

## Comprehensive Health Profile / History

*Please do your best to fill out everything on this intake form. It is important that I understand past and current stressors that may have affected or are currently affecting you physically, emotionally, mentally, chemically, and spiritually. It is important for me to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that I value your time and aim only to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic!*

**Please check the type of care desired:**

Temporary Relief    Stabilization    Family Health/ Prevention    Doctor's Advice

**Is this appointment related to an:**  auto accident    injury on the job? *(If yes, please see receptionist)*

**Name:** \_\_\_\_\_ **Sex:** Male / Female

First                                      Middle                                      Last

**Address:** \_\_\_\_\_

Street                                      City                                      State                                      Zip Code

**Home Phone:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**E-Mail:** \_\_\_\_\_

**Date of Birth:** \_\_\_/\_\_\_/\_\_\_   **Age:** \_\_\_   **Weight:** \_\_\_   **Height:** \_\_\_

**Married/Life Partner?** Yes \_\_\_ No \_\_\_   **Significant Other's Name:** \_\_\_\_\_

**Children(s) Name(s) and Age(s):** \_\_\_\_\_

**Are you currently pregnant?** Yes \_\_\_ No \_\_\_ *(If you are or have ever been pregnant fill out the Pregnancy Profile.)*

**Emergency contact:** Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**Who referred you to our office?** \_\_\_\_\_

### Occupation

**Occupation:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Do you enjoy what you do?** Y N                      **Can we contact you there if needed?** Y N

**Duties/ Habits:** \_\_\_ sit more than 1 hour   \_\_\_ carry equipment/tools on your body (i.e. utility belt, child)

\_\_\_ repetitively bend or twist   \_\_\_ cradle the phone shoulder to ear (which side? L or R)

\_\_\_ repetitively type   \_\_\_ drive on the job (car or other)   \_\_\_ lift more than 10 lbs repetitively

**Are you currently on a work release?** Y N                      **Ordered by whom and why?** \_\_\_\_\_

### About Your Health

*The human body is designed to be healthy. Throughout life events occur and our body has two choices: It can either integrate the physical, mental, chemical, emotional or spiritual stress or it can store that experience to be integrated at a later time when the body is willing, ready and able. These stored experiences eventually become symptoms in the body thus giving us a lesser quality of life. This case history will uncover the layers of stored experiences in your body. Following the Chiropractic Exam, you will get an outline of care that will begin to correct these layers and recover your innate health potential!*

Current Health Concerns

What is the reason for your appointment? \_\_\_\_\_

When did this situation or concern first begin? \_\_\_\_\_

Is this related to an \_\_\_ auto accident \_\_\_ injury on the job \_\_\_ other injury (\_\_\_\_\_)

Have you done anything for or gotten any advice or treatment for this issue? \_\_\_Yes \_\_\_ No

Explain: \_\_\_\_\_

Result: \_\_\_\_\_

What activities aggravate your condition/pain? \_\_\_\_\_

What activities alleviate your condition/pain? \_\_\_\_\_

Is the condition worse during certain times of the day? Y N If yes, when? \_\_\_\_\_

Does it affect your \_\_\_work / \_\_\_relationships or intimacy / \_\_\_decision making / \_\_\_exercise or play \_\_\_attitude, mood, patience / \_\_\_ability to relax or sleep / \_\_\_ day-to-day activities

On a scale of 1-10 (1 least, 10 most), please circle the severity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Do you have \_\_\_pain \_\_\_numbness \_\_\_tingling \_\_\_aches

Is your pain \_\_\_sharp \_\_\_dull \_\_\_throbbing \_\_\_constant \_\_\_intermittent

Do you feel \_\_\_swelling \_\_\_cramping \_\_\_stiffness \_\_\_burning

Are there any other health concerns that are important to you? \_\_\_\_\_

Developmental History (Before Birth through age 18)

