

LIFE CHIROPRACTIC CENTER

Confidential Case History

Patient Name: _____ Male Female Date: _____
 Address: _____ Age: _____
 City: _____ State: _____ Zip: _____ E-mail: _____
 Phone: (H): _____ (W): _____ (Cell): _____
 Date of Birth: _____ Marital Status: M S W D Spouse's Name: _____ # Children _____
 Occupation: _____ Employer: _____
 How did you hear about us? _____
 Person Responsible for Account Me Other:

Will you be using insurance? No Yes, Insurance Co: _____ (please have us photocopy the card for ID numbers)

Was injury due to Automobile Accident? No If Yes, Auto Insurance:

Have you ever visited a Chiropractor? No If Yes, whom? _____ Time under care: _____ Good Experience? Yes No

Reason for today's visit: _____

Injury? Please describe what happened: _____

When did condition begin? _____ Is it: Constant ? Comes/Goes? Getting Worse?

What makes it worse? _____ Does anything make it feel better? _____

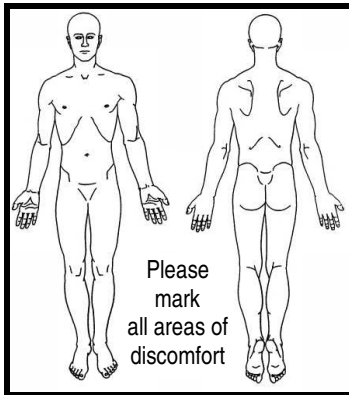
Is it: Burning? Aching? Stabbing? Dull? Radiating, where? _____ Other: _____

Worse in: Morning During Work Evening After Work Middle of Night Other: _____

Have you had this before? No If yes, when? _____ Treatment then: _____

Have you seen any other doctor's recently about this? No If Yes, whom? _____

Have you had recent x-rays? Yes No Females: Are you pregnant? Yes No Not sure



- Current Complaints (Present)**
- Headaches
 - Neck Pain
 - Neck Stiffness
 - Fatigue
 - Dizziness
 - Numbness
 - Pins&Needles
 - Sleeping Prob
 - Depression
 - Cold Hands
 - Irritability
 - Stomach Upset
 - Menstrual Pain
 - Ulcers
 - Low Back Pain
 - Pain Down Leg
 - Freq Urination
 - Heartburn
 - Other: _____

- Health History (Past to Present) – Please check all that apply:**
- Heart Disease
 - Stroke
 - Immune Disorder
 - Joint Replacement
 - Seizures/Epilepsy
 - Kidney Disease
 - Liver Disease
 - Diabetes
 - Cancer: _____
 - Pacemaker
 - Hepatitis
 - Sinus
 - Arthritis
 - Thyroid
 - Asthma
 - Allergies: _____
 - Other: _____
 - Irritability
 - Loss of Weight
 - Loss of Sleep
 - Urinary Problems
 - Depression
 - Fatigue
 - Smoke? ____/day

Past Surgeries or Hospitalizations: _____

Past Injuries (include auto, work, home, fractures, etc): _____

Medications/Supplements (include prescription/non-prescription): _____

Sleep: usually ____ hours/night Side Back Stomach Pillows under head: 0 1 2

Exercise/Strenuous Hobbies: _____

I authorize release of any information concerning my (or my child's) health care, advice or treatment provided for the purpose of evaluation and administering claims for insurance benefits. I understand and agree that all services rendered to me (or my child) are charged directly to me and that I remain personally responsible for payment. I also hereby direct my insurance company to pay this clinic directly for services rendered in accordance with standard assignment of benefits.



Signature of Patient (or parent, if minor) _____ Date _____

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Terms of Acceptance of Chiropractic Care

Patient Name: _____

Terms of Acceptance

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working towards the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Chiropractic has one major goal:

To localize, analyze and correct spinal interference to the nervous system (vertebral subluxation).

Vertebral Subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of electrical impulses. This results in lessening of the body's innate ability to repair, maintain and promote optimal health.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others.

Our only practice objective is to eliminate a major interference to the expression of the body's innate healing ability. Our only method is specific chiropractic adjustments to correct subluxations.

I have read and fully understand the above statements; I therefore accept chiropractic care on this basis.

Signature of Patient (or parent, if minor)

Date