Lotus of Life Chiropractic

info@lotusoflifechiropractic.com

Updated History and Health Concerns

**Please do your best to fill out everything on this intake form. It is important that we understand past and current stressors that may have affected or could affect your child's health. It is important for us to know the following information, even if it may not seem relevant to the reason for which you are coming in for care. Please know that we value your time and aim to provide you the best care possible. Thank you for choosing Lotus of Life Chiropractic and Wellness Center!*

Name: _____ **Date**: _____

Address: _____

Cell Phone: _____ **E-Mail**: _____

Current Health Concerns

List any health concerns that have ***improved or resolved since starting care:***

_____

_____

_____

What are your current health concerns, ***starting with the most important to you***?

_____

_____

_____

Mark any system or issue you have had with ***(S) for Same/No Change, (I) for Improved, (R) for Resolved, (NC) for New Concern***

___ Nervous System	___Prostate	___ Arthritis	___ Accidents/Falls/Injuries/Concussions
___ Musculoskeletal	___ Eyes	___ Sinuses/Allergies	___ Surgeries/Organ Removal
___ Digestive	___ Ears/Nose/Throat	___ Seizures	___ Fractures/Dislocations
___ Respiratory	___ Dental/Jaw issues	___Cancer	___ Cholesterol/Blood Pressure
___ Cardiovascular	___ Thyroid	___Stroke	___ Vaccine Medication Reaction
___ Immune	___ Adrenals	___ Scoliosis	___ Depression/Anxiety
___ Reproductive	___ Learning Difficulties	___ Anemia	___ Diabetes (Type:_____)
___ Bowels/Bladder	___ Headaches/Migraines	___ Dizziness/Vertigo	___ Significant Family History
___ Skin	___ Numbness/Tingling	___ Autism Spectrum Disorder	___Other

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Nutrition / Toxins: mark yes or no in regards to consumption. If yes, write details in space provided.

Drugs: *Prescription* Yes No Type and reason _____

Over the counter Yes No Type and reason_____

Recreational Yes No Type_____

Supplements: *Prescription* Yes No Type and reason _____

Over the counter Yes No Type and reason_____

Caffeine: Yes No Source/frequency/amount:_____

Tobacco: Yes No Source/frequency/amount: _____

Alcohol: Yes No Type/frequency/amount: _____

Water: Yes No Type/amount: _____

What did you eat yesterday?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____**Drinks:**_____

Do you avoid any foods due to allergies, sensitivities, or religion? Yes No _____

Life Health:

What do you do for **exercise** (type, frequency, duration)? _____

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**?

_____

Other Providers and Doctors (Office and provider name, last visit) _____

_____

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Occupation: _____ How long have you been at this job?_____

Do you enjoy what you do? Yes No Is your job physically and/or mentally stressful? Yes No

Explain:_____

Stress Survey:

0 - no awareness of any stress **1**- slightly stressful **2**- moderately stressful **3**- extremely stressful

Please circle a number and the examples that apply to you. If not listed, please write in.

Overall Physical Stress/Trauma:
0 1 2 3

Includes: falls, accident, injuries, repeated postural stress, impacts, difficult birth, physical/sexual abuse, etc. Other:_____

Overall Emotional/ Mental Stress:
0 1 2 3

Includes: loss/separation of loved ones, life changes, abuse, legal concerns, financial concerns, relocation, illness of yourself or loved one, job stress, etc. Other:_____

Overall Chemical Stress:
0 1 2 3

Includes: drugs, medicines, alcohol, nicotine, caffeine, smoke, fumes, chemical agents, pollution, food additives, poor diet (fast food, fried food), pesticides, non-organic food/body products, etc.

Other: _____

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: _____
_____

Participant Signature: _____ Date: _____

**** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in that process!***

Practitioner Name: _____

Practitioner Signature: _____ Date: _____