nipple discharge

MALE ONLY
___ Prostate problems
___ Impotency/ Sexual Dysfunction
___ Discharge

THANK YOU FOR ANSWERING THESE QUESTIONS.
THIS IS YOUR FIRST STEP TOWARD WELLNESS WITH US!