

Comprehensive Health Profile / History

*Please do your best to fill out *everything* on this intake form. It is very important that we understand past and current stressors that may have affected and could possible continue to affect you physically, emotionally, mentally, chemically, and spiritually. It is important for us to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that we value your time and aim only to provide you the best care possible.

Thank you for choosing Lotus of Life Chiropractic!

Please check the type of care desired:

Temporary Relief Stabilization Family Health/ Prevention Doctor's Advice

Is this appointment related to an auto accident injury on the job *(If yes, please see receptionist)*

Name: _____ **Sex:** Male / Female
 First Middle Last

Address: _____
 Street City State Zip Code

Home Phone: _____ **Cell Phone:** _____

(Please star the best number to reach you at.)

Date of Birth: ___/___/___ **Age:** ___ **Weight:** _____ **Height:** _____ **SS#:** _____

Marital Status: S M D W **Significant Other's Name:** _____

E-Mail: _____ **Children('s) Name(s) and Age(s):** _____

Emergency contact: Name _____ Phone _____ Relation _____

How did you discover our office and the professional services we offer? _____

Occupation: _____

Employer: _____ **Work Phone:** _____

Do you enjoy what you do? N Y Explain: _____

Duties/ Habits: sit more than 1 hour carry equipment/tools on your body (i.e. utility belt)

repetitively bend or twist cradle the phone shoulder to ear (which side? L or R)

repetitively type drive on the job (car or other) lift more than 10 lbs repetitively

Are you currently on a work release? N Y Ordered by whom? _____

About Your Health

The human body is designed to be healthy. Throughout life events occur and our body has two choices: It can either integrate the physical, mental, chemical, emotional or spiritual stress or it can store that experience to be integrated at a later time when the body is willing, ready, and able. These stored experiences eventually become symptoms in the body thus giving us a lesser quality of life than we deserve. This case history will uncover the layers of stored experiences in your body, particularly in the nervous system. Following the Chiropractic Exam, you will get an outline of care that will begin to correct these layers and recover your innate health potential!

About Your Care

Chiropractic provides different levels of care. The first is Initial Intensive care, which corrects the most recent layers of stored patterns of tension. This care usually reduces or eliminates symptoms. Then begins Reconstructive Care, which corrects the years of stored patterns of tension that have gotten you where you are now. This is when stabilization is being achieved in the body. Next comes Wellness/Continual Progression Care. The body is designed to excel mind, body and soul. That is the goal at this level of care. All of these options will be explained at your Doctor's Report. You can then decide which level of care fits your goals in health and life!

Developmental History (Birth to Age 5)

Yes	No	(Birth – Age 5)	Participant Comment	Chiropractor’s Comment
		1. Pregnancy		
		<i>Did your mother:</i>		
<input type="checkbox"/>	<input type="checkbox"/>	Smoke/drink alcohol/medications?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have a proper diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise throughout pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any falls/injuries during pregnancy?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Experience any physical/mental abuse?	_____	_____
		2. Birth Process		
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long/difficult?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was there vacuum extraction?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breech/cephalic?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home Birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital Birth?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____	_____
Yes	No	(Birth – Age 5)	Participant Comment	Chiropractor’s Comment
		3. Growth & Development		
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed? How long?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood illnesses/allergies?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs/Medications?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings/family?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse/emotional/physical/sexual abuse?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how)?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when sitting down?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits (nightmares)?	_____	_____

- Did you fall down stairs? _____
- Did you play in a bouncy swing? _____
- Did you crawl before walking? _____
- Were you pulled by your arm? _____
- Hobbies/Sports injuries? _____
- Did you have other traumas? What? When? _____
- Any special diet? _____

Yes	No	(Age 5 - present)	Participant Comment (if answer is Yes)	Chiropractor's Comment
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught proper body movement and care?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink alcohol?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet: Do you eat healthy foods/ follow a certain diet?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in any accidents?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and/or organs removed/replaced?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems? (cavities included)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems? (glasses/contacts)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems? (aids)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise? (type & frequency)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping habits: hours? disturbed? (nightmares? special pillow?)	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental/emotional stress?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other traumas/problems?	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spiritual stress?	_____	_____

What kind of water do you drink? _____

Do you eat organic foods? Yes No

Do you use organic health products (soaps, shampoos, detergents, etc.)? Yes No

What kinds/brands: _____

Do you feel you have good quality of air both at home and at work? Please explain:

Current Habits:	Daily/	Weekly/	Monthly or less/	None/Never
Drugs (OTC/ recreational)	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Soda/Energy Drinks	_____	_____	_____	_____
Soy	_____	_____	_____	_____
Fast food	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Dairy	_____	_____	_____	_____
Meat	_____	_____	_____	_____
Vegetables	_____	_____	_____	_____
Fruit	_____	_____	_____	_____
Daily water intake	_____	_____	_____	_____
Anything else you think we should know?	_____			

Check each you have had in the past or have now. Put "P" for past and "N" for now.

