

PRACTICE MEMBER INITIAL QUESTIONNAIRE

Patient Name: _____ Date: ____/____/____

Your quality of life is our concern. Please complete this form by listing your health concerns (in order of priority) and rate the severity of each from 1-10 with 10 being the worst.

I. Chief Physical Complaints

- 1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 4. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 5. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

II. Chief Emotional Complaints

- 1. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 2. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 3. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 4. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)
- 5. _____ (1) (2) (3) (4) (5) (6) (7) (8) (9) (10)

III. Please list any other concerns that you would like the doctor to know about:

IV. What would you like to accomplish from your healing process in our office?

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Life History Form

The intent of this form is to assist you in your healing process by initiating a thoughtful recognition of your life experiences. Life is a cumulative process; use this form to increase your understanding and appreciation of your own life process and accumulation of stressors, both positive and negative.

Date: _____/_____/_____

PATIENT'S FULL NAME: _____

"Nick Name" or name you like to be called if different: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Pager: _____

Email Address: _____

Would you like to subscribe to our Email Newsletter? Yes No Email Appointment Reminders? Yes No

Date of Birth: _____/_____/_____ Age: _____ Sex: M F Relationship Status: _____

Spouse or Partner's Name: _____ Number of Children: _____

REFERRAL SOURCE: The majority of our practice members come from direct in house referrals.

Were you referred by a patient of ours? Yes No Patient's Name: _____

Were you referred by the internet? Yes No If so, any particular directory or site? _____

Were you referred by: Indigo Sun ANC List Gym Office Sign Other: _____

Primary Contact: Self Spouse Other _____

Employment Status: Full time Part time Retired Unemployed Other _____

Employer _____ Work Phone: _____

Occupation: _____ College Student: Full time Part time None

Financially Responsible Party: Self Spouse Parent Other _____

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR PERSONAL HEALTH HISTORY:

Have you ever had your spine or nervous system examined professionally? Yes No

Have you ever received any form of Chiropractic Care? Yes No

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used?

Have you ever received Network Spinal Analysis Care? Yes No Network Chiropractic Care? Yes No

If yes, who was your Chiropractor/Network Practitioner? _____ State: _____

If yes, for how long did you receive care? _____ How often did you go? _____

When was your last visit? _____ If you stopped, why did you stop? _____

Were you pleased with his or her service? Yes No Somewhat _____

Has anyone ever taken x-rays of your spine? Yes No When? _____

If yes, who would you need to contact for copies of your x-rays? _____

Does anyone in your immediate family receive chiropractic adjustments? Yes No _____

Does anyone in your immediate family receive Network (NSA) Care? Yes No _____

Have you had, or do you receive the following vehicles toward health, growth and development? If yes, please list information like When?, How Often?, Last Session?, and any other comments you wish to share:

Bodywork / Massage: Yes No _____

Osteopathy / Cranial Work: Yes No _____

Homeopathy / Acupuncture: Yes No _____

Meditation: Yes No _____

Psychotherapy: Yes No _____

Movement or Exercise: Yes No _____

Somato Respiratory Integration: Yes No _____

Yoga: Yes No _____

Rebirthing / Breathwork: Yes No _____

Prayer: Yes No _____

Reiki: Yes No _____

Other Healing Modalities: _____

What do you hope to gain from care in this office? _____

The practice of chiropractic is based upon the location and adjustment of Vertebral Subluxations. Spinal Subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL / MENTAL in nature.

Often the first subluxation can be experienced at birth. Please complete these questions as thoroughly as possible based on any information you have or can obtain about your birth history.

PHYSICAL STRESS - Birth History:

Was your mother outwardly ill prior to her pregnancy with you? Yes No _____

Did your mother have a difficult pregnancy with you? Yes No _____

Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No _____

Was your delivery traumatic? Yes No If yes, please explain: _____

Was your delivery: "C" Section Breech Natural Forceps or suction
Cord around neck Prolonged labor Other _____

Describe any other physical /mechanical stress to mother or you as labor and delivery progressed, or as a newborn?

CHEMICAL STRESS - Birth History:

Was your mother regularly taking any drug or medication prior to or during her pregnancy with you? Yes No

If Yes: Alcohol Smoking Medications _____ Other _____

Was her labor chemically induced or altered? Yes No List Details _____

Was your mother: Conscious Semiconscious Unconscious Under Spinal Anesthesia during your delivery?

