WHOLE FAMILY
CHIROPRACTIC

1150 Montreal Ave #105
St Paul, MN 55116
651.789.0033

Welcome!

Your first visit with us is an opportunity for us to learn all about you. It is a time for you to share with us about your health, your family and your goals.

Personal Information- Adult

Name _____ Today's Date _____/_____/_____

Birth Date _____/_____/_____ Biological Gender: ◯ Male ◯ Female

Phone (Home or Cell) _____

Address _____

Number & Street City State Zip

Email Address _____

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

# of Kids _____ How many at home? _____

Kids' 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 us? _____

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? _____

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, select **F for Future**.

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

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

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 both parties are working toward the same objectives. We have one primary goal, and it is important that everyone understands our objective and the methods we will use to move toward that objective.

Your care in our center is not a substitute or alternative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes 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.

If during the course of chiropractic spinal examination we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Our focus is to improve your body's ability to function, therefore, moving it toward increased **health**, **wellness** and an **overall improved quality of life**.

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, _____(print name), have read and understand the above statement and I hereby give permission for Whole Family Chiropractic to continue with my initial consultation and assessment. I also agree to return at a later date to allow Whole Family Chiropractic to report my 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.

Signature_____ Date _____/_____/_____

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