

# Health Story: Adult Practice Member

## Vital Information

Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I prefer to be called \_\_\_\_\_ SSN: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home # \_\_\_\_-\_\_\_\_-\_\_\_\_ Work # \_\_\_\_-\_\_\_\_-\_\_\_\_ Cell # \_\_\_\_-\_\_\_\_-\_\_\_\_

Preferred contact # H | W | C Email \_\_\_\_\_

Birthday \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Gender F | M

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Marital/Relationship status \_\_\_\_\_ Spouse/Partner name \_\_\_\_\_

Do you have any children? Y | N How many? \_\_\_\_\_

Names & Ages of all children \_\_\_\_\_

Reason for seeking *Total's* Services? \_\_\_\_\_

What other action steps have you taken? \_\_\_\_\_

Who can we thank for referring you to *Total Health* or how did you hear about our office?  
\_\_\_\_\_

Have you ever been adjusted by a Chiropractor? Y | N For how long \_\_\_\_\_

Who & Where? \_\_\_\_\_ Date of last adjustment? \_\_\_\_/\_\_\_\_

Do you have a Primary Care Provider? Y | N Date of last visit? \_\_\_\_/\_\_\_\_

Who & Where? \_\_\_\_\_

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

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## Stress Profile

Chiropractic care is based on the concept that the nervous system coordinates the growth, motion, sensations, immunity and overall health of your body. This vital system is protected by the bony spine, skull and pelvis. It is vital to have clear and open communication between the brain and body. Having tension and imbalances in the spinal ligaments and musculature, as well as misalignments in the bony spine can cause interference in the body's natural ability to heal and thrive.

Many of the health challenges that people face originate from stressors experienced during their birth, developmental years and adulthood. These stressors (traumas) may be any chemical, emotional or physical stress that your body cannot properly perceive, adapt to and integrate. *Total's* goal is to help your body release stored tension and the more we know about your health stressors, the more we can help you with your healing process. *Please answer the following questions to the best of your ability.*

### Birth Stress *(if known, please indicate all that apply to your own birth experience)*

- |   |   |   |
|---|---|---|
| <input type="radio"/> hospital birth    | <input type="radio"/> epidural/ meds in labor | <input type="radio"/> breast-fed                  |
| <input type="radio"/> C-section         | <input type="radio"/> induced labor           | <input type="radio"/> bottle-fed formula          |
| <input type="radio"/> vacuum extraction | <input type="radio"/> home birth              | <input type="radio"/> while pregnant, mother used |
| <input type="radio"/> forceps delivery  | <input type="radio"/> midwife/ doula          | cigarettes   alcohol   drugs                      |

Additional Comment(s) \_\_\_\_\_  
\_\_\_\_\_

### Physical Stress *(Please circle the stressors you have experienced as a child, teen and adult)*

	<b>Child</b>	<b>Teen</b>	<b>Adult</b>	<b>Never</b>	<b>Explain</b>
Serious Slips/ Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Physical/ Sexual Abuse	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Serious Falls	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on Wallet	C	T	A	N	_____
Not Enough/ Poor Sleep	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Bag/ Child	C	T	A	N	_____
Repetitive Lifting/ Bending	C	T	A	N	_____
Driving for Many Hours	C	T	A	N	_____
Long Hours of Standing/Sitting	C	T	A	N	_____
Bone Fracture	C	T	A	N	_____
Surgery	C	T	A	N	_____
Other: _____	C	T	A	N	_____

Additional Comment(s) \_\_\_\_\_  
\_\_\_\_\_

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## Chemical Stress *(Please circle the stressors you have experienced as a child, teen and adult)*

	<b>Child</b>	<b>Teen</b>	<b>Adult</b>	<b>Never</b>	<b>Explain/ Amount</b>
Smoking Cigarettes	C	T	A	N	_____
Second Hand Smoke	C	T	A	N	_____
Drinking Alcohol	C	T	A	N	_____
Environmental (ex. poor air/ water)	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs/ Medications	C	T	A	N	_____
Recreational Drugs	C	T	A	N	_____
Over the Counter Drugs (ex. Advil)	C	T	A	N	_____
High Sugar Intake	C	T	A	N	_____
Vaccinations	C	T	A	N	_____
Antibiotics	C	T	A	N	_____
Work with Chemicals/ Poisons	C	T	A	N	_____
Other: _____	C	T	A	N	_____
Additional Comment(s) _____					

## Emotional Stress *(Please circle the stressors you have experienced as a child, teen and adult)*

	<b>Child</b>	<b>Teen</b>	<b>Adult</b>	<b>Never</b>	<b>Explain</b>
Difficult Relationship/ Divorce	C	T	A	N	_____
High Job Stress	C	T	A	N	_____
High Family Stress (ex. Children)	C	T	A	N	_____
Money Stress	C	T	A	N	_____
Recurrent Physical/Mental Illness	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal/ Emotional Abuse	C	T	A	N	_____
Perfectionist Personality	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness/ Loss of Loved One	C	T	A	N	_____
Body Image Issues	C	T	A	N	_____
Other: _____	C	T	A	N	_____
Additional Comment(s) _____					

