LifeLight Chiropractic Center

Personal History

NAME:____ DATE: _____________________

ADDRESS:____ PHONE:________________
Street City State Zip

DATE OF BIRTH:_______________________________ MARITAL STATUS: S M D W

E-MAIL: _________________________________ OCCUPATION: ______________________________

EMPLOYED BY:___________________________________ EMPLOYERS PHONE:_________________________

NAME OF SPOUSE/PARENT:____

NAME AND AGE OF ALL CHILDREN:____
____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?____

REASON FOR CONSULTING THIS OFFICE?____

HAVE YOU SEEN ANYONE ELSE FOR ABOVE ? YES - NO WHO?_________________WHEN?_____________

WHAT WAS THE OUTCOME?____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? YES or NO DATE OF LAST ADJUSTMENT? _____________

CHIROPRACTOR'S NAME:_____________________________

HEALTH GOAL ? Patch up, Regain health, Maintain health, Expand level of Well-being

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Health is the most valuable asset in the world - YOU AND YOUR FAMILY'S HEALTH. ChiropracTIC brings ease and peace to your body and life. The adjustments will restore and ENHANCE the full function and communication within your body, from the brain to every organ, tissue and cell. As you receive adjustments your Innate Intelligence will express your fullest potential for life and healing. In this office we do not treat symptoms and diseases. We offer true healing through ChiropracTIC . Healing includes taking responsibility for your health and meeting your financial obligations. *The insurance industry pays for the treatment of symptoms and disease rather than the maintenance of our well being. ChiropracTIC is not a treatment nor a cure of disease. Therefore, we require your "investment" to be paid at time of service. However, you may submit your claims for your own personal reimbursement.* Your insurance policy is between you and your insurance company, not between your insurance company and us.

I CLEARLY UNDERSTAND AND AGREE that all services rendered to me are charged directly to me and that I am personally responsible for payment. I accept ChiropracTIC based on the above information, my signature below will serve as consent for service.

____ ___________________
SIGNATURE Date

____ ___________________
GUARDIAN'S SIGNATURE Date

(PLEASE COMPLETE REVERSE SIDE)

PLEASE FILL OUT THE FOLLOWING QUESTIONS COMPLETELY AND HONESTLY. THESE ANSWERS WILL HELP US PROVIDE YOU WITH THE BEST SERVICE.

PHYSICAL STRESS:

Have you ever had any falls, auto collisions, or injuries? If yes, briefly describe:______________________
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Have you ever had any surgery? If yes, briefly describe:____
____

Did you experience any birth trauma? If yes, when and how: ____________________________________
____

Please circle your level of physical activity: LOW MODERATE HIGH

CHEMICAL STRESS:

How would you describe your diet?	Meat	Fruits	Vegetables	Breads, Grains, & Cereals
Circle your level of intake:	O L M H	O L M H	O L M H	O L M H
(L-Low; M-Moderate;)				
(H-High; 0-None)	Sugar (candy, snacks, etc....)		Dairy Products	
	O L M H		O L M H	

Check the following products you use and circle the level of use: Tobacco____ O L M H Soda, Coffee, Tea____ O L M H Alcohol_____ O L M H

Do you take medications (drugs)? If yes, for what and how long:___________________________________
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EMOTIONAL STRESS:

Please describe your level of stress in any areas of your life such as work, home, school, relationships, children loss of a love one, divorce, separation, finances, etc.____
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This information is accurate to the best of my knowledge.

____
Signature

PLEASE DO NOT WRITE BELOW THIS LINE

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