

Wise Chiropractic
5875 S. Rainbow Blvd, Suite 201
Las Vegas, NV 89118
(702) 248-6292

GENERAL INFORMATION

Full Name _____ Age _____ DOB ____/____/____ Home
Phone (____) _____ Cell (____) _____ E-mail _____

Home Address _____ City _____ State ____ Zip _____

Marital Status S M D W Name of Spouse _____

Occupation _____ Business Phone _____

Whom may we thank for referring you to our office _____

Names and ages of children _____

Have your children received previous Chiropractic care? Yes No

Have you ever received Chiropractic care? Yes No With whom? _____

How often did you go? _____ Date of last visit: ____/____/____

Reason for ending care _____

Have you had spinal x-rays? Yes No What did they show? _____

Have you ever received Chiropractic Wellness care? Yes No

What hobbies or activities do you enjoy? _____

Name of current medical doctor: _____ Phone # (____) _____

Date of last medical consultation ____/____/____ Reason _____

Do you consult your M.D. on a regular basis? Yes No If so, why? _____

For women: Are you pregnant? Yes No

ABOUT YOUR HEALTH HISTORY

Throughout life, stress and traumatic events can damage your spine and nerve system. This stress may be PHYSICAL, CHEMICAL and/or EMOTIONAL. The information below will help us better understand the stress that you have experienced. We analyze this information along with your examination findings.

HISTORY OF PHYSICAL STRESS (Birth to Present)

Research indicates that the birth process causes trauma to a baby's delicate spine and nerve system. Please circle (to the best of your recollection). Was your birth:

Drug induced C section Breech Natural Home Birth Midwife Vacuum
extraction Prolonged Umbilical cord around neck Forceps Hospital

GENERAL PHYSICAL TRAUMA:

Most traumas occur in the early years (between birth and early twenty's). During that time your spine and nerve system are growing and are more vulnerable to injury.

Have you had accidents related to the following: (Circle all that apply and give dates.)

Automobile Motorcycle Bicycle Sports Other: _____

If yes, please explain: _____

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips): Yes No If yes, please explain: _____

Have you broken any bones or sprained any part of your body? Yes No

If yes, please explain: _____

Have you ever had surgery or have you been hospitalized? Yes No

If yes, please explain: _____

HISTORY OF CHEMICAL STRESS

Chemical stress occurs during life due to toxic substances that are breathed, injected, taken orally, or placed on the skin and absorbed into the body. The following will give us insight into any exposures you may have had.

Have you ever been vaccinated? Yes No How many times? 0-5 6-10 11 or more

Do you currently take? Prescription drugs, Over the counter, Recreational

Please list. _____

Have you previously been exposed to or are you currently exposed to?

Cortisone Flu shots Chemicals Fumes Dust Smoke Cigarettes

Do you consume? Alcohol Coffee Tobacco Diet Soda Fast Food Candy

HISTORY OF EMOTIONAL STRESS

Emotional stress creates tension in your spine and nerve system. Although it is common to be under stress, it can affect your overall health. Please circle the emotional stresses you have encountered.

Childhood trauma Yes No

Loss of Loved One Yes No

Divorce/Separation Yes No

Lifestyle change Yes No

Relationships Yes No

Family Yes No

Financial Yes No

Work Yes No

Illness Yes No

School Yes No

Abuse Yes No

Other Yes No

QUALITY OF LIFE

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional health? Excellent Good Fair Poor

How do you grade your nutritional health? Excellent Good Fair Poor

How do you rate your overall "quality of life"? Excellent Good Fair Poor

REASON FOR SEEKING CHIROPRACTIC CARE

What is the main reason for your visit to our office today?

Please circle the symptoms you either have now or have had within the past year.

Back pain	Numbness	Fatigue	Hair loss
Neck pain	Cold hands/feet	Ears ring	Depression
Leg/knee/foot pain	Asthma	Chest pain	Nail fungus
Shoulder pain	Allergies	Food cravings	Catch colds easy
Elbow/wrist pain	Indigestion	Skin problems	Constipation
Headaches	Hot flashes	Earaches	Diarrhea
Dizziness	Hormone problems	Sinus problems	Arthritis
Insomnia	High blood pressure	Feeling old	Other_____

Have you been Diagnosed with Cancer, Heart Disease or Severe Thyroid Disease? Yes No

Is your current health affecting any of the activities below? (Please circle)

Work: Yes No

Recreation: Yes No

Sleep: Yes No

Social life: Yes No

Walking: Yes No

Sitting: Yes No

Exercise: Yes No

Eating: Yes No

Family: Yes No

School: Yes No

Marriage: Yes No

Finances: Yes No

If your current health condition was allowed to continue for the next 5 years, how do you think it would affect you? _____

PLEASE CHECK YOUR CURRENT HEALTH GOALS

- I am only concerned with my immediate problem and want a temporary quick fix.
- I am concerned with my immediate problem and preventing its return.
- I want to achieve optimum health and well-being on every level!
- I am interested in wellness care for myself and/or my family.

Terms of Acceptance

Wise Chiropractic is a Family Wellness Center specializing in the detection, correction and prevention of vertebral subluxations (spine and nerve system problems). We do not treat or diagnose medical conditions nor dispense Pharmacological drugs. Today you will have a consultation and examination to evaluate the health of your spine and nerve system. The information will be analyzed. You will then be scheduled for a special visit with the doctor to discuss the results of your exam. If we accept your case, you will receive written recommendations outlining the steps needed to improve your health. Our methods include spinal adjustments, nutrition, rehabilitative exercises, orthotics, and stress reduction. If accepted as a patient, I give consent to any and all treatment rendered to Myself or my Children. I have also be given my HIPPA Rights as a patient.

By signing below, I understand and agree to these terms

Signature _____ Date ____/____/____

Signature of Parent (for minor): _____ Date ____/____/____