FULL LIFE
CHIROPRACTIC

New Patient Paperwork - Adult
Today's Date: _____

Acct #_____

Name: Birthdate: Sex: Gender:

Occupation: Height: ' " Weight:

Marital Status: No. of Children:

Address:

Email: Phone number:

How did you hear about us?

Emergency Contact:

Are you currently under the care of another health practicioner?

Please list any current supplements or medications you are taking:

Have you ever seen a chiropractor before? ☐ yes ☐ no

Do you intend to submit for insurance ☐ yes ☐ no If yes, who is your provider?

Reason for seeking chiropractic care:

☐ Improve my physical symptoms ☐ Help with a difficult symptom or diagnosis ☐ Improved quality of life
☐ Improve my ability to respond to stressors In my life ☐ Something else:

Current health condition: **☐ I do not have a complaint. I am seeking wellness care.**

What health concern is bringing you into the office? _____
On a scale of 1-10, 10 being the worst, what is the severity of your symptom? 1 2 3 4 5 6 7 8 9 10
Have you ever had this before? ☐ yes ☐ no When did this begin: _____ Did It begin: ☐suddenly ☐ gradually
Have you seen anyone else for this condition? ☐ yes ☐ no If so, who? _____
How often does this bother you? ☐constantly ☐occasionally ☐randomly
Since this started, does It seem to be getting better or worse? _____
What makes this better? _____
What makes It worse? _____
What does It feel like? _____
Is the pain worse at a particular time of day? ☐ am ☐ pm ☐ unaffected by time of day

Please use the space below to add any additional details you would like the doctor to know about what brings you in today.

The focus of our office is not only to get you out of pain, but to improve function so that they can live out the fullest expression of their life. Do you have any health goals beyond pain reduction?

1. _____
2. _____
3. _____

Cumulative stress has a negative impact on our body's ability to adapt to our environment. When we can't adapt optimally, disease, dysfunction, and degeneration can result. Please check any of the following that apply to you.

Physical Stress	Emotional Stress	Chemical Stress
☐Birth Trauma	☐Relationships	☐Artificial Fragrances
☐Slip/Fall	☐Career	☐Current Smoker
☐Car Accidents	☐Family	☐Past Smoker
☐Sports Injuries	☐Financial	☐2nd hand smoke
☐Physical Abuse	☐Pace of Life	☐Caffeine
☐Heavy Physical Labor	☐Quick temper	☐Alcohol
☐Poor Posture	☐Holding in feelings	☐"Diet/sugar-free" food
☐Heavy computer use	☐Perfectionism	☐Soda intake
☐Heavy phone use	☐Procrastination	☐Prescription drugs
☐Repetitive movements	☐Depression	☐Junk food
☐Prolonged driving/standing	☐Anxiety	☐Recreational drugs
☐Previous Surgery	☐Prioritizing others above self	

Please describe in more detail any of the *physical stressors* you checked off above: _____

_____

_____

Please describe in more detail any of the *emotional stressors* you checked off above: _____

_____

_____

Please describe in more detail any of the *chemical stressors* you checked off above: _____

_____

_____

Overall State of Health

We do not simply see you as a set of symptoms to diagnose, but as a person who wants their life back. We know that optimal living is not merely the absence of symptoms, but on truly optimizing your life experience and cultivating health.

In general, would you say your health is: ☐ excellent ☐ good ☐ fair ☐ poor

What do you feel is the biggest stress in your life? _____

What are the 2 healthiest habits you currently have? _____

What are the 2 habits you would like to change?_____

Why Is your health Important to you? What is poor health preventing you from doing? _____

_____

Has your weight varied In the last 5 years? ☐Yes, gained ☐ Yes, lost ☐ No

If so, by how much, and what do you attribute the weight change to?

Sleep

How many hours do you sleep each night? _____ Do you wake rested? ☐ yes ☐ no
Do you have difficulty falling sleep? ☐ yes ☐ no Difficulty staying asleep? ☐ yes ☐ no

Exercise

Frequency: ☐ none ☐1-2x per week ☐3-5x per week ☐daily
What type of exercise:_____

