LIFEFORCE CHIROPRACTIC

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612.822.7509

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Name ______________________________ Preferred Pronoun ____________ Date of Birth ______________

Address ______________________________ City, State, Zip ______________________________

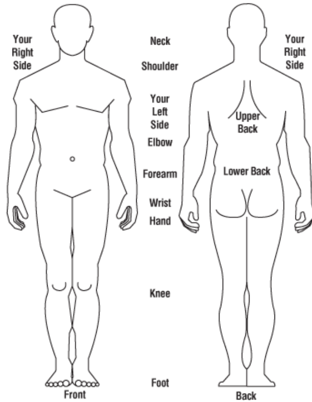
Phone # ______________________________ Email Address ______________________________

Emergency Contact ______________________________ Partner/Spouse ______________________________

Employer/Occupation ______________________________ Work Phone ______________________________

Ages of children ______________________

Draw on Diagram ----->>>>
Area(s) of pain/complaint



Is today's Problem Caused by:

☐ Auto Accident

☐ Work Comp

IF you have NO pain and are interested in wellness care, check here:

☐

Your **PRIMARY** area of complaint: **NECK** **Mid-BACK** **LOWER BACK** **OTHER**:______________________

How did this problem begin? ____ Date of injury: ________________

Please RATE your pain using a scale of **0-10** (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain (circle all that apply) SHARP SHOOTING DULL ACHY STIFF
SHARP with MOTION BURNING TINGLY NUMB OTHER: ________________

How often do you experience symptoms? _____ Constant (75-100% of the day) _____ Frequent (51-74% of the day)
_____ Occsssional (25-50% of the day) _____ Intermittent (1-25% of the day)

How are your symptoms changing with time? _____ Getting worse _____ Staying the same _____ Getting better

What makes the pain worse? (circle) sitting standing walking bending twisting/turning
lifting driving sleep movement/changing positions other: ______________________

What makes the pain better? (circle) ice heat rest stretching laying down pain medication
massage yoga foam rolling sleep other: ____________________________

What else does this issue interfere with? (circle) work exercise child rearing social activiites household chores

Your OTHER (if any) area(s) of complaint: **NECK** **Mid-BACK** **LOWER BACK** **OTHER:**______________

How did this problem begin? ____ Date of injury: ________________

Please RATE your pain using a scale of **0-10** (10 being the worst) 0 1 2 3 4 5 6 7 8 9 10

Please describe your pain (circle all that apply) SHARP SHOOTING DULL ACHY STIFF
SHARP with MOTION BURNING TINGLY NUMB OTHER: ________________

How often do you experience symptoms? _____ Constant (75-100% of the day) _____ Frequent (51-74% of the day)

_____ Occsssional (25-50% of the day) _____ Intermittent (1-25% of the day)

How are your symptoms changing with time? _____ Getting worse _____ Staying the same _____ Getting better

What makes the pain worse? (circle) sitting standing walking bending twisting/turning
lifting driving sleep movement/changing positions other: ________________________

What makes the pain better? (circle) ice heat rest stretching laying down pain medication
massage yoga foam rolling sleep other: __________________________________

What else does this issue interfere with? (circle) work exercise child rearing social activiites household chores

other (please list): ____

FAMILY HISTORY (please mark if any member of your immediate family has any of the following)

☐ Heart problems ___________	☐ Lupus ___________	☐ Cancer ___________
☐ Diabetes ___________	☐ ALS ___________	☐ Rheumatoid Arthritis ___________

REVIEW OF SYSTEMS

PAST	PRESENT		PAST	PRESENT		PAST	PRESENT	
☐	☐	Headaches	☐	☐	Double Vision	☐	☐	Depression
☐	☐	Neck Pain	☐	☐	Weakness	☐	☐	Anxiety
☐	☐	Back Pain	☐	☐	Balance Problems	☐	☐	Drug/Alcohol Dependence
☐	☐	Shoulder Pain	☐	☐	Dizziness	☐	☐	HIV exposure
☐	☐	Elbow/Arm Pain	☐	☐	Concussion	☐	☐	Frequent Infections
☐	☐	Wrist/Hand Pain	☐	☐	Lyme Disease	☐	☐	Persistent rash
☐	☐	Hip Pain	☐	☐	Trouble sleeping	☐	☐	Irregular heartbeat
☐	☐	Knee/Leg Pain	☐	☐	Ear/Throat pain	☐	☐	Stroke
☐	☐	Ankle/Foot Pain	☐	☐	Sinus problems	☐	☐	Heart Attack
☐	☐	Jaw Pain/TMJ	☐	☐	Epilepsy	☐	☐	Chest Pain
☐	☐	Joint Swelling	☐	☐	Incontinance	☐	☐	Heart Burn
☐	☐	Lack of Energy	☐	☐	Heartburn	☐	☐	Change in appitite
☐	☐	Abnormal weight gain/loss	☐	☐	Blood in Stools	☐	☐	Food Intolerance
			☐	☐	Allergies	☐	☐	Abdominal Pain
☐	☐	Cancer/Tumor	☐	☐	Weezing	☐	☐	Nausea/Vomiting

Please explain any of the marked above: ____

Have you seen anyone else for these issues? ☐ Chiropractor ☐ Neurologist ☐ Primary Care
☐ Massage ☐ ER physician
Therapist ☐ Other ______________________

Height ____________ Weight ___________

List any precription medications you are taking: ____

List any nutritional supplements you are taking: ____

List any known allergies to medication: ____

LIst all surgical procedures you have had: ____

What type of exercise do you do? How many days/week? ____

What other activites do you enjoy outside of work? ____

Please rate your overall health ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had chiropractic health care in the past? ☐ **Yes** ☐ **No**

Please check all that apply

☐ I am interested in adjustments and adjustments only
☐ I like the "cracking" feeling
☐ I am interested in acupuncture
☐ I'd like to know more about supplements
☐ I like massage and muscle work, stretching
☐ I'm willing to pay extra for longer appointments

Is there anything else important about your health that you would like us to know? ______________________________________

Who can we thank for referring you to our clinic? ____

Patient Signature _________________________________ Date ___________________________