PRECISEMOVES

WELCOME! WE ARE SO GLAD YOU ARE HERE!

We would like to get to know you so please tell us about yourself:

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Age: ____ Email address: _____

Type of work: _____ Cell Phone: _____

Employer: _____ Height: _____ Weight: _____

How did you hear about our office? _____

What brings you in to see us?_____

How did this happen? _____

Does anything make it better? _____ Does anything make it worse? _____

Where would you rank your health today on a health scale:

Excellent ❑	Very Good ❑	Good ❑	Transitional ❑	Challenged ❑	Very Challenged ❑
95-100%	90-94%	80-89%	70-79%	60-69%	0-59%

Where would you like your health to be? _____

What could make your life healthier? _____

Who was the last doctor who created a health development plan for you?

❑ Massage Therapist ❑ Acupuncturist ❑ Naturopath ❑ Medical Doctor ❑ Other _____

What was your experience? _____

Have you had previous chiropractic care? If yes, what were your results? _____

Please list any surgeries and dates:_____

_____

Please list any medications or vitamins that you are taking:_____

_____

What exercise do you enjoy and how often do you work out? _____

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

How many fruits and vegetables do you eat per day? _____

What do you do for fun? _____

Have you ever experienced any of the following: Your answers enable us to help and guide you on to your health goals. **Please mark an Y for past and X for present.**

Allergies	Anxiety	Immune System Issues
Arthritis	Asthma	Back Problem
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
Loss of balance	Liver problems	Other:

Please mark and X if you have <u>ever</u> experienced stress in the following areas.

Car Accident	Need for Inhaler use	Head Trauma/concussion
Reaction to Medication or Vaccination	Sports Injury:	Repeated/Prolonged Antibiotic Use
Childhood Illness	Emotional Stress or Trauma	Coffee Drinker
Do you Smoke? Yes/No	Alcohol or Drug Use or Abuse	Other stressful events: (list below)

Is there a chance you're pregnant? ❑ Yes ❑ No If so, how many weeks? _____

GOALS: Which best describes you?

❑ Have a specific concern and only require help with 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 to me are charged directly to me and I am personally and financially responsible whether or not insurance submits payments.

Patient/Parent: _____ Date: _____