

THE LIFE CENTER

CHIROPRACTIC

Dr. Jeremy Brook

VITAL INFORMATION

DATE _____

Name _____ Social Security Number _____

Date of Birth _____ Age _____ Gender _____ Height _____ Weight _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Business _____

Phone _____

Email Address _____ Occupation _____

Marital Status: circle one: Single Married Divorced Widowed

Name of Spouse _____ Number of Children _____

Whom may we thank for referring you to The Life Center? _____

Signature _____

Date _____

Guardian's Signature Authorizing Care _____

CHIROPRACTIC EXPERIENCE

Have you ever **experienced Chiropractic**? Circle one. Yes or No

Approximate date of **last spinecheck or adjustment**? _____

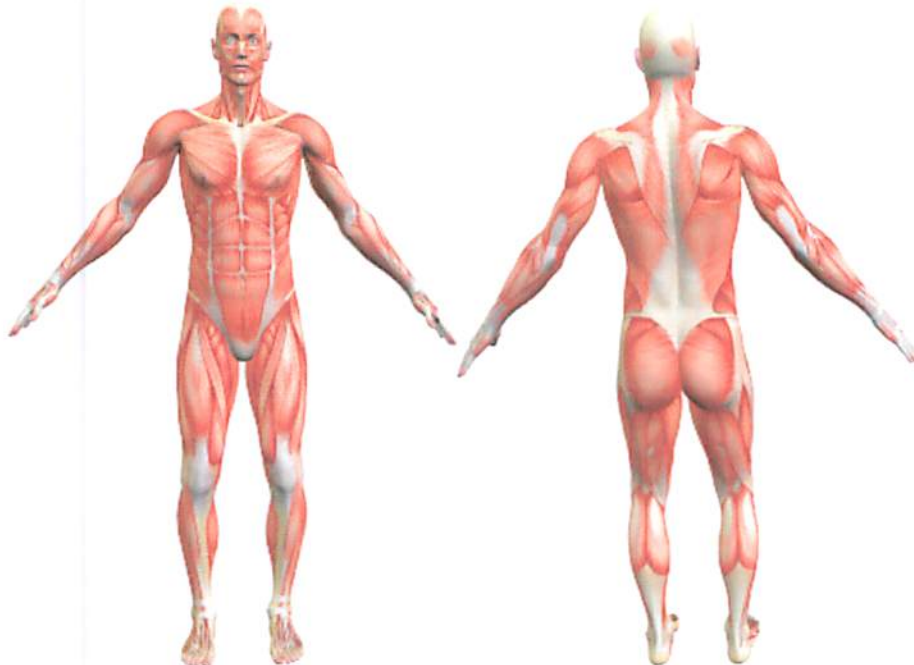
Reason for those visits?

Wellness Visit

Corrective Care

Injury/ Crisis Care

WHAT BRINGS YOU HERE? If applicable, please illustrate the location of your **BODY-MIND** concern?



VITAL DETAILS

When did this health concern **begin**? _____

Is this concern **due to** a:

Injury Chronic Overuse Chronic Disuse Emotional Stress

Describe the **quality** of the sensation:

Sharp Ache Throbbing Burning Tingling Numbness Stabbing

Is your concern in a **single spot** or does it **radiate out**? Circle one.

How often are you **aware** of this sensation?

Constant (75%-100%) Frequent (51%-75%) Occasional (26%-50%) Intermittent (0-25%)

Has this feeling been:

getting better getting worse staying the same coming and going

What makes it feel **better**? _____

What makes it feel **worse**? _____

Is this injury or illness **work-related**? _____ *If yes, have you reported this to your employer?* _____

Is this injury or illness related to an **automobile accident**? _____

Have you **stopped doing anything** since the onset? _____

Does this health concern **affect you at**:

work play romance or love life sleep

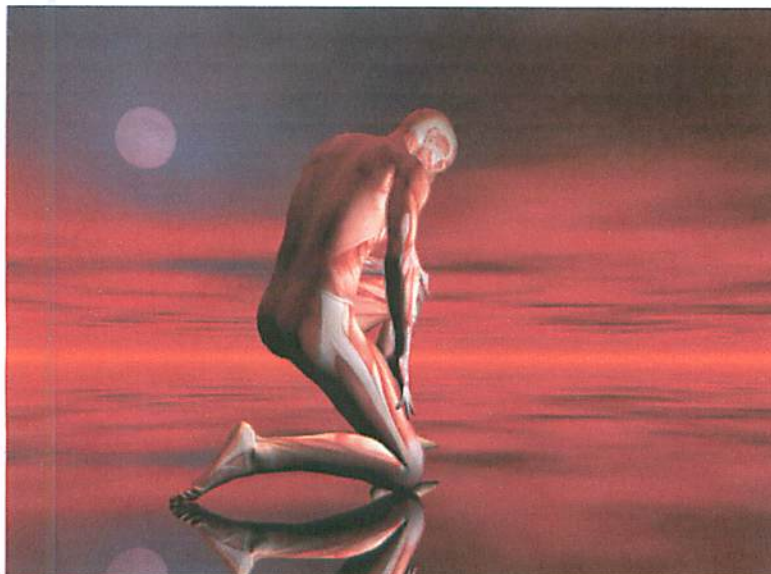
Do You Experience?