## Nutritional Background

Please Check all that apply:

- Vegetarian | Vegan     
  Skip Meals     
  Vitamins: \_\_\_\_\_  
 Junk Food ( \_\_\_\_ x per week)     
  Water ( \_\_\_\_ glasses per day)     
 \_\_\_\_\_

Do you relate any of your nutritional experiences to your current state of health? Y | N

Additional Comment(s) \_\_\_\_\_

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## Questions for Women

Currently Pregnant Y | N How far along? \_\_\_\_\_ Known Complications? \_\_\_\_\_  
Past Pregnancy Y | N How many? \_\_\_\_\_ Date of last \_\_\_/\_\_\_/\_\_\_\_\_ Check all that apply:

Birth Control Pill/ Patch/ Ring Currently | Past | Never For how long? \_\_\_\_\_  
Painful Periods Currently | Past | Never  
Irregular Cycles Currently | Past | Never

Additional Comment(s) \_\_\_\_\_

## System Challenges

Has your body communicated any of the following to you? Although these may seem unrelated to the reason you are seeking care, your nervous system coordinates all your body functions and these could serve as indicators that your nervous system is being challenged. Please mark all that apply.

- |  |  |   |
|--|--|---|
| <input type="radio"/> Neck Pain              | <input type="radio"/> Loss of Sleep              | <input type="radio"/> Fatigue                     |
| <input type="radio"/> Headaches              | <input type="radio"/> Tension Between Shoulders  | <input type="radio"/> Asthma/ Breathing Problems  |
| <input type="radio"/> Allergies              | <input type="radio"/> Chest Pain                 | <input type="radio"/> Hypo/Hyper Thyroid          |
| <input type="radio"/> Ringing in Ears        | <input type="radio"/> Shortness of Breath        | <input type="radio"/> Low Back Pain               |
| <input type="radio"/> Vertigo/ Dizziness     | <input type="radio"/> Heartburn                  | <input type="radio"/> Constipation/ Diarrhea/ Gas |
| <input type="radio"/> Nose Bleeds            | <input type="radio"/> Rashes/ Eczema             | <input type="radio"/> Digestion/ GI Problems      |
| <input type="radio"/> TMJ                    | <input type="radio"/> Heart Conditions           | <input type="radio"/> Stomach Problems            |
| <input type="radio"/> Sinus Problems         | <input type="radio"/> High Blood Pressure        | <input type="radio"/> Ulcers                      |
| <input type="radio"/> Double Vision          | <input type="radio"/> High Cholesterol           | <input type="radio"/> Urinary Changes             |
| <input type="radio"/> Decreased Taste/ Smell | <input type="radio"/> Anemia                     | <input type="radio"/> Prostate Changes            |
| <input type="radio"/> Fever                  | <input type="radio"/> Numbness in Arms/Legs      | <input type="radio"/> HIV                         |
| <input type="radio"/> Anxiety                | <input type="radio"/> Tingling/ Cold Hands/ Feet | <input type="radio"/> PMS                         |
| <input type="radio"/> Depression             | <input type="radio"/> Weight Changes             | <input type="radio"/> Diabetes                    |
| <input type="radio"/> ADD/ ADHD              | <input type="radio"/> Sweats/ Chills             | <input type="radio"/> Arthritis                   |
| <input type="radio"/> Stroke                 | <input type="radio"/> Cancer (Type: _____)       | <input type="radio"/> Insomnia                    |
| <input type="radio"/> Other _____            | <input type="radio"/> Other _____                | <input type="radio"/> Other _____                 |

## Other Avenues of Healing

Have you had or do you use any of the following to optimize your growth, healing or development?  
Please mark all that apply.

- |   |   |  |
|---|---|--|
| <input type="radio"/> Massage/ Bodywork             | <input type="radio"/> Naturopathic Medicine | <input type="radio"/> Personal Training        |
| <input type="radio"/> Acupuncture                   | <input type="radio"/> Vitamins/ Supplements | <input type="radio"/> Nutritional Cleansing    |
| <input type="radio"/> Yoga/ Pilates/ Dance/ Tai Chi | <input type="radio"/> Nutritionist          | <input type="radio"/> Consuming Organic Foods  |
| <input type="radio"/> Meditation                    | <input type="radio"/> Physical Therapy      | <input type="radio"/> Emotional/ Psychotherapy |
| <input type="radio"/> Homeopathy/ Herbalist         | <input type="radio"/> Running               | <input type="radio"/> Other _____              |

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## Life Inventory

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

1= Extremely Dissatisfied

10= Completely Fulfilled

Energy Level	_____	Quality of Sleep	_____
Clarity of Thought	_____	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	_____

