WHOLE FAMILY
CHIROPRACTIC

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. *And away we go!*

Personal Information

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Email Address _____

☐ Single ☐ Married/Partnered ☐ Widowed ☐ Divorced Spouse/Partner's Name _____

# of Kids ____ How many at home? _____ Names & ages: _____

_____

What kind of work do you do? _____ Self-employed? ☐ Yes ☐ No

Have you ever been to a chiropractor before? ☐ Yes ☐ No Approximate date of last visit ____/____/____

Dr.'s Name/City/State: _____ Good results? ☐ Yes ☐ No

Are you under care of any other doctor? Yes/No If Yes, the condition being treated for: _____

Please check if you are here for any of the following: ☐ Motor Vehicle Injury ☐ Work Injury ☐ Other Injury

Whom may we thank for referring you to our center? _____

Favorite hobbies or interests: _____

Let's Find Out Why You're Here...

Reason for seeking chiropractic care: _____

_____

Any other specific concerns? _____

List all current medications and conditions being treated: _____

_____

List any past surgeries and dates: _____

List any past accidents/injuries and dates: _____

_____

Have you ever been under chiropractic maintenance care? _____

Do you know what a subluxation is? If yes, please describe: _____

_____

Quality of Life Inventory

If you have experienced any of the following, please indicate by writing C (Current), P (Past) or CP (Current and Past).

___ Fatigue
___ Sleeping problems
___ Frequent colds
___ Asthma
___ Allergies
___ Digestion problems
___ Weakness
___ Dizziness
___ Headaches
___ Migraines
___ Nausea
___ Fainting
___ Low energy/tired

___ Neck pain/stiffness
___ Shoulder pain
___ Mid back pain
___ Low back pain
___ Hip pain
___ Joint pain
___ Chest Pain
___ Heart problems
___ Pins/ needles in legs
___ Leg/foot pain
___ Numbness in toes
___ Cold feet
___ Anxiety

___ Loss of balance
___ Earaches
___ Ringing in ears
___ Irritability
___ Depression
___ Nervousness
___ Tension
___ Ulcers
___ Pin/needles in arms
___ Arm/hand pain
___ Numbness in fingers
___ Cold hands
___ Sinus congestion

___ Lights bother eyes
___ Cold Sweats
___ Fever
___ Skin Conditions
___ Urinary problems
___ Mood swings
___ Menstrual irregularity
___ Menstrual pain
___ Hot flashes
___ Brain fog
___ Difficulty focusing
___ Cancer
Other:_____

Stress Survey

Please review each of these common stresses and circle when you experienced it in your life. Use **P for Past** and **C for Current**. If you expect or anticipate the possibility of experiencing this stress in the future, circle **F for Future**.

Physical		**Mental**		**Chemical**	
Forceps delivery	P C F	Divorce of parents or spouse	P C F	Take prescription medication	P C F
Falls of any type	P C F	Death of a loved one	P C F	Take over-the-counter drugs	P C F
Broken bones	P C F	Serious illness (self or loved one)	P C F	Consume alcohol	P C F
Strains or sprains	P C F	Financial concerns	P C F	Consume caffeine	P C F
Bad posture	P C F	WORRY	P C F	Use tobacco products	P C F
Poor sleeping habits	P C F	Work environment	P C F	Eat fast foods	P C F
Repetitive movements	P C F	Relationships	P C F	Use artificial sweeteners	P C F
Sports injuries	P C F	Anger by you or at you	P C F	Bad diet (white flour & sugar)	P C F
Heavy lifting or bending	P C F	Feel "not worthy"	P C F	Environmental pollution	P C F
Overweight	P C F	Put things off to the last minute	P C F	Overweight	P C F
Other_____	P C F	Other_____	P C F	Other_____	P C F

Do you notice you store your stress in (please circle):

♦ Your neck/shoulders ♦ Mid-back ♦ Low-back/pelvis ♦ Other_____

Please rate your GENERAL stress level, 0 to 10 _____ At Work/School _____ At Home ____

Your Health

Name/Phone of the last doctor who put you on a health development program?

_____

Were you able to stay on the program? _____ How long? _____ Good results? _____

Are you healthier today than you were 5 years ago? ☐ Yes ☐ No ☐ Not Sure

Will you be as happy and healthy as you are today (or BETTER) in 5 years? ☐ Yes ☐ No ☐ Not Sure

If yes, what will you do to make sure you are? _____

If no or not sure, what *could* you do to *start* getting happier & healthier? _____

_____

What would you like your health to be like 5 years from now? _____

_____

Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function *is* increased **health**, **wellness** and an **overall improved quality of life**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Tye Moe to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Moe to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed_____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!