

Life Story

Vital Information

Name _____ Date ____/____/____

I prefer to be called _____

Address _____

City _____ State _____ Zip _____

Home # _____ - _____ - _____ Work # _____ - _____ - _____ Cell # _____ - _____ - _____

Preferred Contact # h | w | c _____ Email _____

Birthday ____/____/____ Age _____ SSN _____ - _____ - _____

Occupation _____ Employer _____

Marital Status Married Single Widowed

Spouse/Partner Name _____

Do you have children? y | n How many? _____

Names & Ages of all Children _____

Reason for seeking our services? _____

What other action steps have you taken? _____

Who can we thank for referring you to Healing Touch Chiropractic?

Have you ever been adjusted by a Chiropractor? y | n

Who & Where? _____ Date of last adjustment? ____/____/____

Do you have a Primary Care Provider? y | n

Who & Where? _____

Is there anything about your Nerve System and Spine we should know about?

Additional comment (s) _____

Other Avenues of Healing

Have you ever used or do you use any of the following for your growth, healing, and development?

- | | |
|--|--|
| <input type="radio"/> Massage/Bodywork | <input type="radio"/> Homeopathy/Herbalist |
| <input type="radio"/> Emotional Therapy/Psychotherapy | <input type="radio"/> Naturopathic Medicine |
| <input type="radio"/> Physiotherapy/Occupational Therapy | <input type="radio"/> Ayurvedic Medicine |
| <input type="radio"/> Music/Dance/Sound/Light/Aromatherapy | <input type="radio"/> Acupuncture |
| <input type="radio"/> Yoga/Pilates/Dance/Tai Chai | <input type="radio"/> Cranial-Sacral |
| <input type="radio"/> Nutritional Cleansing | <input type="radio"/> Nutritional Counseling |
| <input type="radio"/> Other _____ | |

Questions for Women

- | | | |
|--|--|--|
| <input type="radio"/> Past pregnancy | <input type="radio"/> Currently pregnant | <input type="radio"/> Breast-feeding |
| <input type="radio"/> Birth control pills/patch/ring | <input type="radio"/> Painful periods | <input type="radio"/> Irregular cycles |

Nutritional Background

Nutritional History (please check the items that apply to your typical diet)

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Junk food (_____ x's per week) | <input type="checkbox"/> Excess sugar | <input type="checkbox"/> Skip meals |
| <input type="checkbox"/> Microwave food (_____ x's per week) | <input type="checkbox"/> Artificial sweetener | <input type="checkbox"/> No breakfast |
| <input type="checkbox"/> Gluten-free | <input type="checkbox"/> Dairy-free | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Vegan | <input type="checkbox"/> Omnivore | <input type="checkbox"/> Raw food |
| <input type="checkbox"/> Other special diet _____ | | |
| <input type="checkbox"/> Water (# of glasses per day _____) | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tea/coffee |
| <input type="checkbox"/> Soda | <input type="checkbox"/> Energy drinks | <input type="checkbox"/> Juice |
| <input type="checkbox"/> Caffeine | | |

Do you relate any of the experiences checked above to your current state of health? y | n

If yes, which ones? _____

System Challenges

Has your body communicated any of the following to you? While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment.

- | | | |
|--|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Heart Conditions | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression/Nervousness |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Anemia | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Rashes/Eczema | <input type="checkbox"/> Numbness in Arms/Legs | <input type="checkbox"/> Vision/Hearing Changes |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Constipation/Diarrhea/Gas | <input type="checkbox"/> Urinary Changes | <input type="checkbox"/> Hypo/Hyper Thyroid |
| <input type="checkbox"/> Digestions Problems | <input type="checkbox"/> Weight Changes | <input type="checkbox"/> Prostate Changes |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Sweats/Chills | <input type="checkbox"/> Chest Pain |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Loss of Smell or Taste |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Tension Across Top of Shoulders | <input type="checkbox"/> Cancer | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Tension Between Shoulder Blades | <input type="checkbox"/> Fatigue | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Asthma | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Loss of Sleep | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Other _____ | |

Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.

1 = extremely dissatisfied. 10 = completely fulfilled.

- | | | | |
|-------------------------------|-------|----------------------------|-------|
| Sleep Quality | _____ | Connection to God | _____ |
| Energy Level | _____ | Feelings of Abundance | _____ |
| Clarity of Thought | _____ | Level of Joy in Life | _____ |
| Physical Flexibility and Ease | _____ | Relationships | _____ |
| Mental Flexibility | _____ | Sense of Peace/Hope | _____ |
| Emotional Balance | _____ | Ability to Adapt to Change | _____ |
| Level of Pain | _____ | Overall Health & Wellbeing | _____ |