## Clarifying Your Intentions

People see chiropractors for a variety of reasons. Some go for the relief of symptoms, some go to correct the *origin* of the symptoms and others go to balance their body and optimize their vitality and health. What do you hope to receive from our care? (i.e. abundant health, increased immunity, pain relief, balanced body, safer pregnancy, better adaptability to life stressors, etc.) \_\_\_\_\_

\_\_\_\_\_

What is your level of commitment to yourself, your health and wellbeing? High | Medium | Low

**I have reviewed and certify that all of the information that I have reported above is true to the best of my knowledge.**

Practice Member Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

## Welcome to Total Health...

Thank you for choosing Total Health & Rehab Family Chiropractic and giving us the opportunity to serve you! We are committed to providing you an exceptional chiropractic and healing experience. We are excited to work with you and help you thrive in an active and healthy lifestyle. If at any time during care you have questions, please do not hesitate to ask. All of your questions, even ones you haven't thought of yet, will be answered on your second visit during your doctor's report. We look forward to you joining our health family.

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## Authorization

- I give permission to Total Health & Rehab to use my address, email address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about healthcare and health related information.
- If Total Health & Rehab contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give Total Health & Rehab permission to use my name on a welcome board and referral board
- I give Total Health & Rehab permission to use my photograph on their bulletin board and other informational material such as their brochure, website, and articles in print media.
- I give Total Health permission to use any testimonial written by me for informational purposes such as sharing with other clients, prospective clients, in brochures, on their website, or in ads in print media.
- I give Total Health permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my health information during the course of care. Should I need to speak with the chiropractor at any time in private, the chiropractor will provide a room for these conversations.
- By Signing this form, you are giving Total Health & Rehab permission to use and disclose your protected health information with the directives listed above.

This authorization will remain in effect for the duration of my care at Total Health & Rehab or until revoked by me. You have the right to revoke this authorization in writing at any time. However, your written request to revoke this authorization is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this authorization by mailing or hand delivering a written notice to Total Health. The written notice must contain the following information: your name, social security number, date of birth, a clear statement of your intent to revoke this authorization, date of request and your signature. The revocation is not effective until it is received by Total Health.

You have the right to refuse to sign this authorization. If you refuse to sign this authorization, Total Health & Rehab will still provide care. A copy of this signed form will be provided upon request.

Printed Name of Practice Member: \_\_\_\_\_

Practice Member Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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## Terms of Acceptance

Our purpose in sharing this statement of clinical objectives is to clearly define our approach to Chiropractic, healing and those we serve in this office. We wish to clearly communicate our responsibilities in this exciting relationship. The following concepts are central to the way in which we practice Chiropractic. We are pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

There is intelligence within each individual that not only keeps that person alive, but also coordinates, repairs, renews and heals every cell of the body. The nervous system is the main distribution center and coordinating system for this innate intelligence. Proper coordination, repair, movement, healing and genetic potential cannot be fully expressed when this life power and intelligence is blocked or redirected. The purpose of chiropractic adjustments given in this office is to correct vertebral subluxations, allowing a greater communication of this life power and coordinating intelligence thus promoting better health.

Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible and subluxation-free spine and nervous system. Symptoms are not necessarily a sign of illness, they can occur to alert the individual of the need for change. Specific location of symptoms does not correlate to specific subluxations needing to be adjusted. Severity of symptoms does not correlate to severity of subluxations. The reduction of symptoms is not an effective indicator of improved health. An individual may have symptoms and not need an adjustment on a particular visit. An individual may have no symptoms and may require extensive adjustments on a particular visit. A person's symptoms are not necessarily in direct relationships to his or her prognosis. We do not treat specific symptoms, conditions or ailments, other than vertebral subluxations. We do not imply that any particular adjustment or series of adjustments will have a direct effect on any symptoms or condition a person may be presenting. Research studies show thousands of patients receiving chiropractic adjustments report improved physical and emotional health and well-being. We encourage any individual having concerns about symptoms or ailments to consult with a disease or symptom care specialist.

By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time required for spinal correction. Medication levels for an inflexible body-mind stuck in sickness are not necessarily the same as for a body becoming well. We will not venture into the practice of medicine by advising about the need for reduction of medications. We suggest you speak with your physician to determine the objective and goal to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind. Consistent with the above concepts, we locate and adjust vertebral subluxations using the techniques we believe to be the most honoring and effective.

At Total Health & Rehab, we educate our practice members as to the inherent healing capabilities of the human body. We encourage and empower our practice members to become aware and responsible for their wellbeing. Our intention is to provide you with the best care that we can offer as described above. We do not offer care with the intent of "treating" or "curing" disease or conditions. If during the course of care we encounter non-chiropractic unusual findings, we will advise you of those findings and recommend that you see the services of another health care provider.

## Informed Consent

Chiropractic care, like all forms of health care, while offering considerable benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care in this Chiropractic office, a health story and spinal examination will be completed. These procedures are performed to assess your overall health and, in particular, your spine health. These procedures will assist us in determining if chiropractic care is appropriate, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

I \_\_\_\_\_ have completely read and understand the above statements and choose to receive care.

Practice Member Signature **X** \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_