A Brilliant Life History

Name: ______________________________ Address ______________________________
Date: ______________________________ ______________________________
Phone: H______________________ Date of birth______________________________
W______________________ Children______________________________
Cell______________________ ______________________________
Email address ____
Occupation:____
Emergency contact:____________________________ Phone ______________________
How did you hear about our office? ____
Why are you seeking chiropractic care?____
____
What are your expectations from chiropractic care in this office?_____________________________
____

Past Chiropractic Experience:

Have you ever received adjustments by a doctor of chiropractic? YES or NO
If yes, when was your last visit?____
For how long were your receiving chiropractic adjustments?_______________________
How often did you go to the chiropractor?_________________________________
If you stopped, why?____
Please describe the type of adjustments (or name methods used):____________________
Were you pleased with his/her service?_____________________________________

Does your immediate family receive chiropractic care? YES or NO

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Do you currently have any health concerns? Describe:_______________________________
____

Do (did) you receive or participate in any of the following for your personal growth or health. If yes, please check the following that apply:

meditation/prayer	movement/yoga/dance	Tai Chi/Chi Gong
cranial work	body-work	massage
spiritual work:	psychotherapy	exercise
rebirthing/breath work	oriental medicine	acupuncture

Other____

The objective of Chiropractic is to access more of your inborn potential by releasing the subluxations in your spine affecting the communication systems of your body (i.e. nervous system). Subluxations eventually form when your body receives information that remains stored in your system and never fully integrates. These forces may be chemical, physical or emotional in nature.

The origin of the force does not alter the chiropractor's method when he/she checks your spine and helps your body release subluxations. However, the following information is helpful to you and the chiropractor to begin recognizing possible events or circumstances that may have affected your structural frame. Please answer the following questions regarding some of the forces you have encountered in your life.

Your Birth Forces

1. My mom perceived the pregnancy as: enjoyable easy moderate difficult very difficult ?
2. During the pregnancy, did your mother have any: falls accidents physical injuries ?
3. Prior to or during the pregnancy was your mother exposed to: (Circle all that apply)
   oral contraceptives meds for any condition tobacco petroleum
   fertility drugs strong cleaning agents alcohol other
4. Was your birth: (Circle all that apply)
   natural (no chemicals and vaginal delivery) cord around neck epidural prolonged labor
   chemically induced with Pitocin forceps or suction C-sect breech
5. My birth was perceived by my mother as: enjoyable easy moderate difficult very difficult ?
6. During delivery your mother was: conscious semiconscious unconscious ?
7. My birth was: at home in birthing center hospital other
8. Were you: (Circle all that apply)
   incubated hospitalized circumcised nursed formula bottle-fed mother's milk

General Physical Forces

Please circle all that apply. Explain with dates.(or ages)

sports impact_______________ physical fights_______________
injured your spine____________ broken bones_______________
major dental work____________ knocked unconscious________

Falls

Explain with dates.(or ages)

out of crib _____ off ladder_____ on ice_______ roller-skates/blades_________
out of tree_____ off step ______ off bicycle____ others_____________________

During the day I (circle the main ones that apply)

sit do phone work do heavy lifting
stand do mechanical work do computer work
walk do desk work do exercise

Accidents

Have you (even if you believe your injuries were minimal) been involved in a vehicular collision, or near collision? Please list dates, details of impact to the vehicle and you, rate severity (mild, moderate, or extreme).____
____
____

Hospitalizations:____

Surgeries:(when and what area or organs of your body)___________________________
____

Do you still have all your body parts? (tonsils, adenoids, spleen, appendix, gall bladder, all parts of your vertebrae, etc) Y / N / ?

General Chemical Forces

Current medications: (prescription, over the counter, oral contraceptives, etc) ________________________

____

Medications you have taken on a regular basis?____

____

Do you or did you ever work with any chemical, fumes, dusts, asbestos, powders, smoke or perfumes for any prolonged period of time?____

Is the air that you live in clear of molds, dusts, new carpet fumes, etc?____________________________

How often do you consume the following? Please note if you have consumed large amounts in the past.

diet food/drink __________ alcohol________ chocolate_____ tobacco_______

caffeinated beverages_____ diet soda______ sugar________

artificial sweeteners______ junk food(flavored chips, dips, etc.)_____

Briefly describe your eating habits. (vegetarian, carnivore, some veggies, all fast food, etc)

____

Do you use supplements? Explain?____

Have you ever had a flu shot? Y / N / ? If yes, list years____________________________

Have you had regular vaccinations____

Emotional Forces

Do any of the following affect your life? Grade from 0-5 (5 being the greatest intensity)

work-related stress__________ personal relationship stress__________

stress of feeling sick__________ loss of a loved one________________

any kind of abuse____________ "joyful" experiences ________________

Please rate from 0-5 (5 being the greatest intensity)

How would you rate you life?_________

How would you rate your overall physical, mental, emotional and spiritual health?________

Please rate individually your: physical health__________ emotional health_________

mental health___________ spiritual health__________

In your opinion, can the above four components of health be divided? Y / N / ?

If you rated your overall health or any of the components of your health with a high or low number, why do you feel it deserved that number?____

____

How often do you laugh (really laugh)?____

How often do you cry?____

How often do you exercise to the point of breaking a sweat and beyond?________________________

Please share anything else that you believe will help us to understand you better and/or why you have chosen this office?____

____

Signatures:

______________________________ ______________________________

Practice Member Today's Date

______________________________ ______________________________

Witness Today's Date