Your MOM's Pregnancy with YOU: check all that apply

\_\_\_Tobacco \_\_\_Alcohol \_\_\_Medications \_\_\_Recreational drugs \_\_\_Falls/injuries

\_\_\_Abuse (Physical, sexual, or emotional?) Details of any checked: \_\_\_\_\_

Your Birth: check all that apply

\_\_\_Hospital \_\_\_Home \_\_\_Vaginal \_\_\_Cesarean (Emergency or scheduled?) \_\_\_Vacuum/Suction \_\_\_Forceps

\_\_\_Induced \_\_\_Complications Details of any checked: \_\_\_\_\_

Childhood (Age 0-18): check all that apply

\_\_\_Breast fed \_\_\_Formula fed (Dairy or soy?) \_\_\_Vaccinations (All or Modified?) \_\_\_Surgeries \_\_\_Medications

\_\_\_Abuse (Physical, sexual, or emotional?) \_\_\_Accidents/falls/injuries \_\_\_Dislocations/fractures

\_\_\_Nightmares/night terrors \_\_\_Played in a hanging bouncy swing \_\_\_Crawled before walking \_\_\_Special diet

Details of any checked: \_\_\_\_\_

About Your Care

Chiropractic provides different levels of care. First is Initial Intensive care which corrects the most recent layers of stored patterns of tension. This care helps reduce or eliminate symptoms. Then begins Reconstructive Care which corrects the years of stored patterns of tension that have gotten you where you are now. That is when stabilization is being achieved in the body. Next is Wellness/Preventative Care. The body is designed to excel - mind, body and soul. That is the goal at this level of care. All of these options will be explained at your Doctor's Report. You can then decide which level of care fits your goals in Health and life!

**Adult History (Age 18 to present)**

Mark all that apply with (N) for Now, (P) for Past

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> Weight changes          | <input type="checkbox"/> Frequent Colds/Flu    | <input type="checkbox"/> Asthma/Respiratory disease   | <input type="checkbox"/> Sinus problems/Allergies |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Skin Conditions       | <input type="checkbox"/> Neck/Back pain               | <input type="checkbox"/> High cholesterol         |
| <input type="checkbox"/> Stroke                  | <input type="checkbox"/> High blood pressure   | <input type="checkbox"/> Depression                   | <input type="checkbox"/> Bipolar disorder         |
| <input type="checkbox"/> OCD                     | <input type="checkbox"/> AD/HD                 | <input type="checkbox"/> SAD                          | <input type="checkbox"/> Concussion/Head injury   |
| <input type="checkbox"/> Digestive problems      | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Menstrual problems/ pain     | <input type="checkbox"/> Numbness/Tingling        |
| <input type="checkbox"/> Dental/Jaw issues       | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Diabetes (Type:_____)        | <input type="checkbox"/> Urinary Tract Infections |
| <input type="checkbox"/> Arthritis (Type? _____) | <input type="checkbox"/> Bowel/bladder changes | <input type="checkbox"/> Reproductive Organ Disorders | <input type="checkbox"/> Dizziness/Vertigo        |
| <input type="checkbox"/> Ear/Hearing Issues      | <input type="checkbox"/> Eye/Vision Issues     |   | <input type="checkbox"/> Thyroid Disorder         |

Other: \_\_\_\_\_

Details of any checked: \_\_\_\_\_

- Tobacco  Alcohol  Medications  Recreational drugs  Vaccinations  Falls/injuries  Accidents  
 Surgeries/organs removed  Dislocations/fractures  Sports injuries  Abuse (Physical, sexual, or emotional?)

