VIDA Chiropractic Studio

Getting Acquainted...

Date ___________________

Name____

Address____ City________________Zip_________________

Email Address____ Date of Birth_____________________

Occupation____

Home Ph______________________ Business Ph______________________ Cell Ph_____________________

Best number to contact you: (check one) [ ] Home [ ] Business [ ] Cell

Marital Status:(check one) [ ] Married [ ] Domestic Partner [ ] Single [ ] Widowed [ ] Divorced

Name of Spouse/Partner________________________________Do you have children? [ ] Y [ ] N

Reason for seeking services at VIDA Chiropractic Studio?

Who can we thank for referring you to us? ____

Is there anything about your Nerve system and/or Spine we should know about? (previous surgeries etc.)

What is your level of commitment to yourself, your life and well-being?
[ ] High [ ] Medium [ ] Low

Insurance Information:
Do you have insurance: [ ] Yes [ ] No Would you like to apply your benefits? [ ] Yes [ ] No
If yes, please supply your insurance card and driver's license

Name: ______________________________ Date: ______________________________

Do you use or have you used any prescription, over the counter and or recreational drugs? If yes, please list

Any other health related concerns/challenges? Any previously accepted diagnosis?

DO YOU EXPERIENCE ANY OF THE FOLLOWING SYMPTOMS/PROCESSES?

(check all that apply)

[ ] Headaches	**[ ]** Allergies	**[ ]** HIV	**[ ]** Shortness of breath
[ ] Neck Pain	**[ ]** Chest Pain	**[ ]** Cancer	**[ ]** High Blood Pressure
[ ] Low Back Pain	**[ ]** Loss of Balance	**[ ]** Sweats	**[ ]** Loss of Smell or Taste
[ ] Weight Trouble	**[ ]** Heart Conditions	**[ ]** Depression	**[ ]** Numbness in Arm/Leg
[ ] Stomach Problems	**[ ]** Nervousness	**[ ]** PMS	**[ ]** Tension across tops of shoulders
[ ] Ringing in Ears	**[ ]** Vertigo	**[ ]** Other______________________________	

What is your average sleep/rest per day? (hours per night, naps etc.)______________________________

What is your quality of sleep? **[ ]** Good **[ ]** Fair **[ ]** Poor

Do you wake up refreshed? **[ ]** Yes **[ ]** No

Subluxations are areas in our body where there is interference in the body's communication system, similar to a shorted circuit, such as a short-circuited hair dryer. These patterns of interference are known to be caused by different stressors that in essence create a less the optimal flow of information within the body.

Do you recognize any of these stresses? Circle when in your life you experienced these.
(C = child T = teenagers A = adult N=not al all)

1. Physical Stress					EXPLAIN
Birth Traumas (as a mother or a child)	C	T	A	N	____________________
Slips/Falls	C	T	A	N	____________________
Car Accidents	C	T	A	N	____________________
Sports Injuries	C	T	A	N	____________________
Physical Abuse	C	T	A	N	____________________
Work Injuries	C	T	A	N	____________________
Poor Posture	C	T	A	N	____________________
Sitting on our wallet for years	C	T	A	N	____________________
Sleeping on Stomach	C	T	A	N	____________________
Extensive Computer Work	C	T	A	N	____________________
Carrying Heavy Purse/Bookbag/Child	C	T	A	N	____________________

Name: ______________________________ Date: ______________________________

Repetitive Lifting/Bending	C	T	A	N	________
Driving for Many Hours	C	T	A	N	________
Continuous Standing/Sitting	C	T	A	N	________
Bone fracture/Surgery	C	T	A	N	________

2. Emotional Stress

Relationships	C	T	A	N	________
Career	C	T	A	N	________
Children	C	T	A	N	________
Money	C	T	A	N	________
Hold in Feelings	C	T	A	N	________
Quick Tempered	C	T	A	N	________
Verbal Abuse	C	T	A	N	________
Procrastinator	C	T	A	N	________
Sickness or Loss of Loved One	C	T	A	N	________

3. Chemical Stress

Environment (i.e. pollution)	C	T	A	N	________
Alcohol	C	T	A	N	________
Smoker (please indicate amount)	C	T	A	N	________
Second Hand Smoke	C	T	A	N	________
Poor Diet	C	T	A	N	________
Caffeine (please indicate amount)	C	T	A	N	________
Artificial Sweeteners	C	T	A	N	________
Prescription Drugs	C	T	A	N	________
Over the Counter Drugs (i.e. Advil, Aspirin)	C	T	A	N	________

What do you feel is your primary stress? Please explain. / Additional Comments.

Have you ever received chiropractic in the past? [ ] Yes [ ] N

Chiropractor, name: ________________________ Date of Last Adjustment: ________________

Frequency of Visits: _____ times per week/month; Duration of Care: ____ weeks/months/years

-----------------------------------For Women Only-----------------------------------

Are you Pregnant?	[ ] No	[ ] Yes
Are you currently nursing?	[ ] No	[ ] Yes
Are you taking birth control pills?	[ ] No	[ ] Yes
Do you experience irregular cycles?	[ ] No	[ ] Yes
Do you experience extreme cramping?	[ ] No	[ ] Yes