WHOLE FAMILY
CHIROPRACTIC

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651.789.0033

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

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 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!