

Vibrant Life Chiropractic and Family Wellness Center

511 South Main Street, Sebastopol CA, 95472

707.829.9009



Please Tell Us About Yourself

Name: (last) _____ (first) _____ (mi) _____

Home Address (street) _____

(city) _____ (state) _____ (zip) _____

Home Phone # (_____) _____ Cellular # (_____) _____

Email Address: _____

Birthdate: ____/____/____ Age: _____ Social Security # _____

Employer: _____ Occupation: _____

Work Phone # (_____) _____ Ext. # _____

Male ___ Female ___ Single ___ Married ___ Partnered ___ Divorced ___ Widowed ___ Separated ___

Spouse's/Partner's Name: (last) _____ (first) _____

Employer: _____ Work Phone # (_____) _____

Number of Children: _____ Names and Ages: _____

Emergency Contact: _____ Phone # _____

Whom may we thank for referring you to Vibrant Life Chiropractic? _____

Reason for consulting VLC? _____

How has this affected your life (family, occupation, recreation, concern for future health, etc.)? _____

Is there anything else you would like us to know? _____

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Personal Health History (Confidential)

Name: _____ Date: _____

The Body is designed to be healthy. Throughout life, events and experiences can occur which may have negatively affected your body’s expression of health. The following questions will help uncover possible types of input that may impede your body’s ability to fully express your health potential. The science of Chiropractic revolves around the detection and release of nerve interference and tension patterns stored in the spine and throughout the body called subluxations. Subluxations are caused by physical, chemical and emotional stresses to which the body cannot adapt. In order to understand the current state of your health, please be as thorough as possible with the following information.

Reason for seeking Chiropractic care:

To experience a new level of health and healing _____ To relieve my pain _____ To be more connected to my body _____
Not sure _____ Other reason _____

What is your level of commitment to yourself, your health, and wellbeing? High _____ Medium _____ Low _____

Previous Chiropractic Care: yes / no If yes, date of last adjustment _____ Name of Chiropractor _____

Reason for ending care: _____

Are you currently receiving medical attention and if so for what? _____

Please list any medications you are currently taking (prescription and non-prescription), reason for taking and for how long: _____

Please briefly describe your daily routine, including meals and snacks: _____

What are your daily exercise habits? _____

What are your current play/relaxation activities? _____

How would you rate your current health? Poor Fair Average Good Excellent

How would you describe your family’s health? Poor Fair Average Good Excellent

Are you healthier now than you were 5 years ago? Y / N Why? _____

Do you know the history of your birth? Home _____ Hospital _____ Natural _____ Intervention _____

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Chiropractic Case History

Name _____ Date _____

1. Chief Complaint: _____

Location of Complaint: _____

Complaint began when and how? _____

2. Secondary Complaint: _____

Complaint began when and how? _____

Please circle the Quality of the complaint/pain: dull aching sharp shooting burning throbbing deep nagging other _____

Does this complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____

Do you have any numbness or tingling in your body? Where? _____

Grade Intensity/Severity (0 = no pain, 10 = worst pain imaginable) 0 1 2 3 4 5 6 7 8 9 10

How frequent is complaint present, how long does it last? _____

What makes it better? _____

What makes it worse? _____

What have you done for this complaint?: _____

Doctor's Notes:

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Your Past General Health

Below is a list of conditions which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these challenges can affect your overall course of chiropractic care. Check any of the following conditions you have had or still have:

- | | | | | |
|---|---|--|--|------------------------------------|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza (flu) | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Aids/HIV |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer | | | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Type of Cancer _____ | <input type="checkbox"/> When _____ | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> Mental Disorder | <input type="checkbox"/> Anemia | | | |
| <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Eczema | | | |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Eating Disorder | | | |

Doctor's Notes:

Check any of the following that you have on a **regular** basis, **especially during the last 6 months**:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Pins & Needles in arms or hands | <input type="checkbox"/> Gall bladder trouble | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Fainting | <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Menstrual cramps |
| <input type="checkbox"/> Chronic colds/flu | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Heart attacks | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Shooting head pains | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Wear glasses/contacts | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Nervous stomach | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Muscle spasms in neck | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Urinary dysfunction |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Grating in neck | <input type="checkbox"/> Depression | <input type="checkbox"/> Bowel dysfunction |
| <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Tightness of shoulder muscles | <input type="checkbox"/> Inner tension | <input type="checkbox"/> Painful/swollen joints |
| <input type="checkbox"/> Tightness of throat | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Irritability | <input type="checkbox"/> Slipped disc |
| <input type="checkbox"/> Throat inflammation | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Poor flexibility | <input type="checkbox"/> Pinched nerves in back |
| <input type="checkbox"/> Ear aches | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Pins & needles in legs |
| <input type="checkbox"/> Face flushed | <input type="checkbox"/> Heart pain | <input type="checkbox"/> Liver trouble | <input type="checkbox"/> Swollen ankles |
| <input type="checkbox"/> Twitching of face | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Loss of memory | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Intestinal gas | <input type="checkbox"/> Pains in legs & feet |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> TMJ | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sleeping problems |
| <input type="checkbox"/> Head feels too heavy | | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Allergies | | <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Weight gain/loss |

Doctor's Notes:

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The following can contribute to the vertebral subluxation process. Please check any that apply (or applied) to you and if so when?

Physical Stress

- Birth trauma
- Slip/Fall
- Car accidents
- Sports injuries
- Physical abuse
- Work Injury
- Poor posture
- Heavy computer use
- Repetitive movements
- Prolonged driving/standing

Emotional Stress

- Relationships
- Career
- Family
- Financial
- Pace of life
- Quick temper
- Holding in feelings
- Perfectionism
- Procrastination
- Depression

Chemical Stress

- Environmental
- Smoker
- 2nd hand smoke
- Caffeine
- Alcohol
- "Diet" food intake
- Soda intake
- Prescription drugs
- Junk food
- Recreational drugs

What do you feel is the primary stress in your life? _____

What are the 5 healthiest habits you currently choose in your life? _____

Why is your health important to you (how will your life be better and what will you do once you reach your health goals)?

In our office we are not only interested in your health and wellbeing but also the health and wellbeing of your family and loved ones. Current research indicates that family health patterns often emerge throughout life that can offer useful information about the health of individuals. Please mention any health conditions or concerns you may have about your:

Spouse/Partner: _____

Children: _____

Parents: (including significant medical history) _____

Siblings: _____

Financial Information: Who is responsible for this account with Vibrant Life Chiropractic? _____

At VLC we do not offer to diagnose or treat any symptom or disease condition. Our sole purpose is to analyze your system for subluxation patterns and help your body release them so it can more fully express its innate ability to heal. Wellness is a dynamic equilibrium between health and disease and exists when all organs of the body function at 100% under the direction of the nerve system and the Innate Intelligence of the body. If during your assessment a non-chiropractic finding arises, you will be informed and referred to an appropriate health care provider to serve you.

I, _____, have answered the above questions to the best of my knowledge. Based on the information I provided, I grant VLC, permission to assess, locate and release my subluxation patterns.

Your signature _____ **Date** _____