ROF ____
TY ____

Boulder Spinal Health and Wellness Center

Today's Date: _____

Name:_____
Address:_____
City:_____
State:_____Zip:_____
Home Phone:_____
Business Phone:_____
Occupation:_____
Employer: _____
E-mail:_____

Date of Birth: ___/___/___ Age:_____
Sex: M F
Marital Status: S M D W
Name of Spouse/Partner:
_____

Names and ages of Children:
_____
Insurance Carrier _____
Social Security # _____

How did you discover our office, and Network Chiropractic? _____
_____

Boulder Spinal Health and Wellness Center is dedicated to serving children, adults, and entire families. The primary focus of our office is to increase quality of life for all members of the practice. We achieve this by increasing the function of your nervous system, which allows you to better perceive, adapt to, and recover from the influences of the world around you.

Part I

Have you ever had your spine or nervous system examined professionally? _____

If Yes, when, and by whom? _____

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? _____

If yes, when was your last visit?_____
For how long were you receiving chiropractic adjustments?_____

How often did you go? _____ If you stopped, why did you stop going? _____
_____

Do you know what type of adjustments the chiropractor performed, or what techniques(s) or methods he or she used? _____

Were you pleased with his or her service?_____

Does your immediate family receive chiropractic adjustments? _____

Part II

Boulder Spinal Health and Wellness Center provides care to people of all ages and walks of life. Some of our practice members originally came to us because of painful symptoms, while others started receiving care when they were asymptomatic, because they were interested in increasing the quality of their lives. The techniques we use in this office were demonstrated to increase many areas of quality-of-life in a 3,000 patient study conducted at the University of California-Irvine medical school.

Reason you came for today's appointment?_____
_____

☐ If you came to our office today with no current health concerns, please check the box and move ahead to Part III of this form. If you currently have a health concern of which you would like us to be aware, please complete the section below.

Your Current Health Concern:

When did this concern and/or symptom begin? _____

Describe your concern and/or symptoms and how they began: _____
_____

Have you done anything about this or received any advice or treatment for it? Yes No
If yes, what was done? _____

What was different after treatment?_____
_____

Please grade the level to which this health concern affects these aspects of your functioning/ quality of life.

0- It does not seem to affect me
1- It seems to slightly affect me
2- It seems to moderately affect me
3- It seems to drastically affect me.

Work _____	Recreation/Play _____	Rest/sleep _____
Social Life _____	Walking _____	Sitting _____
Exercise _____	Eating _____	Love Life _____
Concern about this particular symptom/condition _____		Concern about Health _____
How aware of this are you during the day? _____	at night? _____	

Is there any activity during which you totally, or almost totally, forget about this condition, symptom or concern? _____

Is there any time of day which makes you more/less aware of it? _____

Why do you think this has happened or continues to happen to you? _____
_____

Do you think this is the sole cause? _____

If no, what else is involved? _____

If this condition or symptom were to go away tomorrow, what would be different about your life?
_____

Are you doing anything differently because of this condition/symptom/concern?
_____

Part III- Your Health Profile

Why Part III is important:

On a daily basis we experience physical, chemical, and emotional stresses that can accumulate and result in a serious loss of health potential. Most often the accumulation of stress is gradual and not felt until it becomes overwhelming. Answering the following questions will give us an understanding of the specific stresses you have faced in your lifetime. This will allow us to better assess the challenges to your nervous system and health potential.

Physical, Chemical, and Mental/Emotional Stresses from Birth to Present

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at and before birth. Please answer the following questions to the best of your ability.

PHYSICAL

Did your mother have a difficult birth delivery with you? Yes No Unsure
Was your delivery: Forceps Suction Drug Induced
Breech Birth C-section

Were you, or are you active in any particular sports? Yes No Unsure
Which sports?_____
Have you ever been injured in these sports? _____

Have you had any serious falls? Yes No Unsure
Please Describe _____

Have you been in any car accidents? Yes No
Please list approximate dates and severity (Mild, Moderate, or Extreme) _____
_____

Have you been in any accidents involving a bus, bicycle, motorcycle, train, airplane, or other type of vehicle? Yes No

Have you ever been knocked unconscious? Yes No Unsure
Comments:_____

Have you ever broken any bones? Yes No Unsure
Which ones? _____

Have you ever been hospitalized? Yes No Unsure
If yes when and what was actually done to you?_____
_____

Have you had surgery? Yes No Unsure
When and what kind of surgery?_____

CHEMICAL

Were you vaccinated? Yes No Unsure

Are you now taking any drug (prescription or over-the-counter) regularly? Please list:

_____

_____

How long do you expect to be using the medication(s)?_____

When was your last appointment with your prescribing physician? _____

In the past have you taken any medication regularly? (For example, prolonged use of antibiotics or an inhaler) _____

_____

Do you currently take any nutritional supplements and/or herbs? If so, which ones:

_____

Do you, or have you worked with any chemical, fume, dust, powder, and/or smoke for prolonged periods? Yes No Unsure

How often do you consume the following? D-Daily W-Weekly FW-Few Times Weekly M-Monthly FM-Few Times Monthly

Alcohol _____	Eggs _____	Beef _____
Coffee _____	Canned vegetables _____	Poultry _____
Tobacco _____	Raw vegetables _____	Fish _____
Artificial Sweetners _____	Fruit _____	Seafood _____
Soda _____	Whole Grains _____	Weight Control Diet _____
Diet Food _____	Dairy (milk products) _____	Fasting _____
Refined Sugar _____	Fried Foods _____	Organic Foods _____

How many cups of water do you drink in a day?_____ The type of diet I usually follow is: _____

MENTAL/EMOTIONAL

Please write in "P" for past or "C" for current.

	MILD	MODERATE	SEVERE		MILD	MODERATE	SEVERE
Childhood Stress	____	____	____	Work Related Stress	____	____	____
School Stress	____	____	____	Stress of Commuting	____	____	____
Financial Stress	____	____	____	Change in Lifestyle	____	____	____
Family Stress	____	____	____	Change in Vocation	____	____	____
Personal Relationships	____	____	____	Abuse	____	____	____
Stress of Being Sick	____	____	____	Loss of Loved One	____	____	____

How do you grade your emotional/mental health? Excellent Good Fair Poor Getting better Getting worse

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

When you feel ill, why do you feel you are ill?_____

When you feel well, why do you feel you are well? _____

Is there anything you can tell us that may help to serve you better?_____

_____

THANK YOU!