Power of LIFE
Chiropractic Wellness
A Healthy Choice for the entire Family

Name: _____ DOB: _____ Age: _____

Address: _____ City: _____ ST: _____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Employer: _____

Marital Status (circle): Single Married Partnered Separated Divorced Widow(ed)

Children: Y N Number of Children: ____ Ages(s): _____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____

How did you hear about our office: _____

What is the main purpose for consulting our office? _____
_____
_____
_____

Have you ever had any infectious disease from which you never fully recovered? _____
_____

Have you ever taken antibiotics for a prolonged period of time? _____

Current Medications

Prescription Medications	Dose	Since	Adverse Effects?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Supplement and/or Over the Counter Medications

Supplements/OTC Med	Brand	Dose/Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any difficulty swallowing pills/supplements? Y N

Do you use any of the following?

Cigarettes or tobacco:	Y	N	How much? _____	For how long? _____
Marijuana or other drugs:	Y	N	Frequency: _____	
Alcohol:	Y	N	Drinks per day/week? _____	
History of alcohol addiction:	Y	N	History of alcohol treatment?	Y N
History of eating disorder:	Y	N		
Soda/Pop:	Y	N	If so, Diet or Regular? _____	
Artificial Sweeteners:	Y	N		

Are you allergic to any medications? If so, which one(s) and what is your reaction?
_____

Present weight: _____ Height: _____ Weight 1 year ago: _____
Maximum weight & when: _____ Minimum weight as an adult & when: _____
Ideal weight: _____

How often do you exercise? _____ What type of exercise? _____
For how long? _____

How many hours do you sleep per night? _____ What time do you go to sleep? _____
Quality of sleep? _____
If you wake up frequently, what is the reason? _____
Nightmares: Y N Wake refreshed: Y N Must nap during the day: Y N
Sleep walk: Y N Grind teeth: Y N Snore: Y N

Do you eat any of the following on a weekly basis? (please circle) Pasta Bread Rice Potatoes

Social History
Enjoy work: Y N Hours worked per week: _____
Active spiritual practice: Y N
Quality of significant relationship: _____
History of sexual abuse: Y N
Stress level: Mild Moderate Severe
What activities do you enjoy doing? _____
_____

How committed are you towards making changes in your health: Little Moderate Very