# Welcome to
# Active Life Chiropractic & The Wellness Loft

**Print Name** _____ **Today's Date** ___ / ___ / ___

**Email** _____ **Date of Birth** _____ / _____/ _____ **Age** _____

**Street Address** _____ **City** _____ _____ **State** _____ **Zip** _____

**Phone Numbers: Home**_____ **Work** _____ **Cell** _____

***Please Check*** ✔ Sex: Male❑ Female❑ Right handed❑ Left handed❑ Married❑ Single❑

How did you hear about our office, or who referred you? _____

## Personal & Family History:

Your Occupation:_____ Work Duties _____

Spouse's health status_____

Children's ages and health status:_____

## Chiropractic History:

Have you ever been to a Chiropractor before? Yes❑ No❑ If yes Doctor's Name _____

Date of last chiropractic visit_____ How long were you under care? _____

Are other family members under chiropractic care? - Yes❑ No❑ Who? _____

## Wellness Commitment

At Active Life Chiropractic we are dedicated toward achieving the goal of total lasting health for our patients. Based on a scale of 10% to 100%, how committed are you to doing what it takes to get healthy?

**10% 20% 30% 40% 50% 60% 70% 80% 90% 100%**

## Health History:

Current health concern and reason for seeking chiropractic care:_____

Check here if you have **NO** health concerns and are seeking wellness care. ✔ [ ]

Describe any other health problems, including how long you've had them: _____

_____

**Please Fill in Below:** **If you have ever had the following *Please*** ✔

| Condition | Frequently | Occasionally | Condition | Frequently | Occasionally | Condition | Frequently | Occasionally |
|---|---|---|---|---|---|---|---|---|
| Headache | ❑ | ❑ | Skin Condition | ❑ | ❑ | Ringing in Ears | ❑ | ❑ |
| Migraines | ❑ | ❑ | Dizziness | ❑ | ❑ | Digestive Problem | ❑ | ❑ |
| Neck Pain | ❑ | ❑ | Nausea | ❑ | ❑ | Allergies | ❑ | ❑ |
| Arm/Hand Pain | ❑ | ❑ | Weakness | ❑ | ❑ | Asthma | ❑ | ❑ |
| Mid Back Pain | ❑ | ❑ | Fatigue | ❑ | ❑ | Menstrual issues | ❑ | ❑ |
| Low Back Pain | ❑ | ❑ | Nervousness | ❑ | ❑ | Fertility Problems | ❑ | ❑ |
| Leg/Foot Pain | ❑ | ❑ | Trouble Sleeping | ❑ | ❑ | Urinary Problems | ❑ | ❑ |
| Disc Problems | ❑ | ❑ | Numbness | ❑ | ❑ | Osteoporosis | ❑ | ❑ |
| Arthritis | ❑ | ❑ | Frequent colds | ❑ | ❑ | Scoliosis | ❑ | ❑ |

## Physical Stress:

Any significant injuries, falls or traumas during infancy or childhood? **Yes No Unsure**

(if yes, please explain)_____

Any significant injuries, falls or traumas during adulthood? **Yes No Unsure**

(if yes, please explain) _____

Any hospital visits? **Yes No** Explain _____

Are you in prolonged postures (ex: repetitive work, lifting, sitting, driving) **Yes No Unsure**

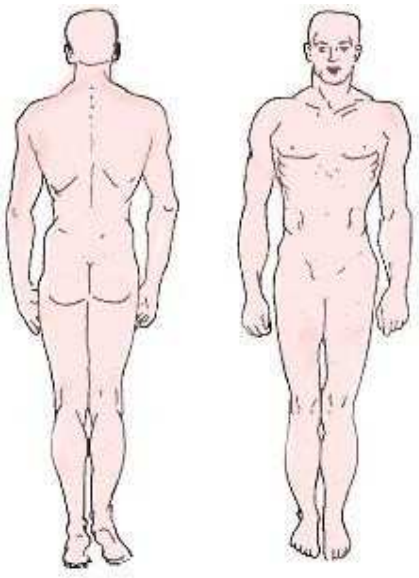
(if yes, please explain) _____

Any hobbies that are physically strenuous or have repetitive movements? **Yes No Unsure**

(if yes, please explain) _____

What is your normal exercise routine? _____

Any fractured bones or dislocations? _____



Please circle any areas you have problems.

## Chemical Stress:

Are you taking prescription or over-the-counter medications? **Yes No**
(if yes, please indicate what you are taking and why) _____

_____

Are you currently taking supplements? **Yes No**
(If yes, which ones) _____

Do you smoke? **Yes No Quit** (if yes, how often?) _____

Do you drink alcohol? **Yes No Quit** (if yes, how much?) _____

Are you happy with your diet? **Yes No** Do you wish assistance with it? **Yes No**

Do you drink bottled/ filtered water? **Yes No Occasionally**

Are you exposed to pollutants, strong smells, chemicals, aerosols? **Yes No Occasionally**

Do you eat organic? **Yes No Occasionally**

Do you use natural or environmentally friendly products in your home?
*Ex: Cleaning supplies, hair and makeup etc?* **Yes No** _____

## Mental/Emotional Stress:

Psychological stress has been show to negatively affect many systems, please let us know how you are coping with life's stresses.
***(Rank from 1 to 10 with 1 being minimal and 10 being extreme)***

Life in general ____ Work and career ____ Relationships ____ Quality of sleep ____

Financial stress ____ Time management ____ Family life ____ Health and wellbeing ____

If you are experiencing significant or ongoing stress, please explain _____

_____

Do you practice some form of stress reduction to reduce stress? **Yes No Explain** _____

_____

Are you interested in learning more about stress reduction practices? **Yes No**