Check All Current Problems You Have

☐ Dizziness	☐ Throat Issues	☐ Kidney Problems	☐ Liver Disease	☐ Disc Problem
☐ Headaches	☐ Asthma	☐ Mid Back Pain	☐ Shoulder Pain	☐ Infertility
☐ Vertigo	☐ Ulcers	☐ Irritable Bowel	☐ Chronic Fatigue	☐ Gastric Reflux
☐ Ear Infections	☐ Numbness in Arms	☐ Sciatica	☐ Lupus	☐ Other
☐ Nausea	☐ Numbness in Hands	☐ Numbness in Legs	☐ Fibromyalgia	_____
☐ TMJ	☐ Menstrual Disorder	☐ Numbness in Feet	☐ Chest Pain	_____
☐ Neck Pain	☐ Heart Disorders	☐ Low Back Pain	☐ Arm Pain	_____
☐ Migraines	☐ Stomach Disorders	☐ Hip Pain	☐ ADD/ADHD	_____
☐ Anxiety	☐ Bladder Problems	☐ Leg Pains	☐ Nervousness	_____
☐ Chronic Sinus	☐ Thyroid Problems	☐ Knee Pain	☐ Epilepsy	_____

Have you ever seen other doctors for these conditions? ☐ Yes ☐ No

If Yes: ☐ Chiropractor ☐ Medical Doctor ☐ Other_____

Who & When? _____

Name of Primary Care Physician _____

Check Any Condition You Have Now/Have Had:

☐ Stroke	☐ Cancer	☐ Heart Disease	☐ Spinal Surgery
☐ Scolosis	☐ Diabetes	☐ Spinal Bone Fracture	☐ Seizures

List all surgical operations & years_____

_____

List all over-the-counter & prescription medications you are on, and the reason for each_____

_____

Were you ever in an auto accident? If so, when?_____

Have you ever been knocked unconscious? ☐ Yes ☐ No

If so, please describe_____

Other trauma _____

Activities of Life

Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

Activities	No Effect	Painful (can do)	Painful (limits)	Unable to Perform
Carrying Groceries				
Lifting Groceries				
Sit to Stand				
Climbing Stairs				
Pet Care				
Driving				
Extending Computer Use				
Household Chores				
Lifting Children				
Concentration (Reading)				
Bathing				
Dressing				
Shaving				
Sexual Activities				
Sleep				
Static Sitting				
Static Standing				
Yard Work				
Walking				
Washing/Bathing				
Sweeping/Vacuuming				
Dishes				
Laundry				
Garbage				
Dressing				
Other:				

Please sign below to acknowledge that the information written in this form is true and representative of your current state of health.

Signature: Date:

Notice of Privacy Practices Acknowledgement

Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

initial _____ The undersigned certifies that he/she has read the foregoing, received a copy of the Notice of Privacy Practices and is the patient, or the patient's personal representative.

Medical Record Release

initial _____ I hereby authorize Full Life Chiropractic to release medical records to my primary care provider, Dr._____ at _____.

_____ I do not authorize Full Life Chiropractic to release medical records to my medical provider,.

Photo Release

initial _____ I authorize Full Life Chiropractic to take pictures of me and/or my family in the office for use on social media and/or advertising.

_____ I do not authorize Full Life Chiropractic to photograph my child or my family.

X-Ray Authorization

As your healthcare provider, we are legally responsible for your chiropractic records. We must maintain a record of your x-rays in our files. At your request, we will provide you with a copy of your x-rays in our files. Please Note: X-rays are utilized in this office to help locate and analyze vertebral subluxations. These x-rays are not used to investigate for medical pathology. The doctor of Chiropractic does not diagnose or treat medical conditions. However, if any abnormalities are found, we will bring it to your attention so that you can seek proper medical advice.

initial _____ By signing below, you are agreeing to the above terms and conditions.

Female Patients Only:

initial _____To the best of my knowledge, I BELIEVE I AM NOT PREGNANT at the time x-rays are taken at Full Life Chiropractic..

_____

Name of Patient Signature of Patient Date

Informed Consent to Chiropractic Treatment

There are risks and possible risks associated with the manual therapy techniques used by doctors of chiropractic. In particular you should note:

A. While rare, some patients may experience short term aggravation of symptoms or muscle and ligament strains or sprains as a result of manual therapy techniques. Although uncommon, rib fractures have also been known to occur following certain manual therapy procedures;

B. There are rare reported cases of disc injuries identified following cervical and lumbar spinal adjustment, although no scientific evidence has demonstrated such injuries are caused, or may be caused, by spinal adjustments or other chiropractic treatment;

I acknowledge I have read this consent and I have discussed, or have been offered the opportunity to discuss, with my chiropractor the nature and purpose of chiropractic treatment in general, (including spinal adjustment), the treatment options and recommendations for my condition, and the contents of this consent.

I consent to the chiropractic treatment recommended to me by my chiropractor including and recommended spinal adjustments.

I intend this consent to apply to all my present and future chiropractic care.

Dated this _____ day of _____, 20____.

_____

Patient Signature (Legal Guardian) Witness of Signature

_____

Name Name