Details of any checked: \_\_\_\_\_

- Particular diet (type: \_\_\_\_\_)  Vitamins or supplements (details: \_\_\_\_\_)  
 Regular exercise (frequency? \_\_\_\_\_ / type? \_\_\_\_\_)  
 Occupational stress  Mental/emotional stress  Physical stress  Chemical stress

Details of any checked: \_\_\_\_\_

- Sleep habits:**  Hours per night /  Sound or  Disrupted /  Nightmares /  Sleep apnea /  Snoring  
 Age of mattress  yrs / Type of mattress \_\_\_\_\_  
 Age of pillows  yrs / Type of pillows \_\_\_\_\_ / Locations \_\_\_\_\_

Details of any checked: \_\_\_\_\_

**For Females Only:** Please fill out the following questions regarding your own pregnancies/births.

Have you had any abortions or miscarriages? Yes No

Please explain: \_\_\_\_\_

**Past Deliveries:** (Check regarding most recent delivery; include stories on all deliveries.)

Third Trimester Presentation: Vertex \_\_\_\_\_ Breech \_\_\_\_\_ Transverse \_\_\_\_\_ Face/Brow \_\_\_\_\_

Type of Birth: Vaginal \_\_\_\_\_ Forceps \_\_\_\_\_ Cesarean \_\_\_\_\_ Suction Cup or Vacuum \_\_\_\_\_

Interventions: Pitocin \_\_\_\_\_ Epidural \_\_\_\_\_ Ruptured Membranes \_\_\_\_\_ Episiotomy \_\_\_\_\_ Assisted Pushing \_\_\_\_\_

Delivery Location: \_\_\_\_\_ OB/Midwife: \_\_\_\_\_

Pregnancy/Birth Stories: \_\_\_\_\_

**Current Pregnancy:**

Do you plan on delivering at: Home \_\_\_\_\_ Birthing Center \_\_\_\_\_ Hospital \_\_\_\_\_

If not delivering at home, please name birthing location: \_\_\_\_\_

Do you plan on using a: Midwife \_\_\_\_\_ Doula \_\_\_\_\_ Nurse Midwife \_\_\_\_\_ OB \_\_\_\_\_ (circle all that apply)

Names: \_\_\_\_\_

Do you plan on breastfeeding? Yes No

For how long? \_\_\_\_\_ or why not? \_\_\_\_\_

Do you plan on vaccinating this child? Yes No

If yes, what type of schedule are you choosing: Full \_\_\_\_\_ Delayed \_\_\_\_\_ Modified \_\_\_\_\_

Why? \_\_\_\_\_

### Chiropractic History

Have you been to a chiropractor before? Yes No

How old were you the 1<sup>st</sup> time you were *professionally* adjusted? \_\_\_\_\_

Who was your most recent chiropractor? \_\_\_\_\_

When was your last adjustment? \_\_\_\_\_

Duration of care: \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Result: \_\_\_\_\_

Technique used: \_\_\_\_\_

In your own words, what do chiropractors do? \_\_\_\_\_

Do any of your family or friends receive chiropractic care? Yes No

If yes, do they use chiropractic for \_\_\_\_\_ health maintenance/optimization

\_\_\_\_\_ health problems \_\_\_\_\_ both

Are you seeking chiropractic care for \_\_\_\_\_ health maintenance/optimization

\_\_\_\_\_ health problems \_\_\_\_\_ both

Is there some aspect of your life that very much **pleases you**, brings you joy, or helps you to feel better about yourself?

\_\_\_\_\_

Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel **impair** your opportunity for full, unimpeded health?

\_\_\_\_\_

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or **adds to your health**?

\_\_\_\_\_

Is there **anything else** which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: \_\_\_\_\_

\_\_\_\_\_

*\* Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide me with the information I need to best help you achieve your health goals.*

*Congratulations on taking an active step toward health and thank you for giving me the opportunity to participate in this process.*

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

We offer many payment options in an attempt to keep down prices and minimize your time at each visit. Please check which you prefer from each list. This information does not commit you to anything; it serves only to help us assist you better.

Payment Frequency:

\_\_\_ Pay at each visit

\_\_\_ Pay ahead with a discount

Type of Payment:

\_\_\_ Credit or Health Savings Card

\_\_\_ Check or Cash

If using a Card:

\_\_\_ Pay in person

\_\_\_ Auto-pay with a card on file