YOUR VITAL INFORMATION

WELL…come to your first step toward optimal health and healing!
"Our mission is to inspire, educate, adjust and empower those who want to become better by helping them know their ***wellth*** and be their ***best***,
so they can get BACK into life and experience drug-free health…for life!"

Please <u>complete</u> all questions using black ink.

Full Name: **Today's Date:**

Address: City/State/Zip:

PLEASE CIRCLE THE BEST NUMBER TO REACH YOU:

Home Phone: Work Phone: Cell Phone:

O.K. to call? Y or N O.K. to leave message? Y or N O.K. to call? Y or N O.K. to leave message? Y or N O.K. to call? Y or N O.K. to leave message? Y or N

Is it O.K. for us to text you? Y or N

Birthdate: **Age:** Social Security #:

Marital Status: M W D S Your E-Mail address:

O.K. to e-mail? Y or N

Your Employer: Occupation:

Spouse's/Significant Other's Name: Spouse's/Significant Other's Employer:

Children's Names & Ages: Is your family supportive of your pursuit of health and wellness?

Your Favorite Hobbies: Are you currently able to enjoy hobbies/activities of daily living without pain or stress?

Most patients are referred to our office by a caring family member or friend…

Who may we thank for referring you? Other?

Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime? Never

Last visit? Dr.

Are you here because of a recent auto or work injury? Date of Accident:

Who was the last doctor who put you on a total health development program?

Drugs can cause various side effects, hide the severity of health conditions and/or hinder the body's ability to heal.

What drugs do you currently take? Vitamins / Supplements?

Stress can cause or accelerate spinal damage. Rate your stress level over the past 90 days? (1-10 scale with 10 = high)

Surgeries you've had: Ever diagnosed with cancer? Type?

Poor posture leads to poor health and often indicates a spinal condition. How would you rate your posture? (1-10 scale with 10 = Excellent)

Family History of: heart disease cancer stroke back problems other ______________________________
(please circle)

What are your health objectives / goals for care after your current symptoms go away and you are feeling better?

Are you healthier than you were 5 years ago? If so, how did you achieve that?

If not, what is your plan to help you prevent illness and disease, as well as create "health" for your future?

If the doctor feels that chiropractic can help you, are you willing to follow-through with her best recommendations?

Emergency Contact: **Phone Number:** **Relationship:**

The vast majority of our patients have experienced literally hundreds of impacts that could cause subluxations (spinal misalignments).
Help us discover a few of yours.

1. How many total auto accidents have you been in? ____________ Motorcycle accidents? Yes No

Briefly describe type of accident(s) (i.e. rear-ended, head on collision, etc.), speed of impact, any care received & date(s):
____
____

2. Which of the following sports have you been involved in? (please circle) football, basketball, soccer, field hockey, gymnastics, horseback riding, martial arts, roller blading, other: ______________________________

3. Have you ever…(please check) ( ) fallen down the stairs ( ) slipped on ice or snow ( ) broken a bone ______________________ **explain & give date(s)**

( ) had a stress or strain while working ( ) had a sports injury ( ) been hospitalized ______________________ **explain & give date(s)**

4. Repetitive activities can cause subluxation…for example, do you … (please check)
( ) sit more than four hours per day ( ) spend a lot of time on the telephone
( ) spend a lot of time at the computer ( ) drive more than two hours per day

5. Are you a …(please check) ( ) computer operator ( ) assembly line worker ( ) construction worker ( ) truck driver
( ) single or working mother ( ) ______________________

Subluxations (spinal misalignments) can cause dysfunction in the entire body. They can also put pressure on nerves for months or even years before you feel the effects. Please check the health complaints or body signals you are currently experiencing and describe each. **What is your primary complaint today?** ______________________________

	Body Signal	How long have you had the below complaints?	How often do you have the below complaints?	Describe (dull, sharp, achy, burning, throbbing, numbness)	Worse in AM, PM, anytime? After activity?
	Low Back Pain				
	Fatigue				
	Carpal Tunnel Syndrome				
	Neck Pain				
	Leg/Foot Problems				
	Ear Infections				
	Headaches				
	Asthma				
	Frequent Colds/Infections				
	Upper/Mid Back Pain				
	Allergies				
	Extremity Pain/Joint Pain				
	Shoulder Pain				
	Sinus Problems				
	Digestive Problems				
	Menstrual Problems				
	Other? ________________ i.e. High Blood Pressure, etc.				

______________________________ ______________________
Patient's Signature Date

______________________________ ______________________
Guardian's Signature Authorizing Care for Minor Date

• I acknowledge and agree that I have received a copy of the Notice of Rights for access to health records and privacy practices for review and to keep for my records on the date identified below.
• I authorize cornerstone4health CHIROPRACTIC, P.C. to release any information needed to help me receive insurance reimbursement.