- | | | |
|----------------------------------------------------------|---------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Weight changes | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Respiratory disease |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hardening of arteries |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Numbness/Tingling |
| <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Digestive problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Menstrual problems/ pain | <input type="checkbox"/> HIV or AIDS |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Headaches (___x/___) |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Stress difficulty | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Diabetes (Type:_____) | <input type="checkbox"/> Arthritis (OA or RA?) | <input type="checkbox"/> Jaw trouble |
| <input type="checkbox"/> Changes in bowel/bladder habits | <input type="checkbox"/> Concussion /Head injury | <input type="checkbox"/> Neurological issues |

Other: _____

Family history of any of those listed? No Yes Which and who? _____

Vitamins or supplements you are *currently* taking and your reason for taking them: _____

Medications you are *currently* taking (including prescription, non-prescription, and birth control) and your reason for taking them: _____

Vitamins or supplements you have taken in the *past* for a period of longer than 3 months and your reason for taking them: _____

Medications you have taken in the *past* for a period of longer than 3 months and your reason for taking them: _____

What were you told (if anything) about the medications, vitamins, or supplements you currently take or have taken? _____

Did you do any research for yourself on any medications, vitamins, or supplements you use/have used? _____

Were you vaccinated as a child? Y N Explain: _____

Have you chosen to get any vaccinations as an adult (i.e. flu shot)? Y N Which? _____

Your Health Concerns or Symptoms and How They May Affect Your Life

If female, do you suspect or know that you are pregnant? ___ No ___ Yes

Do you have any current health concerns? Please list all that you would like to address while under care here at Lotus of Life Chiropractic, starting with the most important to you. _____

When did this situation or concern first begin? _____

Is this related to an ___ auto accident ___ injury on the job ___ other injury (_____)

Date of most recent flare-up: _____

Have you had this or something similar before? ___N ___Y When? _____

What did you do about it then? _____

Have you done anything for or gotten any advice or treatment for this issue? ___Yes ___ No

Explain: _____

Result: _____

Did it seem to work? _____

What activities aggravate your condition/pain? _____

What activities alleviate your condition/pain? _____

Is the condition worse during certain times of the day? ___No ___Yes When? _____

Does it affect your ___work ___home life ___decision making ___attitude ___mood ___patience
___ability to do perform household duties ___ability to be intimate ___productivity
___ability to exercise/ play sports ___ability to relax/ do hobbies

Stress Survey:

- 0 – no awareness of any stress
- 1- slightly stressful situation
- 2- moderately stressful situation
- 3- extremely stressful situation

Please circle the ones that apply to you. If not listed, please write in.

Overall Physical Stress, Trauma: Includes: falls, accident, injuries, repeated postural stress, impacts, difficult birth, physical/sexual abuse.
Other: _____

Overall Emotional/ Mental Stress: Includes: loss of loved ones, rapid changes in life, abuse, legal concerns, financial concerns, separation/divorce/break up, move of home/school, stress of being ill, job stress.
Other: _____

Overall Chemical Stress: Includes: drugs, medicines, alcohol, nicotine, caffeine, smoke, fumes, chemical agents, pollution, food additives, poor diet (fast food, fried food).
Other: _____

Do you have a history of physical, emotional, verbal, sexual abuse, or rape? ___No ___Yes

If yes, please explain to the degree to which you feel comfortable: _____

Your Specific Needs and Hopes for Help at Lotus of Life Chiropractic

Your answers to the following questions will allow us to help you to better participate in a program of care specifically focused on your spine, your nervous system, and your overall health and wellness.

Which of the following five choices is currently of most interest to you? How do you hope to benefit from care in the office? What are your immediate goals?

- a) improvement of my physical symptoms
- b) improvement of emotional/mental symptoms
- c) improvement of my ability to react or respond to stress
- d) improvement in enjoyment of life and the ability to make constructive choices
- e) overall improved quality of life

How do you hope to benefit from care in this office in the long run? What are your long-term goals?

- a) improvement of my physical symptoms
- b) improvement of emotional/mental symptoms
- c) improvement of my ability to react or respond to stress
- d) improvement in enjoyment of life and the ability to make constructive choices
- e) overall improved quality of life

When communicating to you about your spine, nervous system, health and wellness: (circle your preference)

- a) Mostly speak with me about the clinical findings and tell me the changes I am making.
- b) Mostly show me in written form the clinical findings, and let me see the changes that I am making.
- c) Mostly let me get a sense of the clinical work and help me to feel the difference in my body.

Previous Chiropractic Care

Has your spine ever been *professionally* adjusted? Yes No

Have you ever been to a chiropractor before? Yes No

Who? _____ When? _____

Duration of care: _____ Reason for visit: _____

Are you still going? Yes No Result: _____

Were you pleased? Yes No Technique used: _____

Does your family currently receive chiropractic care? Yes No

If no, have they in the past? Yes No

Were you and/or your family ever under preventative chiropractic care? Yes No

Is there some aspect of your life that very much pleases you, brings you joy, or helps you to feel better about yourself? _____

Are there any particular factors or elements about your life, experiences, family, work, recreation, past injuries, genetics, dietary programs, exercises, outlook, etc. that you feel impair your opportunity for full, unimpeded health? _____

Are there any particular factors or elements about your life, experiences, family, work, recreation, genetics, dietary programs, exercises, outlook, etc. that you feel give you an edge or adds to your health? _____

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Is there anything else which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: _____

* Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in that process.

Signature: _____ Date: _____

Copies: _____