Any other chemical stress that your mother may have been subject to during pregnancy or labor: _____

EMOTIONAL / MENTAL STRESS - Birth History:

My birth was: At home In a birthing center In a hospital Other _____

Were you incubated or isolated after birth? Yes No List Details _____

Were you: Bottle fed formula Bottle fed mother's milk Nursed Nursed and bottle fed

GENERAL - PHYSICAL STRESS: Next to each potential cause of vertebral subluxation is a check box. Please check 'P' for Past, 'C' for Current (or both if they apply) under the level of trauma severity.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports Impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls down/up steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls on ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Have you ever been knocked unconscious? Yes No Date: _____

Comments: _____

Have you ever used crutches, a walker, or cane? Yes No Date: _____

Comments: _____

Have you ever broken any bones? Yes No Date: _____

Comments: _____

Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? Yes No

Date: _____ Comments: _____

Have you had extensive dental or orthodontial work done? Yes No Date: _____

Comments: _____

Have you served in the military? Yes No Date: _____ to _____ Were you involved in combat? Yes No

During the day, I: sit stand walk drive do desk work phone work mechanical work heavy lifting

I exercise: daily weekly monthly List Details: _____

SPORTS & LEISURE:

In the past I was active in sport(s)? Yes No Which one(s)? _____

I am currently active in sports? Yes No Which one(s)? _____

Have you been hurt in any of these activities? Yes No When? _____

Please explain: _____

Do you read for prolonged periods? Yes No Do you play a musical instrument? Yes No _____

Do you have a particular position for watching television or reading? Yes No _____

I wear: Glasses Bifocals Trifocals Contact lenses N/A Other _____

AUTOMOBILE ACCIDENTS: Have you (even as a passenger and even if you do not think you were hurt) been involved in a vehicular collision or near collision? Please list approximate dates and severity (Mild, Moderate, Severe or Extreme)?

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, mo-ped, or other vehicles: _____

MEDICAL TREATMENT: Have you ever been hospitalized? Yes No When? _____

If yes, why? _____

If yes, what was actually done to you? _____

Have you ever had surgery? Yes No If yes, please explain: _____

Do you still have all your body parts? Yes No If no, please explain: _____

Have you had: a spinal tap spinal injections physiotherapy neck collar spinal brace traction
heel lift radiation treatments corrective shoes or bars on shoes extensive diagnostic x-rays
acupuncture chemotherapy blood transfusion bone in a cast or immobilized?

GENERAL - CHEMICAL STRESS: Are you now taking any drug (prescription or over-the-counter) regularly?

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Drug: _____ Date Prescribed: _____ Reason: _____

Are these drugs being prescribed by a physician? Yes No Last visit: _____

If you were previously taking any other medication regularly, please describe: _____

Do you or did you work with any chemical, fume, dust, powder, or smoke for prolonged periods? Yes No

Please explain: _____

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

O - Do not consume this

D - Consume this daily

W - Consume this weekly

M - Consume this monthly

FD - Consume this a few times per day

FW - Consume this a few times per week

FM - Consume this a few times per month

IA - I'm addicted

_____ Alcohol _____

_____ Coffee _____

_____ Tobacco _____

_____ Artificial Sweeteners _____

_____ Soda _____

_____ Diet Food _____

_____ Refined Sugar _____

_____ Eggs _____

_____ Cooked, canned vegetables _____

_____ Raw Vegetables _____

_____ Fresh Fruit _____

_____ Whole Grains _____

_____ Dairy _____

_____ Fried Foods _____

_____ Beef _____

_____ Poultry _____

_____ Fish _____

_____ Seafood _____

_____ Weight Control _____

_____ Fasting _____

_____ Organic Foods _____

The type of diet I usually follow is classified as: _____

GENERAL - EMOTIONAL / MENTAL STRESS: For each of the following potential spinal stress situations, please check 'P' for Past, 'C' for Current (or both if they apply) under the level of trauma severity.

	MILD		MODERATE		EXTREME			MILD		MODERATE		EXTREME	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work Related Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress of Commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play or Recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in vocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting Worse

And your emotional / mental health? Excellent Good Fair Poor Getting Better Getting Worse

If you consider yourself ill, why do you feel you are ill? _____

If you consider yourself well, why do you feel you are well? _____

Is there anything else you wish to share, which has not been discussed, that may help us to better understand you and why you have chosen to see the doctor in this office? _____