



WHOLE FAMILY CHIROPRACTIC

Dr. Tye Moe

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. And away we go!

Personal Information

Name _____ Birth Date ____/____/____ Today's Date ____/____/____

Phone (H) _____ (W) _____ Ext. _____ (Cell) _____

Address _____
Number & Street City State Zip

Email Address _____

Single Married/Partnered Widowed Divorced Spouse/Partner's Name _____

of Kids ____ How many at home? ____ Names & ages: _____

What kind of work do you do? _____ Self-employed? Yes No

Have you ever been to a chiropractor before? Yes No Approximate date of last visit ____/____/____

Dr.'s Name/City/State: _____ Good results? Yes No

Are you under care of any other doctor? Yes/No If Yes, the condition being treated for: _____

Please check if you are here for any of the following: Motor Vehicle Injury Work Injury Other Injury

Whom may we thank for referring you to our center? _____

Favorite hobbies or interests: _____

Let's Find Out Why You're Here...



Reason for seeking chiropractic care: _____

Any other specific concerns? _____

List all current medications and conditions being treated: _____

List any past surgeries and dates: _____

List any past accidents/injuries and dates: _____

Have you ever been under chiropractic maintenance care? _____

Do you know what a subluxation is? If yes, please describe: _____

Health Inventory

If you have experienced any of the following, please indicate by writing C (Current), P (Past) or CP (Current and Past).

- | | | | |
|---------------------------------------------|------------------------------------------------|----------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Neck pain/stiffness | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Lights bother eyes |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Earaches | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Irritability | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Depression | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Tension | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Heart problems | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Menstrual pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Pins/ needles in legs | <input type="checkbox"/> Pin/needles in arms | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Leg/foot pain | <input type="checkbox"/> Arm/hand pain | <input type="checkbox"/> Brain fog |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold feet | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Low energy/tired | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Sinus congestion | Other: _____ |

Stress Survey

Please review each of these common stresses and circle when you experienced it in your life. Use **P for Past** and **C for Current**. If you expect or anticipate the possibility of experiencing this stress in the future, circle **F for Future**.

<u>Physical</u>	<u>Mental</u>	<u>Chemical</u>
Forceps delivery P C F	Divorce of parents or spouse P C F	Take prescription medication P C F
Falls of any type P C F	Death of a loved one P C F	Take over-the-counter drugs P C F
Broken bones P C F	Serious illness (self or loved one) P C F	Consume alcohol P C F
Strains or sprains P C F	Financial concerns P C F	Consume caffeine P C F
Bad posture P C F	WORRY P C F	Use tobacco products P C F
Poor sleeping habits P C F	Work environment P C F	Eat fast foods P C F
Repetitive movements P C F	Relationships P C F	Use artificial sweeteners P C F
Sports injuries P C F	Anger by you or at you P C F	Bad diet (white flour & sugar) P C F
Heavy lifting or bending P C F	Feel "not worthy" P C F	Environmental pollution P C F
Overweight P C F	Put things off to the last minute P C F	Overweight P C F
Other _____ P C F	Other _____ P C F	Other _____ P C F

Do you notice you store your stress in (please circle):

- ◆ Your neck/shoulders ◆ Mid-back ◆ Low-back/pelvis ◆ Other _____

Please rate your GENERAL stress level, 0 to 10 _____ At Work/School _____ At Home _____

Your Health

Name/Phone of the last doctor who put you on a health development program?

Were you able to stay on the program? _____ How long? _____ Good results? _____

Are you healthier today than you were 5 years ago? Yes No Not Sure

Will you be as happy and healthy as you are today (or BETTER) in 5 years? Yes No Not Sure

If yes, what will you do to make sure you are? _____

If no or not sure, what *could* you do to *start* getting happier & healthier? _____

What would you like your health to be like 5 years from now? _____

Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function *is* increased **health, wellness** and an **overall improved quality of life**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Tye Moe to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Moe to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed _____ Date ____/____/____

We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.

We look forward to helping you maximize your experience and expression of health and life!

