New Client Information

ADULT

1

Date _____

Full name _____

Address _____

City, state & zip _____

Home phone_____ Business phone _____

Cell_____ Cell Provider _____

Birthdate_____ Age_____ Sex M F Height _____ Weight _____

E-mail _____

Business/Employer _____

Type of work_____

Circle one: married, single, widowed, divorced, separated

Referred to this office by _____

No. of children (names/ages)_____

_____

_____

_____

_____

Will you be requesting any other party to help you pay for care? yes/no

❑ Spouse ❑ Workman's Compensation ❑ Medicare ❑ Auto Insurance

❑ Personal Health Insurance ❑ Other _____

Addressing what brought you to this office

If you have no symptoms or complaints and are here for Chiropractic Wellness Services, please skip to "Where have you been." (next page)

If you do have symptoms or complaints, please briefly describe your chief concern.

_____

_____

_____

_____

_____

_____

Health Concerns

List according to severity	Rate of severity 1=mild 10=worst imaginable	When did this episode start? month/year	If you had the condition before, when?	Did problem begin with an injury?	Are symptoms constant (C) or intermittent (I)?
1._____					
2._____					
3._____					
4._____					

2

Where Are You Now?

Your Health Profile

Why this form is important

At Performance Chiropractic, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Circle best answer:

If you are experiencing pain, is it?: sharp/dull ache

Does the pain travel/radiate anywhere? yes/no

Please describe:

_____

_____

_____

3 What help have you sought for these concerns?

(i.e.: medications, ice, nothing)

_____
_____
_____
_____

What changes resulted from this help?

_____
_____
_____

Were the changes permanent? yes/no

Have you ever been to a Chiropractor? yes/no
Who and when?

_____
_____

4 Where have you been?

Circle if you've experienced:

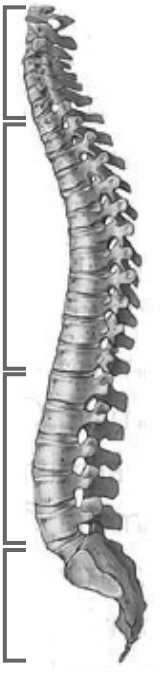
Sleep issues
Anxiety
Sore throat
Stiff neck
Radiating arm pain
Hand/finger numbness
Asthma
Allergies
High blood pressure
Heart conditions

Cervical C1–C7

Thoracic T1–T12

Lumbar L1–L5

Sacral S1–S5



Headaches
Migraines
Dizziness
Sinus problems
Fatigue
Head colds
Vision problems
Difficulty concentrating
Hearing problems

Middle back pain
Congestion
Difficulty breathing
Bronchitis Pneumonia
Gallbladder conditions
Stomach problems
Ulcers
Gastritis
Kidney problems
Restless Legs

Constipation
Colitis
Diarrhea
Gas pain
Irritable bowel
Bladder problems
Menstrual problems
Low back pain
Pain or numbness in legs
Reproductive problems

5 How did you get here?

On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times, the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses, past and present, that you face and allow us to better assess the challenges to your health potential.

Please list your top 3 stresses in each category:

1. Physical stress: traumas that take place through our body (falls, accidents, work posture, etc.)

a. _____
_____
b. _____
_____
c. _____
_____

2. Bio-chemical stress: stress that affect our organs (smoke, unhealthy foods, missed meals, dehydration, drugs, etc.)

a. _____
_____
b. _____
_____
c. _____
_____

3. Psychological stress: mental and/or emotional stress (work, relationships, finances, self-esteem, etc.)

a. _____
_____
b. _____
_____
c. _____
_____

Diet. Do you use any of these things?

❑ Alcohol ❑ Tobacco ❑ Coffee ❑ Soda ❑ Diet Soda
❑ Artificial sweetener ❑ Refined sugar ❑ Weight control diet food

How much water do you drink daily? ____oz.

Some providers use surgical intervention to alter their patients health concern.

Have you had any surgery? Please include all surgery.

1. type_____date _____
outcome _____
2. type_____date _____
outcome _____
3. type_____date _____
outcome _____
4. type_____date _____
outcome _____

Chemical attempts at resolving health problems are common.

Please list all medications you are taking and why (prescription and non-prescription):

1. type_____start date _____
why _____
2. type_____start date _____
why _____
3. type_____start date _____
why _____
4. type_____start date _____
why _____
5. type_____start date _____
why _____

If more than 5 medications, please notify the doctor.

Vitamin & Mineral Supplements

Please list all supplements you are taking.

