

Life Expressions

Personal History

NAME: _____ DATE: _____

ADDRESS: _____ PHONE: _____
Street City State Zip Cell: _____

DATE OF BIRTH: _____ MARITAL STATUS: S P M D W

E-MAIL: _____ OCCUPATION: _____

EMPLOYED BY: _____ EMPLOYERS PHONE: _____

NAME OF SPOUSE/PARENT: _____

NAME AND AGE OF ALL CHILDREN: _____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

REASON FOR CONSULTING THIS OFFICE? _____

HAVE YOU SEEN ANYONE ELSE FOR ABOVE ? YES - NO WHO? _____ WHEN? _____

WHAT WAS THE OUTCOME? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES or NO DATE OF LAST ADJUSTMENT? _____

CHIROPRACTOR'S NAME: _____

HEALTH GOAL?(circle) Patch up, Regain health, Maintain health, Expand level of Well-being
Clarify: _____

YOU AND YOUR FAMILY'S HEALTH is the most valuable asset in the world -. Chiropractic brings peace and ease to your body and life. The adjustments will restore and ENHANCE the full function and communication within your body, from the brain to every cell, tissue and organ. As you receive adjustments your Innate Intelligence will express your fullest potential for life and healing. In this office we do not treat symptoms and diseases. We offer true healing through Chiropractic. Healing includes taking responsibility for your health and meeting your financial obligations. The insurance industry pays for the treatment of symptoms and disease rather than the expense of our well being. Chiropractic is not a treatment nor cure of disease. Therefore, we require your "investment" to be paid at time of service. However, you may submit your claims for your own personal reimbursement. Your insurance policy is between you and your insurance company, not between your insurance company and us.

I CLEARLY UNDERSTAND AND AGREE that all services rendered to me are charged directly to me and that I am personally responsible for payment. I accept Chiropractic based on the above information, my signature below will serve as consent for service.

SIGNATURE Date

GUARDIAN'S SIGNATURE Date

(PLEASE COMPLETE REVERSE SIDE)

PLEASE FILL OUT THE FOLLOWING QUESTIONS COMPLETELY AND HONESTLY.
THESE ANSWERS WILL HELP US PROVIDE YOU WITH THE BEST SERVICE.

PHYSICAL STRESS:

Have you ever had any falls, auto collisions, or injuries? If yes, briefly describe: _____

Have you ever had any surgery? If yes, briefly describe: _____

Did you experience any birth trauma? If yes, when and how: _____

Please circle your level of physical activity: LOW MODERATE HIGH

CHEMICAL STRESS:

How would you describe your diet? Meat Fruits Vegetables Breads, Grains, & Cereals
Circle your level of intake: O L M H O L M H O L M H O L M H
(0-None L-Low;;)
(M-Moderate H-High;) Sugar (candy, snacks, etc....) Dairy Products
 O L M H O L M H

Check the following products you use and circle: Tobacco____ Soda, Coffee, Tea____ Alcohol____
the level of use O L M H O L M H O L M H

Do you take medications (drugs)? If yes, for what and how long: _____

EMOTIONAL STRESS:

Please describe your level of stress in any areas of your life such as work, home, school, relationships, children,
loss of a love one, divorce, separation, finances, etc. _____

This information is accurate to the best of my knowledge.

Signature

PLEASE DO NOT WRITE BELOW THIS LINE

