total lifestyle
chiropractic | nutrition | massage

Patient Information

Date: ____________________

Patient Name: ____
Last Name

____
First Name Middle Initial

Address: ____
City: ____
State: ________________________ Zip: ____________________
E-Mail: ____
Sex: ☐ Male ☐ Female Age: __________________
Birthdate: ____________________________________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Spouse's Name: ____

Birthdate: ____

Do you have children? ☐ Yes ☐ No

If so, how many? ____________

Occupation: ____

Patient Employer/School: ______________________________________
Employer/School Phone: (______) ______________________________

To whom may we thank for referring you? __________________________

Phone Numbers

Cell Phone: (_____) ____________________________
Home Phone: (_____) ___________________________
Best time and place to reach you:

____

IN CASE OF EMERGENCY, CONTACT:

Name: ______________________________________
Relationship: _______________________________
Cell Phone: _________________________________
Home Phone: ________________________________

Accident Information

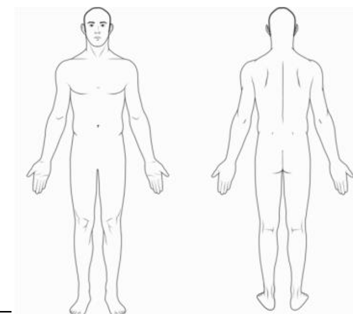
Is condition due to an accident? ☐ Yes ☐ No
Date of Accident: _______________________________
Type of Accident: ☐ Auto ☐ Work ☐Home ☐ Other
To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp ☐ Other
Attorney Name (if applicable):

____

Patient Condition

Reason for Visit: ____
When did your symptoms appear? ____
Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) __________

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching
☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling

How often do you have this pain? ____
Is it constant or does it come and go? ____

Does it interfere with your… ☐Work ☐ Sleep ☐ Daily Routine ☐ Recreation
Activities or movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐Bending ☐ Lying down

Health History

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy
☐ Chiropractic Services ☐ None ☐ Other ________________

Name and address of other doctor (s) who have treated you for your condition: ________________

____

Date of last: Physical Exam: ________ Spinal X-Ray: ________ Blood Test: ________
Spinal Exam: ________ Chest X-Ray: ________ Urine Test: ________
MRI, CT Scan, Bone Scan: ________________

Place a mark in the box, if you have had any of the following:

☐ AIDS/HIV	☐ Chicken Pox	☐ Measles	☐ Scarlet Fever
☐ Alcoholism	☐ Diabetes	☐ Migraine Headaches	☐ STI/STD
☐ Allergy Shots	☐ Emphysema	☐ Miscarriage	Which one(s)? ________
☐ Anemia	☐ Epilepsy	☐ Mononucleosis	☐ Stroke
☐ Anorexia	☐ Fractures	☐ Multiple Sclerosis	☐ Suicide Attempt
☐ Appendicitis	☐ Glaucoma	☐ Mumps	☐ Thyroid Problems
☐ Arthritis	☐ Goiter	☐ Osteoporosis	☐ Tonsillitis
☐ Asthma	☐ Gout	☐ Pacemaker	☐ Tuberculosis
☐ Bleeding Disorders	☐ Heart Disease	☐ Parkinson's Disease	☐ Tumors, Growths
☐ Breast Lump	☐ Hepatitis	☐ Pinched Nerve	☐ Ulcers
☐ Bronchitis	☐ Hernia	☐ Pneumonia	☐ Whooping Cough
☐ Bulimia	☐ Herniated Disk	☐ Polio	☐ Other ________
☐ Cancer	☐ High Cholesterol	☐ Prostate Problem	________
☐ Cataracts	☐ Kidney Disease	☐ Psychiatric Care	________
☐ Chemical Dependency	☐ Liver Disease	☐ Rheumatoid Arthritis	________

Exercise

☐ None
☐ Moderate 1-2x/wk
☐ Daily 2-4x/wk
☐ Heavy 4-6x/wk

Work Activity

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

Habits

☐ Alcohol — Drinks/Week: ________
☐ Coffee/Caffeine Drinks — Packs/Day: ________
☐ Fruits & Vegetables — Serving/Day: ________
☐ High Stress Level — Reason: ________
☐ Water Intake — Ounces/Day: ________

Are you pregnant? ☐ Yes ☐ No Due Date: ________________

Injuries/Surgeries you have had…	Description	Date
Falls	________	________
Head Injuries	________	________
Broken Bones	________	________
Dislocations	________	________
Surgeries	________	________

Medications

____
____
____
____
____
____

Allergies

____
____
____
____
____
____

Vitamins/Herbs/Minerals

____
____
____
____
____
____