Welcome to Wellness!

Name_____ D.O.B._____Age____Height_____Weight_____

Address_____ City_____ Zip_____

SS#_____ Email _____

Home Ph_____ Business Ph_____ Cell Ph_____

Employed by_____Occupation_____

If Under 18: Parent(s)/Guardian(s) Name(s)_____
I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature_____ Date_____

Emergency Contact: Name_____ Ph_____ Relationship_____

Name of Spouse/partner_____ Do you have children? Yes No

Number of children?_____ Do they live at home?_____

Who can we thank for referring you to us? _____

Best number to contact you: (circle one)
- Home
- Business
- Cell

Marital Status: (circle one)
- Married
- Single
- Domestic Partner
- Widowed
- Divorced

Addressing What Brought You Into This Office:

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1= mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

_____

_____

Since the problem started is it: About the same? ○ Getting better? ○ Getting worse? ○

What have you done for this condition? Was it of benefit?

_____

_____

What activities aggravate your condition?

_____

Is this condition interfering with any of the following?

Work ○ Sleep ○ Daily routine ○ Sports/exercise ○ Other ○ (please explain)

_____

Vital Information

The Beginning Years: Many of the health challenges that people face originate from stressors experienced during developmental years. These stressors (traumas) may be **emotional, mental, physical** or **chemical**. Please answer the questions to the best of your ability.

Birth history:

○mother smoked/drank/drugs during pregnancy
○forceps delivery
○epidural/meds in labor
○vacuum extraction
○C-section
○induced labor

Childhood history (0-17):

○recurrent physical/mental illness
○car accidents
○serious accidents
○mental/emotional abuse
○physical abuse
○antibiotics/other meds
○surgery
○active in sports
○alcohol or drug abuse
○broken bones
○vaccinated
○made fun of/teased
○body image issues
○car accident
○other_____

Adult history (18-present):

○smoker past/present
○alcohol use
○high personal stress
○high job stress
○not enough/poor sleep
○no exercise
○repetitive lifting/bending
○money stress
○work injury
○play sports
○sit a lot/traffic
○do not drink much water
○surgery/hospitalization
○sit on wallet
○loss of loved one
○do not feel valued
○body image issues
○quick tempered
○OTC/prescription meds
○poor diet (processed/refined)
○other injuries
○car accident
○hold in feelings
○caffeine/artificial sweetener

Do you relate any of the above experiences to your current state of health? ○Yes ○No
If yes, which ones? _____
_____

Has your body communicated any of the following to you?

○Headaches
○High blood pressure
○Low back pain
○Neck pain
○Ringing in ears
○Rashes/eczema
○Mood swings
○Allergies
○Chest pain
○Dizziness
○Cancer
○Fatigue
○Asthma
○Heartburn
○HIV
○Vertigo
○Anxiety
○Sweats/chill
○PMS
○Fever
○Last menstrual period _____
○Shortness of breath
○Loss of smell/taste
○Stomach problems
○Heart conditions
○Weight changes
○Urinary changes
○Sinus headaches, pain, congestion
○Tension between shoulder blades
○Numbness in arms/legs
○Depression/nervousness
○Constipation/diarrhea/gas
○Cold hands/feet
○Other_____

For Women Only:

Are you pregnant? no yes
If yes, any bleeding____ spotting____ unusual discharge____ diarrhea ____
fever____ chills____ weight loss_____ feeling like the baby might fall out____
difficulties _____
What week are you in? _____ Have you had ultrasounds? __ no __ yes
OB/GYN or Midwife (name and number) _____
Do you have a birth plan? __ no __ yes ` Do you have a doula? __ no __ yes
Due date? _____
If week 32 or further: Baby's position? __ LOA __ ROP __ Breech __ Don't know
Are you currently nursing? no yes
If yes, difficulties? _____
Are you taking birth control pills? no yes
Do you have excessive menstrual flow? no yes
Do you experience irregular cycles? no yes
Do you experience extreme cramping? no yes
Do you have breast implants? no yes

Clarifying Your Intentions

What is your level of commitment to yourself, your life and well being? ○High ○Medium ○Low

Is NOW the right time for you to make a commitment to these goals? _____

Personal Life Inventory

Date: _____

Since chiropractic is a wholeness and possibility- based approach to health and wellness, I like to get an idea of where you rate yourself as far as how satisfied you are with the various individual aspects of your current life situations. This form is strictly for your and my eyes only. Please mark all that apply.

Please rate each of the following areas of your current life from zero to ten (0-10).
0 = totally dissatisfied, 10 = 100% completely joyful

Energy Level _____
Happiness/Joy _____
Ease of Movement _____
Amount of Sleep _____
Quality of Sleep _____
Ease of Digestion _____
Ease of Respiration _____
Peace of Mind/Harmony _____
Ability to Express Love _____
Relationship with Partner _____
Relationship with Others _____
Satisfied with Friendships _____
Financial Freedom/Abundance _____
Spirituality/
Sense of Connectivity _____
Certainty/
Confidence in Yourself _____

Perception of Self _____
Time with Family _____
Time in Nature _____
How Loved Do You Feel? _____
Health _____
Time for Yourself _____
Other ( ) _____
Clarity of Thought _____
Overall Job Satisfaction _____
Sense of Purpose _____
Excitement About Future _____
Overall Wholeness _____

Understanding Our Service

When a person seeks chiropractic care, it is essential for both the individual and the chiropractor to be working towards the same objective.

In this office, chiropractic adjustments are given to help every individual whether a newborn, an athlete or a grandparent to express more health. **Health** is defined as the state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. **Adjustments** are specific applications of forces delivered to facilitate the body's correction of subluxations. **Subluxations** are patterns of tension stored in the body causing an alteration of nerve function and interference to the transmission of mental impulses, the essential impulses that allow the expression of health, vitality and personal expression.

Healing is a non-linear path, which means that one might experience ups and downs during a course of chiropractic care. This might include the experience of emotions, soreness, fatigue and sensation awareness as subluxations are released and the body finds a new alignment. It also might mean greater energy, rest, ease, creativity and connectivity.

Chiropractic is not a substitute, an alternative or a preventative form of medicine. The only diagnosis made in this office is that of subluxations. However, if during the course of chiropractic care, non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire diagnosis or treatment for these findings, the chiropractor will recommend that you seek the services of another health care provider.

I, _____, the undersigned, have completely read and understood the above statements and choose to be served by Dr. Stacey Cantrell and/or Dr. Christine Maguire with this understanding for myself. All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Signature _____ Date _____

Signature of Parent or Guardian (for anyone under the age of 18)

_____ Date _____

Doctor's Signature_____ **Date** _____