LIVE WELL
CHIROPRACTIC

Adult and Adolescent Health Questionnaire

Name:_____ Address:_____

City:_____ State: _____ Zip: _____

Telephone home: _____ Cell phone: _____

Are you a veteran?_____ If yes what is your Social Security Number? _____

Email address: _____ Marital status: _____

Occupation: _____ Employer: _____

Birth date: _____

Height: _____ft. _____in Weight: _____

Health insurance name: _____ Do you have a HSA/HRA? (health savings account) __Yes__No

Names and ages of children: _____

Present medical Doctor : _____ Present medical clinic: _____

Previous Chiropractor :_____

Last visit date: _____ Reason for leaving : _____

How did you hear about our office?

___ Referral from friend/family/co-worker (name please _____)

___Internet/Google ___Yellow Pages ___drive by ___Facebook ___ other

What is your main reason for this visit?

_____

_____

How long have you suffered with this problem? _____

How did it start? _____

Could have it been caused by a work injury or auto accident? _____ If yes, please explain: _____

_____

What have you tried to get rid of this problem? _____

What gives you temporary relief? _____

What makes it worse? _____

What areas of your life are being most affect because of this? _____)_

List top 3 items in your life which would improve if we could help resolve you reason for coming into the office

1._____ 2._____ 3. _____

Other professionals seen for main health concern: _____

Treatment and results: _____

Any additional complaints? _____

_____

Do you have any other health problems we should be aware of? _____

Show areas of pain or unusual feeling. Mark the areas on the diagram below and please include altered sensation and referral pain.

Include all affected areas.

Show area(s) of pain or unusual feeling. Mark the areas on this body where you feel the described sensations. Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

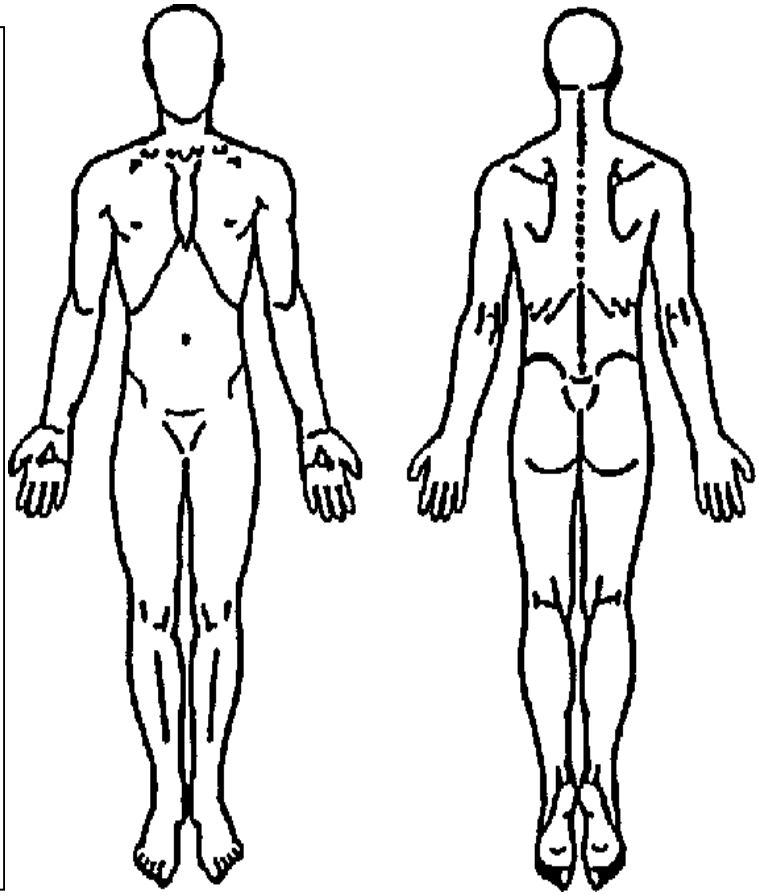
Numbness: ••••••
••••••

Burning: XXXXXXX
XXXXXXX

Aching: *******
****

Stabbing: /////////
/////////

Pins/Needles ○○○○○
○○○○○



THIS SECTION FOR PREGNANT WOMEN ONLY

Have you been to a Chiropractor with a previous pregnancy? ___ If so who/when? _____

Is this your first pregnancy? ___ How many births have you had? ____ Who is your birth provider? _____

Where do you plan on delivering? _____How many weeks pregnant are you now? _____

What is your due date? _____

Have you had any physical traumas during your pregnancy? ___ If yes please describe: _____

_____

Have you had any evaluation procedures (ultrasound, amniocentesis, etc)? _____ If yes please describe the results: _____

Describe any stressful events in your life during this pregnancy: _____

_____

What are your most significant fears associated with this birth? _____

_____

Do you have someone that will be supporting you during delivery other than birth care provider? _____

Have you completed a birth plan? _____

FOR WOMEN ONLY

Date of last menstrual period? _____ If used list any means of contraception: _____

Do you suffer severe cramping with your menstrual period? ___ Do you suffer from PMS? _____

Patient Review of Systems

THE NERVOUS SYSTEM CONTROLS AND COORDINATES ALL ORGANS AND STRUCTURES OF THE HUMAN BODY

Please check the corresponding boxes for each symptom or condition you have experienced – including both past and present.

