



PATH OF LIFE

CHIROPRACTIC HEALTH CENTER

About You

Last Name _____ First Name _____ MI ____ Suffix ____

I'd prefer to be called _____

Address _____

City _____ State _____ Zip _____

Email _____

Phone (H) _____ (W) _____ (C) _____

Date of Birth ____ / ____ / ____ Are you enrolled in Medicare? Y N (circle one)

Gender *M F* Marital Status *Single Married Sep/Div* # of children ____

Employment status (circle one) full-time part-time unemployed student

Place of employment _____

Occupation _____

Emergency Contact _____

relationship to you _____ Phone _____

Who referred you to Path of Life? _____

Reason(s) for Today's Visit

Please circle the area(s) that bother you.

___ Wellness / Prevention

___ Symptom Relief

___ Auto Accident

Other _____

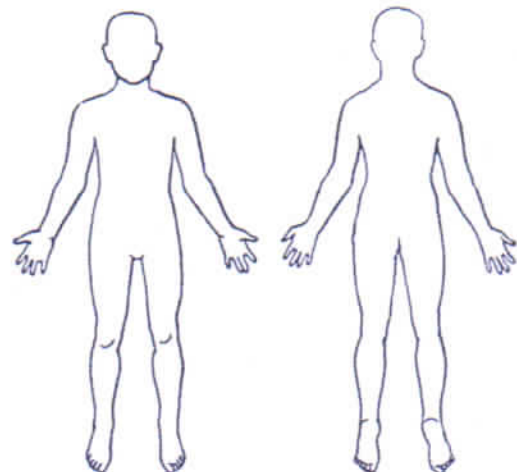
Previous chiropractic care? Y N

Chiropractor's Name _____

Were you on a spinal correction program to optimize the structure and function of your spine?

Y N

What are your health goals, and how do you plan to achieve them? _____



Health History

Please list all previous surgeries and dates _____

Please list all current medications and supplements (specify amount if possible) _____

Please list all auto accidents and dates _____

Please indicate whether you have experienced any of the following symptoms **during the past year** (circle all that are applicable):

fractured bones	neck pain/stiffness	numbness/tingling
auto accidents	jaw pain/click (TMJ)	foot trouble
other accidents / falls	pregnancy	chest pain
arthritis	heart problems	stroke
high blood pressure	diabetes	varicose veins
seizures	shoulder pain	liver trouble
arm/hand trouble	dizziness	thyroid issues
gall bladder trouble	skin problems	heartburn
headaches	cancer	depression / anxiety
irritability	ringing in ears	hearing loss
allergies / asthma	frequent colds/flu	trouble sleeping
vision problems	upper back pain	low back pain
mood swings	PMS / female issues	leg pain / hip pain
ear infections	sinus problems	constipation or diarrhea
diarrhea	high stress levels	attention deficit, ADHD

Other: _____

Of these symptoms, which is your major complaint? _____

Please fill out a Current Health Complaint section for EACH of the symptoms circled above that you experience currently. Please be as thorough as possible so we can best assess how to help you!

Please read and sign below

The information I have provided on these case history forms is true and accurate to the best of my knowledge. I give Dr. Amy Haas permission to render care to me today. This initial visit includes a health history / consultation, chiropractic examination, and any initial care that is determined to be clinically necessary and mutually agreed upon.

Signature (parental signature for minor) _____ Date _____

Current Health Complaints

Complaint: _____

When did this condition start? _____

Was onset due to a trauma or accident? Y N explain: _____

Location of pain: _____

Quality of pain: (i.e. dull, stabbing, sharp) _____

Severity of condition: (1= minimal symptoms, 10= the worst possible)

1 2 3 4 5 6 7 8 9 10

Duration: (i.e. constant, 2 days/ week, comes and goes) _____

Time of day that condition is worst: _____

What makes the condition better? (i.e. rest, medication, inactivity, ice)

What makes the condition worse? (i.e. activity, work, standing etc.)

Please list any secondary symptoms or conditions that have been caused by this condition? _____

On a scale of 0 to 10, please rate how this condition has affected your lifestyle: (0- not affected by it, 10 - extremely affected by it)

Ability to:

Perform work responsibilities: _____	lift/carry things _____
sit at a computer _____	meet deadlines _____
work full workday _____	complete tasks _____
sit in meetings _____	concentrate _____

Perform home responsibilities: _____	yard work _____
laundry _____	shop _____
clean the house _____	walk the dog _____
run errands _____	take care of the pets _____

take part in recreational activities _____	cardio exercise _____
lift weights _____	play sports _____
live a healthy lifestyle _____	be active _____
play with your children _____	take part in hobbies _____
enjoy life _____	

This has affected my relationships with:

My spouse _____ co-workers _____ friends _____ family _____

This condition has caused me to:

Experience more stress? Y N Experience depression? Y N

Experience overall decreased health? Y N

Please request additional forms for each additional complaint.