Loneliness Guilt Worry Grief Loss Anxiety Rage Fear Anger Shame Sadness

Have you ever **had anything similar**? Explain _____

Have you **consulted any type of health practitioner** for this concern? _____

Type of Practitioner: _____ Results? _____



About Your Health and Lifestyle

What other things have you done to improve your health and well-being?

Circle those that apply.

Massage Acupuncture Yoga Meditation Homeopathy Herbs Supplementation Lift Weights Run
Cleanse Consume Organic Foods Home Air Filtration System
Other _____

How many **hours do you sleep?** _____

Describe **the quality of your sleep** _____

Do you **sleep on your side/back/ stomach?** Circle one.

Do you **sleep with a cervical pillow?** no yes

Do you **drink water?** _____ Liters/ day

How many **bowel movements/ day?** _____

Do you **drink alcohol?** _____ Drinks/ day

Do you **drink coffee or tea?** ____Cups/day

Do you **smoke?** no yes _____Cigs/ day

Do you **floss your teeth?** no yes

Do you **grind or clench your teeth?** no yes

Do you **breathe consciously?** no yes

How many **hours do you sit?** _____

Do you **play a musical instrument?** no yes

Do you **use personal care products devoid of Industrial chemicals?** no yes

Do you use **Whole foods supplementation?** Omega 3's from fish oil Green food Pro-Biotics Other

What are your **hobbies?** _____



GOALS FOR CARE

People choose to receive Chiropractic care for many different reasons. What best describes your choice?

Check all that apply!

- ☐ **Repair:** As a healing art for physical challenges or emotional distress.
- ☐ **Remodeling:** As a healing art to stabilize, & correct the cause of the problem.
- ☐ **Optimizing** As a holistic component for strengthening and invigorating the body.
- ☐ **Dr. Brook's Call** I would like Dr. Brook to select the care appropriate for me.

Are you taking any drugs currently or have you been on any medication in the past? Circle those that apply.

Pain Killers	Muscle Relaxers	Stimulants	Tranquilizers	Anti-depressants
Anti-inflammatory	Blood Pressure	Anti-anxiety	Birth Control	Diet Pills
Thyroid	Other _____	Over the Counter _____		
Recreational drugs (name them) _____				

Major Surgeries/ Operations/ Hospitalizations:

Include year

_____	_____
_____	_____
_____	_____

Traumas & Accidents:

Please describe any accidents you have experienced from birth to present.

_____	_____
_____	_____
_____	_____
_____	_____

Below is a brief list of conditions,

which may seem unrelated to the purpose of your appointment.

However, these questions must be answered carefully as these problems provide

Dr. Brook a window to your overall health status.

Please circle if you've experienced any of the following recently or a check next to something that occurred in the past:

Headache	Congenital Heart Defect	Asthma	Kidney Problems	Thyroid Problems	Neck Pain
Fever	High Blood Pressure	Chronic Cough	Frequent Urination	Anemia	Pain between the
Allergy	Low Blood Pressure	Frequent Colds	Painful Urination	Hepatitis A, B, or C	shoulders
Dizziness	Difficulty Breathing	Tuberculosis	Blood in Urine	Shingles	Low back Pain
Low Energy	Varicose Veins	Pneumonia	Venereal Disease	Cancer	Tail Bone Pain
Sinus Troubles	Poor Circulation	Constipation	Prostate Problems	Chemotherapy	Numbness or Pain
Sore Throat	Pain Over Heart	Poor Digestion	Inability to Control Urine	HIV/ AIDS	in Arms, Hands, Legs,
Pain in Eyes	Heart Attack	Nausea	Bed Wetting	Diabetes	or feet
Deafness	Stroke	Vomiting	Loss of Sleep	Ulcers/ Colitis	Poor Coordination
Ear noises	Heart Murmur	Flatulence	Psoriasis		Inability to Concentrate
Tinnitus	Swollen Ankles	Diarrhea	Eczema		
		Digestive Problems			

For Women Only

Are you pregnant?	<input type="checkbox"/> no <input type="checkbox"/> yes	Excessive flow?	<input type="checkbox"/> no <input type="checkbox"/> yes	Breast Implants?	<input type="checkbox"/> no <input type="checkbox"/> yes
Are you nursing	<input type="checkbox"/> no <input type="checkbox"/> yes	Irregular cycles?	<input type="checkbox"/> no <input type="checkbox"/> yes		
Are you taking birth control?	<input type="checkbox"/> no <input type="checkbox"/> yes	Cramps?	<input type="checkbox"/> no <input type="checkbox"/> yes		

B R O O K C H I R O P R A C T I C , I N C