1. name/brand:_____amount: _____
2. name/brand:_____amount: _____
3. name/brand:_____amount: _____
4. name/brand:_____amount: _____
5. name/brand:_____amount: _____
6. name/brand:_____amount: _____
7. name/brand:_____amount: _____
8. name/brand:_____amount: _____

6 Where would you like to go?

Reaching our maximum health potential is no different than other aspects of our life … without a goal, we can drift aimlessly. By answering these questions, thoughtfully, we will better be able to help you reach your goals.

In addition to the main reason for your visit today, what additional health objectives do you have for your future?

_____
_____
_____
_____
_____

Have you ever been to another doctor who put you on a Health Development Program? yes/no/not sure
If yes, doctor's name: _____
How long were you able to stay on the program? _____
What were the results?_____
Have the results lasted? yes/no/somewhat

Are you as healthy (or healthier) today as you were 5 years ago? yes/no/don't know

If yes, what strategies have you used?

_____
_____
_____
_____

Will you be as healthy (or healthier) as you are today, 5 years from now? yes/no/don't know

If yes, what strategies will you implement to get there?

_____
_____
_____
_____

If no or don't know, what strategies could you implement to get there?

_____
_____
_____
_____

From a lifestyle standpoint would you say that your choices are (circle one): healthier than your parents, the same as your parents or worse than your parents. Please describe:

_____

_____

_____

_____

How far will you take your Chiropractic Care?

We would like to know what your goal is as you come to our office. Please check one of the circles on the left side that applies the most to you.

Being Your Best

We experience our lives through our nervous systems. Optimizing our spines and nervous systems is the key to becoming all that we can be. Chiropractic care and other healthy habits create new possibilities.

Early Detection

Beyond preservation, is the realm of prevention. Periodic chiropractic check-ups can help catch new problems early. Those who value their health often take this proactive approach.

Keep Your Health

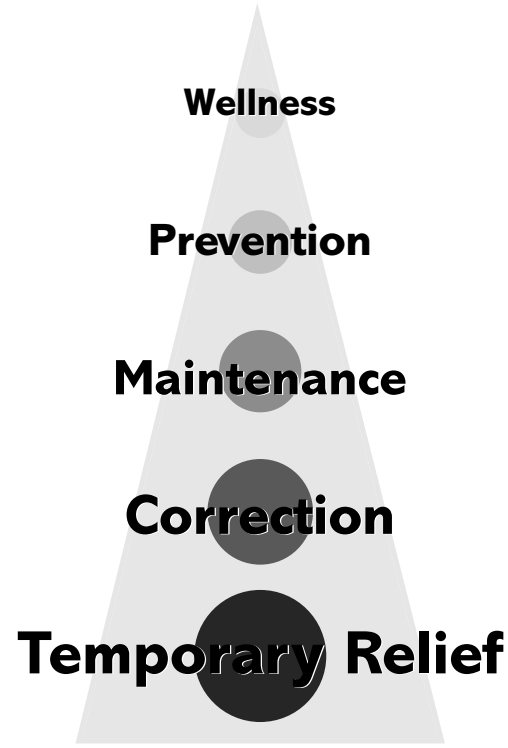
Regular chiropractic care can help maintain your progress and avoid a relapse. Your visit schedule will vary based on your age, condition and the stresses in your life.

Fix the Problem

With the obvious symptoms reduced, many opt to continue their care. This helps stabilize and strengthen the spine. Rehabilitative care builds on the investment used to get relief and helps make changes that are more lasting.

Temporary Relief

Many people begin here. Their ache, pain and other obvious symptom is often what prompts them to begin chiropractic care. Careful! If you stop care as soon as you feel better, before muscle and soft tissues heal, you can invite a needless relapse.



I hereby certify that the statements and answers given on this form are accurate to the best of my recollection and knowledge. I agree to allow this office to perform an assessment on me in order to make as complete an evaluation as possible.

Signed_____Date _____

Performance Chiropractic · Dr. Donald F. Piché · Dr. Julie Brons · 551 Garfield · Suite B · Traverse City, MI 49686 · 231-922-0110

Dietary Intake for 2 days before appointment:

Instructions:

Write down the type of food you eat at each meal. Record ANYTHING and EVERYTHING that passes your lips. This includes snacks and the pass-thru-the-kitchen-to-get-to-the-other-room nibbles. Be as specific as possible. Include sauces, gravies or any condiments – with the brand name.

Be specific –

If you eat a BLT, write it down. Include WHAT you eat with it (bread, mayo, cheese, onion rings, fries, cappuccino, chips, etc.) If you use oil to cook with, write down the exact oil used (olive, sesame, coconut, butter, etc).

Breakfast:	**Breakfast:**
Snacks:	**Snacks:**
Lunch:	**Lunch:**
Snacks:	**Snacks:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**