REGIONS	FUNCTIONS	SYMPTOMS (PAST / PRESENT)			
Cervical	• Autonomic Nervous System • ENT System • Vision, Balance & Coordination • Speech • Immune System • Digestive System • Nerve Supply to Shoulders, Arms & Hands • Sympathetic Nucleus • Metabolism	☐☐ Colic & Excessive Crying ☐☐ Ear & Sinus Infections ☐☐ Allergies & Congestion ☐☐ Immune Deficiency ☐☐ Headaches & Migraines ☐☐ Vertigo & Dizziness ☐☐ Sore Throat & Strep ☐☐ Swollen Tonsils & Adenoids ☐☐ Vision & Hearing Issues ☐☐ Low Energy & Fatigue ☐☐ Difficulty Sleeping ☐☐ Pain, Numbness & Tingling in Arms to Hands		☐☐ Epilepsy & Seizures ☐☐ Sensory & Spectrum ☐☐ ADD / ADHD ☐☐ Focus & Memory Issues ☐☐ Anxiety & Stress ☐☐ Balance & Coordination ☐☐ Speech Issues ☐☐ TMJ / Jaw Pain ☐☐ Stiff Neck & Shoulders ☐☐ Depression ☐☐ High Blood Pressure ☐☐ Poor Metabolism & Weight Control
Upper Thoracic	• Upper G.I. • Respiratory System • Cardiac Function	☐☐ Reflux / GERD ☐☐ Chronic Colds & Cough ☐☐ Asthma		☐☐ Bronchitis & Pneumonia ☐☐ Functional Heart Conditions	
Mid Thoracic	• Major Digestive Center • Detox & Immunity	☐☐ Gallbladder Pain / Issues ☐☐ Jaundice ☐☐ Fever		☐☐ Indigestion & Heartburn ☐☐ Stomach Pains & Ulcers ☐☐ Blood Sugar Problems	
Lower Thoracic	• Stress Response • Filtration & Elimination • Gut & Digestion • Hormonal Control	☐☐ Behavior Issues ☐☐ Hyperactivity ☐☐ Chronic Fatigue ☐☐ Chronic Stress		☐☐ Allergies & Eczema ☐☐ Skin Conditions / Rash ☐☐ Kidney Problems ☐☐ Gas Pain & Bloating	
Lumbar, Sacrum & Pelvis	• Lower G.I. (Absorption & Motility) • Gut-Immune System • Major Hormonal Control	☐☐ Constipation ☐☐ Chrohn's, Colitis & IBS ☐☐ Diarrhea ☐☐ Bed-wetting ☐☐ Bladder & Urination Issues ☐☐ Cramps & Menstrual Issues ☐☐ Cysts & Endometriosis ☐☐ Infertility ☐☐ Impotency ☐☐ Hemorrhoids		☐☐ Sciatica & Radiating Pain ☐☐ Lumbopelvic / SI Joint Pain ☐☐ Hamstring Tightness ☐☐ Disc Degeneration ☐☐ Leg Weakness & Cramps ☐☐ Poor Circulation & Cold Feet ☐☐ Knee, Ankle & Foot Pain ☐☐ Weak Ankles & Arches ☐☐ Lower Back Pain ☐☐ Gluten & Casein Intolerance	

EXERCISE	WORK ACTIVITY	HABITS	
◯ None	◯ Sitting	◯ Smoking	Packs per day_____
◯ Moderate	◯ Standing	◯ Alcohol	Drinks per week_____
◯ Daily	◯ Light Labor	◯ Coffee/Caffeine Drinks	Cups/Ounces per day _____
◯ Heavy	◯ Heavy Labor	◯ High Stress Level	Reason _____

Medication Name	Condition taking for	Number of times per day
Supplements/Vitamin	**Mg per dose**	**Number of times per day**
Allergies To Medication		
Allergies General		

In case of emergency please notify: _____

Relationship and telephone number: _____

At our office we are not only interested in your health and well being, but the health and well being of your family as well. Please mention any health conditions or concerns you may have about your…

Children:

_____

Spouse:

_____

Mother:

_____

Father:

_____

TERMS OF ACCEPTANCE

When a patient seeks chiropractic care and we accept a patient for such care, it is essential for both to be working for the same objective. Chiropractic has only one goal. It is important that each patient understands both the objective and the method that which will be used to attain it. This will prevent any confusion or disappointment.

ADJUSTMENT: The adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method of correction is by specific adjustment to the spine.

HEALTH: The state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer the diagnosis or treatment of any disease. **We only offer to diagnose either vertebral subluxation complex and/or neuro-musculoskeletal conditions.** However, if during the course of a chiropractic spinal examination we encounter unusual findings which are outside the scope of practice for a Doctor of Chiropractic, we will advise you. If you desire advice, diagnosis, or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatments prescribed by others. **OUR ONLY PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom.** Our only method is the specific adjustment to correct vertebral subluxation. However, we may use other procedures to help your body hold those adjustments.

AUTHORIZATION FOR CARE

I authorize Live Well Chiropractic and its doctors to administer care as they deem necessary. I authorize the doctors to perform an exam and administer treatment. I clearly understand and agree I am personally responsible for payment of any fees not covered by my insurance.

I, _____ have read and fully understand the above statements.

(printed name)

Signature: _____ Date: _____