THE LIFE CENTER CHIROPRACTIC

BROOK CHIROPRACTIC, INC.

Confidential Patient Info

Date _____

Name _____Social Security Number _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Address _____City _____State_____ Zip _____

Home Phone _____ Cell Phone _____

Email Address _____Occupation _____

Marital Status: circle one: Single Married Divorced Widowed

Name of Spouse _____ Number of Children _____

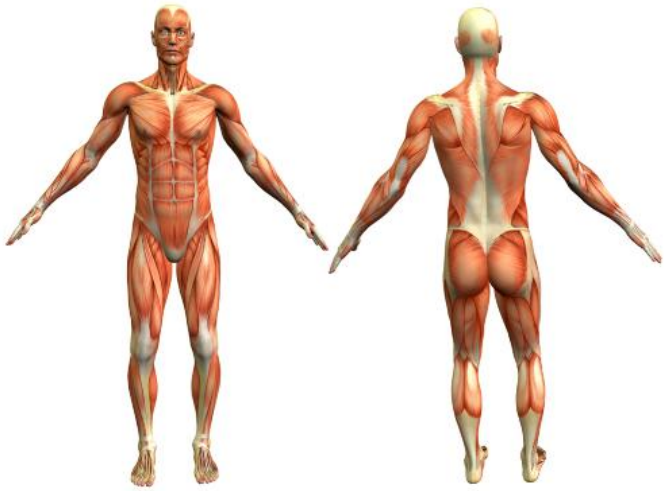
Whom may we thank for referring you to The Life Center? _____

_____ _____ _____

Signature Date Guardian's Signature Authorizing Care

What Brings You Here?

If applicable, please illustrate the location **of your BODY-MIND concern?**



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 or trauma?**	**%** **of the time pain is present**
1.					
2.					
3.					

Health Concerns

Describe the **Quality** of the sensation: Circle all that apply

Sharp Ache Throbbing Burning Tingling Numbness Stabbing

Since the **Problem Started** has it been:

getting better getting worse staying the same coming and going

What makes it feel **better?** _____

What makes it feel **worse?** _____

Is this injury or illness **work-related?** _____ *If yes, have you reported this to your employer?* ___ Is this injury or illness related to an **automobile accident?** _____

Is this condition interfering with any of the following: Check those that apply.

Work □	**Sleep** □	**Daily routine** □	**Sports/exercise** □	**Other** □ **(please explain):**

Other doctors you have seen for this condition:

Chiropractor Results? _____	☐
Medical Doctor Results? _____	☐
Other (please describe) Results? _____	☐

I do / do not have a family history of this or similar symptoms (Please explain):

_____

Chiropractic Experience

Have you ever experienced Chiropractic? Circle one. Yes or No
Approximate date of last spinecheck or adjustment? _____

About Your Health and Lifestyle

How many **hours do you sleep**? _____

Describe **the quality of your sleep**_____

Do you **sleep on your** side/back/ stomach? Circle one.

Do you **sleep with a cervical pillow**? no yes

How many **hours do you sit**? _____

Do you **grind or clench your teeth**? no yes

Are you taking any drugs currently or have you been on any medication in the past?

Circle those that apply.

Pain Killers	Muscle Relaxers	Stimulants	Tranquilizers
Anti-depressants	Anti-inflammatory	Blood Pressure	Anti-anxiety
Birth Control	Diet Pills	Thyroid	

Over the Counter _____ Other _____

Recreational drugs (name them) _____

Past Surgeries/ Operations/ Hospitalizations (*Include year)*

1.
2.
3.
4.

Stressors

Because accumulation of stress affects our health and ability to heal, **please list your top stresses** (you have ever had) in each category:

1. **Physical Traumas (**falls, car accidents, work postures, etc.)
   a. _____
   b. _____
2. **Bio-chemical Toxins**
   (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)
   a. _____
   b. _____
3. **Psychological or mental/emotional stress** (work, relationships, finances, self-esteem, etc.)
   a. _____
   b. _____

Past Health History

Please mark the following conditions you may have had or have now **(- have had + have now):**

□ Alcoholism	□ Allergy	□ Anemia	□ Arteriosclerosis	□ Arthritis	□ Asthma
□ Back Pain	□ Cancer	□ Cold Sores	□ Constipation	□ Convulsions	□ Depression
□ Diabetes	□ Diarrhea	□ Eczema	□ Emphysema	□ Epilepsy	□ Gall Bladder
□ Gout	□ Headaches	□ Heart Attack	□ Heart Disease	□ High Blood Pressure	□ HIV (AIDS)
□ Irregular Periods	□ Low Blood Sugar	□ Malaria	□ Measles	□ Menstrual Cramps	□ Migraines
□ Miscarriage	□Multiple Sclerosis	□Mumps	□ Neck Pain	□ Nervousness	□ Neuritis
□ Pleurisy	□ Pneumonia	□ Polio	□ Rheumatic Fever	□ Ringing in ears	□Sinus Problem
□ Stroke	□ Thyroid Problems	□Tuberculosis	□ Ulcers	□ Venereal Disease	□ Whooping Cough

For Women Only

Are you pregnant? ☐ **no** ☐ **yes**

Excessive flow? ☐ **no** ☐ **yes**

Are you nursing ☐ **no** ☐ **yes**

Irregular cycles? ☐ **no** ☐ **yes**

Are you taking birth control? ☐ **no** ☐ **yes**

Cramps? ☐ **no** ☐ **yes**

Breast Implants? ☐ **no** ☐ **yes**