AUSTIN LIFE CHIROPRACTIC

your home for upper cervical family care

Date_____

Whom may we thank for referring you:_____

Last Name:_____ First:_____ SS#_____

Address:_____City:_____State:_____ Zip:_____ Date of Birth:_____Age:____

Email:_____Phone: Cell _____ Home_____

Emergency Contact:_____Phone:_____Married: yes no Spouse's Name:_____

Are you pregnant? yes no If so, how far along are you?_____ Due Date:_____

Children's Names and Ages:_____

Have your children been under previous chiropractic care? yes no

Occupation:_____Empolyer:_____May we contact you at work? yes no Phone:_____

Prior Chiropractic Care:

Doctor's Name:_____ Clinic Name:_____ Phone:_____

For how long:_____Results Achieved: Excellent Good Fair Poor

X-rays taken: yes no If so, when:_____What areas:_____

Medical Doctor:

Doctor's Name:_____ Clinic Name:_____ Phone:_____

Doctor's Name:_____ Clinic Name:_____ Phone:_____

Other Healthcare Providers:

Doctor's Name:_____ Profession:_____ Phone:_____

Doctor's Name:_____ Profession:_____ Phone:_____

Reason for Visit:

The reason(s) that have prompted you to seek care today:_____

_____

When did you flrst start noticing this?_____

How often does this occur?_____

Is this interfering with: Work Sleep Routine Other_____

Other Doctors seen for this reason?_____

What medications are you taking?_____

Have you had surgery? yes no What?_____ When?_____

How would you rate your overall health?

Worst you have ever been — Best you have ever been

Review of Systems: (Please mark all that are applicable.)

Neurological
- Allergies
- Anxiety
- Depression
- Dizziness
- Nervousnes
- Numbness
- Loss of Sleep
- Pins & Needles

Digestive
- Excessive gas
- Colon Problems/IBS
- Constipation
- Diarrhea
- Hemorrhoids
- Gall Bladder/Liver Trouble
- Anorexia/Bulimia
- Ulcers

Eyes, Ears, Nose & Throat
- Ear Infection
- Eye Infection
- Sore Throat
- Sinus Infection
- Tonsillitis
- Ringing in Ears
- Hearing Loss
- Swelling of Ankles

Muscle & Joint
- Arthritis
- Bursitis
- Foot/Ankle Pain
- Hip disorders
- Knee Pain
- Neck Pain
- Poor Posture
- Scoliosis
- TMJ Disorder
- Low Back Pain

Cardiovascular
- High Blood Pressure
- Low Blood Pressure
- Rapid Heartbeats
- High Cholesterol
- Pain Over Heart
- Poor Circulation
- Excessive Bruising
- Swelling of Ankles
- Abnormal Heartbeat
- Varicose Veins

Respiratory
- Asthma
- Apnea
- Difflculty Breathing
- Emphysema
- Chronic Cough

Genitourinary
- Bedwetting
- Infertility
- Kidney Infection
- Erectile Dysfunction
- Prostate Issues

Skin
- Acne
- Dryness
- Eczema
- Rash
- Yeast/Fungus

Constitutional
- Fainting
- Fatigue
- Low Libido
- Poor Appetite
- Weakness

Female
- Heavy Flow
- Irregular Cycle
- Painful Cycle
- Discharge
- Menopausal Yes No

Other:
- Acid Refflux
- Austism
- Fibromyalgia
- Herniated Disc
- AIDS
- ADHD
- Gout
- Hepatitis
- Anemia
- Cancer
- Glaucoma
- Migraines
- Alcoholism
- Diabetes
- Heart Disease
- Spine Degeneration
- Arnold Chiari
- Epilepsy
- Multiple Sclerosis
- Rheumatoid Arthritis
- Other_____

Family History:

	Heart Disease	Arthritis	Cancer	Diabetes	Other
Father's Side					
Mother's Side					

Social History:

Do you exercise regularly? yes no
Do you drink? yes no
Do you smoke? yes no
Do you take supplements? yes no

YOUR GOALS FOR CARE:

- Feel better quickly/pain relief.
- Feel better and prevent its return.
- Have a healthier spine.
- I want optimum health and to live a healthier lifestyle.

We invite you to discuss with us any questions regarding our services. The best health services are based upon afriendly, mutual understanding between our team and yourself. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with our office.

Client's Signature_____ Date_____