

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 speak with 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): _____

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: How many weeks are you? _____

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 _____ (check 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 1st 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

Participant Consent Form

When a participant seeks chiropractic health care and we accept a participant for such care, it is essential for both to be working toward the same objectives. It is important that each participant understand both the objectives and the methods that will be used to attain said objectives. This will prevent any confusion or disappointment. You have the right, as a participant, to be informed about the condition of your health and the recommended care and management to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health.

Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

Subluxation is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance.

Subluxations are corrected and/or reduced by an **adjustment**. An adjustment is the specific application of forces to correct and/or reduce subluxation. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I will call the office if I have any questions or if any problems arise before each scheduled follow-up visit. I have read and understand all of the above statements.

Print Name

Signature

Date