****

**Life Source Chiropractic, LLC**

***“Experience the Difference”***

**NOTE: This office is an Affordable Alternative to Insurance Offices. We do not file, accept nor provide Insurance Billable Forms. This allows us to keep our fees low.**

**General Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_

Phone – Best number to reach you (H) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ⁪ Male ⁪ Female \_\_# Children ⁪ Married ⁪ Single ⁪ Widowed

**Email Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who Can We *THANK* for Referring You?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary Reason For This Visit:**

**What do you want: \_\_\_\_Relief Only \_\_\_Get Well \_\_\_Stay Healthy \_\_\_Best Life Possible**

**In Order of Severity, list your Present Complaint(s):** **Rate your Pain**

 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 1 2 3 4 5 6 7 8 9 10

**How does this affect your life?**  Irritable  Loss of Energy  Difficult Sleeping  Work Loss

**How long have you had this problem?** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Since it began, is it the….. \_\_\_ Same \_\_\_ Better \_\_\_ Worse \_\_\_ Variable**

**What makes it better? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**What makes it worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Is this related to an injury? \_\_\_\_ Yes (Date of Injury: \_\_\_\_\_\_\_\_\_\_) \_\_\_\_ No

If Yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Doctors seen for this condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any current medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you using any home remedies? If so, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Accidents (Motor Vehicle/Work/Falls) & Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgeries & Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Symptoms: Please check each symptom that you have now or have had in the past. Even though they may seem unrelated to the purpose of this visit, they can have an effect on your overall health and care plan.

\_\_\_ Headaches \_\_\_ Migraines \_\_\_ Neck Pain/Stiffness \_\_\_ Back Pain/Stiffness \_\_\_ Stress/Tension

\_\_\_ Dizziness \_\_\_ Depression \_\_\_ Irritability/Anger \_\_\_ Anxiety/Nervousness \_\_\_ Fatigue

\_\_\_ Loss/Smell \_\_\_ Allergies \_\_\_ Sinus Problems \_\_\_ Loss/Taste \_\_\_ Loss/Balance

\_\_\_ Cold Sweats \_\_\_ Cold Feet \_\_\_ Cold Hands \_\_\_ Diarrhea/Constipation \_\_\_ Buzz/Ringing Ears

\_\_\_ TMJ \_\_\_PMS \_\_\_ Menopause \_\_\_ High Blood Pressure \_\_\_ Diff Sleeping

\_\_\_ Heartburn \_\_\_ Hot Flashes \_\_\_ Impotence/Infertility \_\_\_ Miscarriage \_\_\_ Diff Urinating

\_\_\_ Pins/Needles in Arms/Hands \_\_\_ Pins/Needles in Legs/Feet \_\_\_ Shortness of Breath \_\_\_ Infections

\_\_\_ Eyes Sensitivity \_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Family history of: Heart Disease Arthritis Cancer Diabetes Other Age deceased**

 Father’s Side \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

 Mother’s Side \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

**Loss of Health:**

***Let’s begin at birth, when you first damaged your nervous system, and began your journey to ill health.***

**Birth History: Please check all that apply**

**\_\_\_ Mother smoked/drank/drugs during pregnancy \_\_\_ Epidural/Meds in Labor**

**\_\_\_ Breech Vaginal Delivery \_\_\_ C-section \_\_\_ Forceps Delivery**

**\_\_\_ Vacuum Extracted \_\_\_ Labor Induced \_\_\_ Complications**

**\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Childhood Years: (Age 0-17 years) Please check all that apply**

**\_\_\_ Frequent Illness \_\_\_ Serious Falls \_\_\_ Active in Sports**

**\_\_\_ Very Inactive \_\_\_ Car Accident(s) \_\_\_ Surgery/Stitches**

**\_\_\_ Alcohol/Drug Use \_\_\_ Smoker \_\_\_Antibiotics/Meds**

**\_\_\_ Vaccinated \_\_\_ Chiropractic Care \_\_\_Broken Bones**

**\_\_\_ Severe Emotional Trauma(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Adult Years: (Age 18 to present) Please check all that apply**

**\_\_\_ Smoker \_\_\_ OTC/Prescription Meds \_\_\_Alcohol Use**

**\_\_\_ Surgery/Stitches \_\_\_ Play Sports \_\_\_Car Accident(s)**

**\_\_\_ Work Injury \_\_\_ High Stress (Life/Job/etc) \_\_\_ Sit alot**

**\_\_\_ Drive alot \_\_\_ Poor Sleep \_\_\_ Poor Diet**

**\_\_\_ Exercise \_\_\_ Lack of Exercise \_\_\_ Flat Feet**

**\_\_\_ Orthotics/Lifts \_\_\_ Severe Health Problems \_\_\_Hard Falls**

**\_\_\_ Broken Bones \_\_\_ Chiropractic Care → Last Adjustment \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_ Other Injuries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**On a scale of 1 – 10, describe your stress level: (1=none/ 10=Extreme) \_\_\_Work \_\_\_ Personal**

**About Your Health:**

***The human body is designed to be healthy. Throughout life, events occur which damage your health. This health profile is designed to identify the underlying layers of damage to your nervous system, which results in poor health, so that we may begin your journey of recovering your innate health potential.***

**I hereby certify that the statements and answers given on this form are accurate**

**to the best of my recollection & knowledge.**

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Guardian (If Minor)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dated \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5/2019