FULL LIFE CHIROPRACTIC

PATIENT INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ____/____/____

ADDRESS: _____ **CITY** _____ **STATE** ____ **ZIP** _____

E-MAIL ADDRESS: _____

HOME PHONE #: _____ **CELL #:** _____

EMPLOYER: _____ **OCCUPATION:** _____

SEX: ❑FEMALE ❑MALE **MARITAL STATUS:** ❑SINGLE ❑MARRIED ❑DIVORCED ❑WIDOWED

Approx. Height:_____ **Approx. Weight:**_____ **Age:**_____

Do you experience any of the following conditions even if they are minor and go away on their own?

___High Blood Pressure	___Diabetes	___Headaches	___Hypoglycemia
___Cancer	___Neck Pain	___Upper Back Pain	___Thyroid Problems
___Heart Disease	___Digestive Problems	___Arthritis	___Chronic Fatigue
___Fibromyalgia	___Numbness	___Stress/Irritability	___Sinus/Allergy
___Hip/Knee Pain	___Osteoporosis	___Chronic Inflammation	___Other

How did you find out about our weight loss program? _____

(personal referral, website, facebook, event booth, radio, TV, printed ad, on-line search)

Are you currently **pregnant, breast feeding, have active cancer, or cholecystitis (active gall bladder attacks)**? Yes❑ No❑

(***If yes, you are not eligible to participate in this program)***

Are you currently scheduled for any surgeries or procedures or traveling out of town in the next 10 weeks? **Yes❑ No❑**

Are you interested in the following?

❑ Non-invasive Laser Body Sculpting Program ❑ Physician Supervised Weight Loss Program ❑ Both

At what age did you first have trouble with weight?_____ How much weight have you decided to lose? _____

What was your highest weight and at what age?_____What was your lowest adult weight and at what age? _____

What do you consider to be barriers to weight loss? _____

Have you ever suffered from an eating disorder such as bulimia or anorexia? _____

Why do you currently want to lose weight? _____

Have you tried other programs? If so, what were your results? _____

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Do you consider your health an expense or an investment? _____

Do you currently have any open wounds? Yes❑ No❑

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REVIEW OF SYMPTOMS

Check box if you have any of the following symptoms:

Respiratory

❑ shortness of breath

gain

❑ congestion

palpitations

loss

❑ cough

veins

appetite

❑ short of breath on exertion

Endocrine

sensation

❑ cold intolerance

❑ heat intolerance

Ophthalmology

Female Reproductive

❑ pregnant

❑ menopause

Hematology

❑ easy bruising

❑ bleeding

Psychology

❑ depression

❑ anxiety

Cardiology
General

❑ chest pain

❑ weight

❑

❑ weight

❑ varicose

❑ loss of

❑ sweating

❑ fevers

❑ swelling

❑ weakness

❑ fluttering

❑ fatigue

❑ high stress

❑ diminished vision

❑ blurring of vision

❑ loss of vision

❑ vision floaters

Neurology

❑ headaches

❑ tingling

❑ fainting

❑ dizziness

❑ difficulty walking

❑ memory loss

❑ increased thirst

Gastroenterology

❑ nausea

❑ heartburn

❑ constipation

❑ diarrhea

❑ difficulty swallowing

❑ indigestion

❑ abdominal pain

Male Reproductive

❑ difficulty with erection

Urology

❑ frequent urination

❑ difficult or painful urination

❑ blood in urine

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Operations and/or Hospitalizations:

Dermatology

- ❑ rash
- ❑ flushing
- ❑ wound
- ❑ dry skin

Musculoskeletal

- ❑ joint pain
- ❑ leg cramps
- ❑ back pain
- ❑ arm pain
- ❑ neck pain
- ❑ leg pain
- ❑ muscle pain

Reason	Date	Reason	Date

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE CURRENTLY TAKING

NAME OF DRUG/SUPPLEMENT	DOSAGE	REASON

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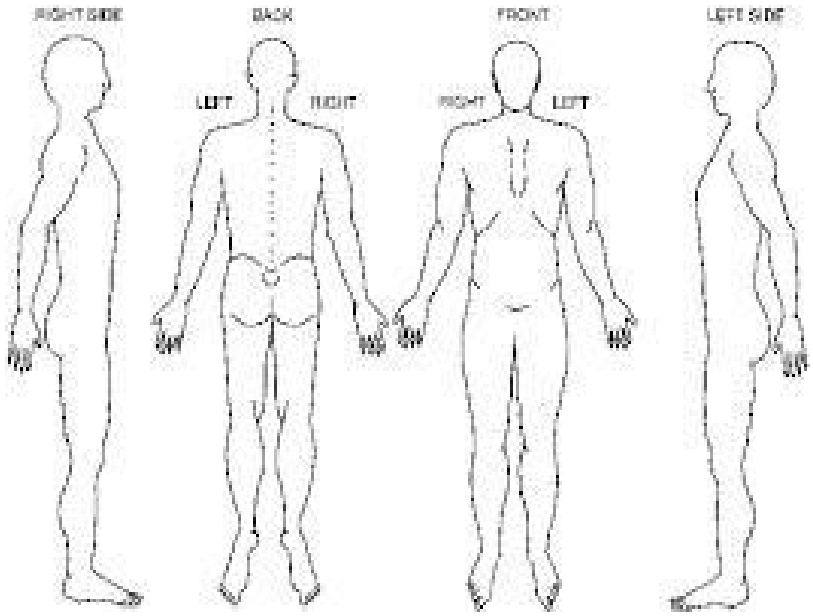
PHYSICIAN INFORMATION

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

AREAS OF THE BODY THAT YOU WANT TO CHANGE



ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have received the Full Life Chiropractic Notice of Privacy Practices. I understand that my protected health information may be used as described in the notice.

Printed Name _____ Signature _____ Date _____