Welcome to Chiropractic Alchemy!

Date: _____ / _____ / _____

Name:_____

Street Address:_____ City: _____ State: ____ Zip: _____

Occupation: _____Cell Phone: _____Email: _____

Date of Birth: _____ Age: _____ Marital Status: S M W D Number of Children: _____

Emergency contact: _____ Phone number of emergency contact: _____

Who referred you and/or how did you hear about our office and the services we offer?

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS

1) Reasons for seeking support (can be physical, emotional, mental, spiritual)

1. _____
2. _____
3. _____

2) In what ways have you already worked with the reasons that you are seeking support?

_____

3) What concerns, if any, do you have around the reasons you are seeking support?

_____

4) What areas of life, if any, feel like they are not in full expression? (circle)

Work Family Personal relationships Hobbies Life enjoyment Relaxation Other:_____

5) What triggers you out of presence of alignment? (circle)

Pain Movements Environmental factors Foods Emotions Repeating thoughts

Other:_____

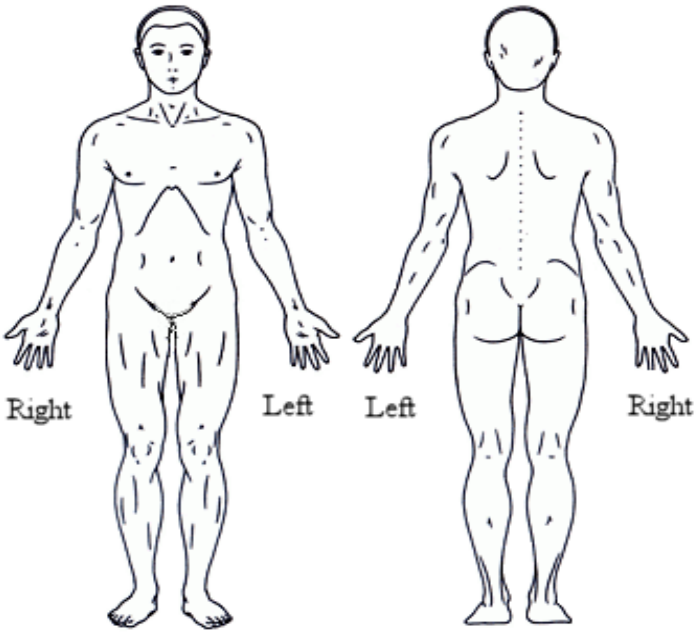
GENERAL INJURY HISTORY

GENERAL PHYSICAL TRAUMA:
List any physical injuries, along with dates of injury, that are of significant to why you are seeking support

_____

Please mark on the diagram all the places in your body that you have ever been injured.

Please also mark any areas of effected by disease. (Examples include heart disease, cancer, stroke, multiple sclerosis, etc.)



PAST MEDICAL HISTORY:
Please list any past medical history including surgeries, procedures, and medical diagnoses:

_____
_____

FAMILY MEDICAL HISTORY:
Please list any pertinent family history:

_____
_____

NERVOUS SYSTEM	MUSCLES & JOINTS	CARDIO & RESPIRATORY	PSYCHOLOGICAL
__ Convulsions/seizures __ Dizziness __ Easily fatigued __ Fainting __ Loss of balance __ Headache __ Migraine __ Memory loss __ Nervousness __ Numbness __ Hyper-sensitivity __ Hypo-sensitivity	__ Back pain __ Neck pain __ Arm pain __ Leg pain __ Swollen Joints __ Painful Joints __ Stiff Joints __ Sore Muscles __ Weak Muscles __ Muscle cramps __ Muscle twitching	__ Poor Circulation __ Cold hands/feet __ Tightness in the chest __ Asthma __ Chronic Cough __ Difficulty Breathing __ Shortness of breath	__ Anxiety __ Depression __ Addictions __ Difficulty making decisions __ Easy to anger __ Excessive worry __ Easily stressed __ Irritability __ Difficulty sleeping

GASTRO-INTESTINAL	GENITO-URINARY	EYE/EAR/NOSE/THROAT	FOR WOMEN ONLY
__ Nausea __ Constipation __ Loose stools __ Diarrhea __ Poor digestion __ Poor appetite __ Weight Loss/Gain __ Abdominal pain/bloating	__ Frequent urination __ Decreased urination __ Decreased strength of flow __ Frequent UTIs __ Frequent night urination __ Prostate problems __ Increased libido __ Decreased libido	__ Ear Noises (ringing) __ Nasal Blockage __ Nose Bleeds __ Sinus problems __ Frequent Colds __ Sore Throats __ Dry mouth/throat __ Teeth/gum pain __ Grinding teeth	__ Cramps/Backaches __ Excessive Flow __ Light flow __ Irregular Cycle __ Painful Periods __ Painful intercourse __ Pregnancies # _____ __ Miscarriages # _____ __ Abortions # _____ Pregnant at this Time Y/N

CHEMICAL HISTORY

1) Please list any prescription or over-the-counter medications you are currently taking

1._____ 2._____

3._____ 4._____

EMOTIONAL HISTORY

With each of the following potential stressful situations, please indicate the severity either past or current

Potential Spinal Stress/Tension Sources	PAST	CURRENT
Childhood Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
School Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Family Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Personal Relationships	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Stress of Being Sick	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Work Stress	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Loss of Loved One	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Change in Lifestyle	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Change in Vocation	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme
Abuse (Verbal, Physical, Emotional, Sexual, etc)	□Mild □Moderate □Extreme	□Mild □Moderate □Extreme

OVERALL STRESS SURVEY

Please grade your Current Life Stresses using the following scale:
0 - *No* awareness of any stress 1 - *Slightly* stressful 2 - *Moderately* stressful 3 - *Extremely* stressful

0 1 2 3	***Overall Physical Stress/Trauma:*** (includes: falls, accidents, injuries, repeated postural stress, impacts, difficult birth, physical abuse, loss of consciousness, broken/fractured bones, etc.)
0 1 2 3	***Overall Emotional/Mental Stress:*** (includes: loss of loved ones, rapid change in life situations, abuse, move of /school, legal concerns, financial concerns, divorce, relationships, etc)
0 1 2 3	***Overall Chemical Stress:*** (includes: prescription drugs, smoke, alcohol, caffeine, fumes, food additives, anesthesia from surgery, over-the-counter medications, etc.)

YOUR SPECIFIC NEEDS AND HOPES FOR HELP IN THIS OFFICE?

What is your commitment level to improving your overall well-being? _____%

What are your goals with us?
1._____
2._____
3._____

Is there anything else you may wish to share which may help us to better understand you and your reasons for seeking support?

_____

_____

Signature: _____ Date: _____