



VITAL INFORMATION

Date _____

All information is strictly confidential and is only available for Lifeworks staff to serve you best.

First Name: _____ Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Age: _____ Date of Birth: ____/____/____ Email: _____

Marital Status (check): Married Single Partnership Widowed Divorced

Name of Spouse: _____ Do you have children? Yes No

of children: _____ Ages of Children: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____

How were you referred to Lifeworks? _____

PERSONAL HEALTH HISTORY

Reason for seeking services at Lifeworks Chiropractic (Chief concern): _____

Is this due to an: Auto accident Worker's compensation case Neither

Since this started it is: the same getting better getting worse

This impacts your: work family time leisure sleep athletics other (please list): _____

Are you currently seeing another doctor for this issue? Yes No

Name of Doctor(s): _____

Medications you currently take:

- NSAID'S (Advil, etc.) Statins Blood Pressure Painkillers
- Muscle Relaxers Allergy Anti-Depressants Cold Medications
- Hormones Other: _____

COMMITMENT TO WELLNESS

Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life. "...a state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity."

- The World Health Organization

Please mark the scale with the following indicators:

'X' = current level of health

'O' = your desired level.



What is your current level of commitment to yourself, your life and well-being? (circle)

No Commitment 1 2 3 4 5 6 7 8 9 10

What change(s) would you most like to experience with care in this office?

- Symptom Relief/Temporary Relief Restore Health Maximum Correction
 Wellness & Prevention Improved Performance
 Other: _____

Since the nervous system controls EVERYTHING in your body it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. What other specific goal(s) might you have?

- Better sleep More energy Keep up with children/grandchildren
 More joy and ease Cease medication Reach full potential
 Other goals not listed: _____

HISTORY OF INJURY/REPETITIVE STRESSES

How many auto accidents (including fender benders) have you had? +5 3-4 1-2 None

What sports are/were you involved in? _____

Have you ever: Fallen down the stairs Slipped and Fell Had a sports injury Stress/Strain at work

Broken a bone -- If so, which ones? _____

Other Injuries: _____

Do you: Sit > 4 hours/day Drive > 2 hours/day Perform Repetitive Tasks

(Typing/Lifting) Have you had:

Surgery -- if so, when & for what condition(s)? _____

Hospitalizations -- if so, when & for what condition(s): _____

Chronic Illness(es) -- Explain: _____

WORK & FAMILY HISTORY

Your Occupation: _____ Duties: _____

Do you find your profession stressful? Yes No

Health Status of:

- | | | | | |
|-----------|-------------------------------|-------------------------------|-------------------------------|------------------------------------|
| Spouse: | <input type="checkbox"/> Poor | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
| Children: | <input type="checkbox"/> Poor | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
| Parents: | <input type="checkbox"/> Poor | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |
| Siblings: | <input type="checkbox"/> Poor | <input type="checkbox"/> Fair | <input type="checkbox"/> Good | <input type="checkbox"/> Excellent |

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? Yes No Approx. how long ago? _____

Reason for previous chiropractic care? _____

Name of previous chiropractor? _____ City & State: _____

What care plan was given including at-home exercises? _____

Did you follow the care plan? Yes No If not, why? _____

Are your family members under chiropractic care? Yes No If yes, who? _____

WELLNESS HISTORY

What activities other than Chiropractic care do you do to support your health and well-being?

Diet Massage therapy Counseling Acupuncture

Yoga Meditation Prayer/Spirituality Nutritionist Fasting

Vitamins/supplements -- if so, what kind? _____

Exercise -- if so, what kind? _____

Other: _____

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you?

Great job so far! You are almost done!!!

We just need a quick review of your bodily systems.

Please continue to the next page.

NAME: _____

Only mark "P" for had in the Past or "C" for Currently have.

GENERAL

- Fever
- Chills
- Unintended weight loss
- Night sweats
- Fatigue
- Night pain
- Irritability
- Trouble sleeping

SKIN

- Rashes
- Lumps
- Sores
- Dryness
- Changes to hair
- Changes to nails
- Changes in moles

HEAD/NECK

- Head injuries
- Lumps
- Swollen glands
- Stiffness
- Thyroid problems
- Neck pain
- Jaw pain, TMJ

EYE, EAR, NOSE, THROAT

- Vision changes
- Redness
- Double vision
- Blurred vision
- Hearing loss
- Discharge
- Vertigo
- Ringing in ears
- Frequent colds/ flu
- Hay fever
- Nose bleeds
- Sinus/ drainage problems
- Allergies
- Frequent sore throat
- Hoarseness of voice
- Sore tongue
- Swollen tongue
- Difficulty swallowing

HEART

- Chest pain
- Palpitations
- Fainting
- Shortness of breath

LUNGS

- Prolonged Cough
- Coughing up mucus/sputum
- Coughing up blood
- Sleep apnea
- Difficulty breathing
- Asthma

GI/BOWELS

- Heartburn
- Abdominal pain
- Diarrhea
- Constipation
- Bloody or Black or tarry stool
- Incontinence
- Change in bowel habits
- Prolonged bloating
- Ulcers
- Digestive issues

BLADDER

- Visible blood
- Burning
- Change in urinary habits
- Difficulty passing urine
- Urgency
- Increase frequency
- Kidney Stones
- Up multiple times at night to urinate

NEUROLOGICAL

- Headaches
- Seizures
- Numbness
- Tingling
- Paralysis
- Tremors
- Convulsions/ Epilepsy
- Pain with cough/ sneeze
- Dizziness
- Loss of balance

VASCULAR

- Leg cramps
- Leg swelling
- Blood clots
- Anemia
- Easy Bruising
- Wounds take excessive time to hea

MUSCULAR/ BONE

- Muscle pain or cramps
- Weakness
- Scoliosis
- Swollen or painful joints
- Deformity of hands or feet

GLANDS

- Intolerance to heat or cold
- Appetite changes
- Excessive thirst
- Swollen or tender glands

PSYCHIATRIC

- Nervousness
- Depression
- Insomnia
- Mood changes
- Eating Disorder

FEMALE ONLY

- Pregnant
- Irregular cycle
- Irregular or excessive bleeding
- Menopause
- PMS
- Fertility Issues
- Sexual problems
- Breast lumps
- Nipple or skin changes
- Nipple discharge

MALE ONLY

- Prostate problems
- Impotency/ Sexual Dysfunction
- Discharge

**THANK YOU FOR ANSWERING THESE QUESTIONS.
THIS IS YOUR FIRST STEP TOWARD WELLNESS WITH US!**