PRECISE MOVES CHIROPRACTIC WELLNESS FORM

PERSONAL INFORMATION:

First Name: ____________________________ Last Name: ______________________________________

Address: __________________________________ City: ________________________ State: ___ Zip _______

Date of Birth: ________________ Age: ____ Email address: ___________________________________

Occupation: __________________________ Home Phone: ____________________________________

Employer: ____________________________ Cell Phone: ___________________________

Kids and ages: ________________________ Height: ____________ Weight: _________

How did you hear about our office? ____

HEALTH INFORMATION:

Are you visiting our office for ❑ Chiropractic ❑ Amino Frequency Therapy ❑ Other: ________________
Note: ANF is supplemental to Chiropractic or body work and is not used alone.

What brings you into our office? ____

____

Who was the last doctor who created a health development plan for you? ______________________________
What were your results? ____

What other professionals do you currently see for your health care? ❑ Massage Therapist ❑ Acupuncturist
❑ Naturopath ❑ Homeopath ❑ Medical Doctor ❑ Other _______________________

Where would you rate your general health?
❑ Excellent ❑ Very Good ❑ Good ❑ Transitional ❑ Challanged ❑ Very Challanged

Have you had previous chiropractic care? If yes, when and for what goal? ______________________________

Please list any surgeries and dates:____

____

Please list any medications you are taking:____

____

LIFESTYLE INFORMATION:

Do you exercise? ❑ Yes ❑ No
If yes, what type, how much and how often?____

Do you smoke? ❑ Yes ❑ No
If yes, how much? ____

Do you drink alcohol? ❑ Yes ❑ No
If yes, how much and how often?____

Do you drink water? ❑ Yes ❑ No
If yes, how much and how much per day? ____

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HEALTH HISTORY:

Please indicate any health concerns below even if you think it does not relate to your present health concern.
Please mark an Y for past and X for present.

Allergies	Anxiety	Immune System
Arthritis	Asthma	Breathing Issues
Bladder Problems	Cancer	Circulatory disorder
Depression	Diarrhea	Constipation
Digestive Problems	Dizziness	Headaches
Heartburn	Reflux	Fatigue
Kidney Disease	Menstrual Cramps	Mood Swings
Neck dysfunction	Numbness/Tingling	Osteoporosis
Sinus Trouble	Low back pain	Skin Conditions
Urinary Difficulty	Heart Condition	Vertigo
Difficulty sleeping	Shoulder pain	Foot pain
Other:	Other:	Other:

STRESS HISTORY:

Please circle whether you have ever experienced stress in the following areas. Your answers enable us to determine which factors have contributed to your present health concerns.

1) **Childhood**:

Car Accident	Inhaler use	Head Trauma
Vaccination	Sports	Repeated/Prolonged Antibiotic Use
Childhood Illness	Prescription Medications	Other emotional or physical Traumas: ______________________________

2) **Adulthood:**

Emotional Stress	Inhaler use	Head Trauma
Vaccination	Sports	Coffee Drinker
Prescription Medications	Extreme Sports	Emotional or Physical Traumas: _______________
Drug Use/Alcohol Abuse	Other: _________________	Other: __________________

Women only, is there a chance you're pregnant? ❏ Yes ❏ No If so, how many weeks? ______

GOALS:

Which best describes the reason you are consulting our office?

❏ Have a specific concern and require help with only this concern

❏ I want to ensure my health concerns don't become an ongoing problem impacting my future health

❏ I want to be healthier 5 years from now than I am today

I the undersigned agree that I am responsible for payment for all services rendered by Precise Moves Chiropractic. I hereby authorize any insurance rights and benefits (if applicable) directly to Precise Moves Chiropractic for services rendered. I clearly understand and agree that all services rendered me are charged directly to me and I am personally and financially responsible whether or not insurance submits payments.

Patient/Parent: ____ Date: ______________