Pravo Wellness

Please fill out this form as completely and accurately as possible.

PERSONAL DATA

Today's Date :

Name_____ Age _____ Date of Birth _____

Parents' names (if you are under 18) _____

Home Address_____

City _____ State_____ Zip _____

Home Phone (_____) _____ Business Phone (_____) _____

Cell Phone (_____) _____ E-Mail Address_____

Occupation_____ Employer _____

Marital Status ❒ S ❒ M ❒ D ❒ W Spouse/Partner's Name:_____

Names and ages of children _____

Emergency Contact: Relation-_____Phone_____

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

Social security **#:** _____

REASON FOR SEEKING CHIROPRACTIC CARE

What concerns do you feel Chiropractic can address for you?

_____

Are these concerns affecting your quality of life? (Please circle only those applicable to you)

Work	Y N	Driving	Y N	Sleep	Y N
School	Y N	Walking	Y N	Sitting	Y N
Eating	Y N	Other	Y N	Exercise/sports	Y N

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ❒ Y ❒ N Name of D.C. _____

How long under care? ❒_____ days ❒_____ weeks ❒_____ months ❒_____ years

Date of last visit: _____Why did you stop?_____

How was your experience?_____

Have you consulted, or do you regularly consult, any of the following providers? (Check all that apply.)

❒ Medical Physician ❒ Naturopath ❒ Acupuncturist ❒ Homeopath

❒ Massage Therapist ❒ Psychotherapist ❒ Energy Healer ❒ Dentist

Reason why: _____

Primary Care Doctors Name and Location: _____

FOR WOMEN ONLY

Are you pregnant? ❒ Y ❒ N Possible/Unknown ❒ **If pregnant** due date? _____
Name of OBGYN or Midwife: _____
If x-rays are recommended, your signature is required to indicate that you are **not pregnant**.
Signature:_____ Date:_____

HEALTH, WELLNESS AND CHIROPRACTIC CARE

The primary system in the body, which coordinates health, is the CENTRAL NERVE SYSTEM. The vertebrae, the bones of the spinal column, surround and protect the delicate NERVE SYSTEM. Chiropractors are specialists trained in "early detection" of injury to the SPINE AND NERVE SYSTEM.

The information below will help us to see the types of PHYSICAL, EMOTIONAL and CHEMICAL stressors you have been subjected to and ***how they may relate to your present spinal, nerve and health status.***

CURRENT PHYSICAL STRESS

Please describe your usual work position and how long you maintain it during the day. For example, do you work at a computer, talk on the phone or stand at a machine for most of the day?

_____

Does your job require regular airline travel and hotel stays? ❒ Y ❒ N If yes, how often? _____
How long is your daily commute? _____ How many hours do you typically work in a week? _____
How many hours per week do you watch T.V.? _____ Are you sitting or lying on a couch? _____
Please describe your exercise/sports program including type and frequency:

_____

_____

How many hours of sleep do you typically get each night? _____ Do you sleep well? ❒ Y ❒ N
Do you ever sleep on your stomach? ❒ Y ❒ N How old is your mattress? _____
Do you wear orthotics (foot supports) or a heel life? ❒ Y ❒ N If yes, for how many years? _____
Do you use a cervical pillow? ❒ Y ❒ N

PAST PHYSICAL TRAUMAS

Were you born at home or in a hospital? Medication used? ❒ Y ❒ N C-section? ❒ Y ❒ N
Forceps/vacuum ? ❒ Y ❒ N Did you have any **significant childhood injuries**? (fractures, stitches, falls, sports-related, etc.) Please list dates, injury and treatment: _____

_____

Have you had any **significant adult injuries**? Please list dates, injury and treatment:

_____

_____

Have you had any **automobile accidents or work-related injuries**?
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____
Date:_____ driver/front passenger/rear passenger Seatbelt? Y N Airbag discharged? Y N
Injuries: _____ Care received: _____

FAMILY HISTORY

____Arthritis ____Asthma ____Back Pain ____Cancer _____Depression _____Diabetes _____Epilepsy
_____Genetic Spinal Condition ____High Blood Pressure ____Heart Problems ____Multiple Sclerosis
____Neurological Problems ____Polio _____Parkinson's _____Prostate Problems _____Stroke/Heart Attack
Other:

EMOTIONAL STRESS

Please indicate if you have experienced any of the emotional stresses below:

Childhood trauma	❒	Y	❒	N	Loss of loved one	❒	Y	❒	N	Abuse	❒ Y ❒ N
Work or school	❒	Y	❒	N	Divorce/separation	❒	Y	❒	N	Financial	❒ Y ❒ N
Lifestyle change	❒	Y	❒	N	Parents divorce	❒	Y	❒	N	Illness	❒ Y ❒ N

CHEMICAL STRESS

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g., food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you **vaccinated?** ❒ Y ❒ N If yes, did you have a **reaction**? ❒ Y ❒ N
Have you been **exposed to** any of the following on a regular basis, past or present?
❒ Toxic chemicals ❒ Radiation ❒ Second hand smoke ❒ Chemotherapy ❒ Drug therapy ❒ Other
If yes, please explain:_____
Do you have any **food allergies**? ❒ Y ❒ N **If yes, please list:** _____
_____
How many **fast food meals** do you eat per week? _____
How many **alcoholic beverages** do you drink per week? _____
Do you smoke **tobacco products**? ❒ Y ❒ N If yes, how many packets per day? _____
How many glasses of **water** do you drink per day? _____
How many **caffeinated beverages** (coffee, tea, soda) do you drink per day? _____
Are you currently on **prescription** or **over-the counter medication?** ❒ Y ❒ N

Please list, indicating dose & frequency_____

_____

_____

Please list any **nutritional supplements** you are taking: _____

_____

How do you rate your **physical health**? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

QUALITY OF LIFE

How do you rate your **emotional/mental health**? ❒ Excellent ❒ Good ❒ Fair ❒ Poor
How do you rate your overall **"quality of life"**? ❒ Excellent ❒ Good ❒ Fair ❒ Poor

EXPECTATIONS

I would like to have the following benefits from ***Chiropractic Care***: (Check all that apply)

__ Relief of a symptom or problem
__ Relief and prevention of a symptom or problem
__ Healthier spine and nerve system
__ Optimal health on all levels

What are your top three health goals?

1. _____

2. _____

3. _____

I hereby certify that the information provided is true and accurate.

Patient Signature: _____ Date: _____

CHIROPRACTIC CLINICAL OBJECTIVE

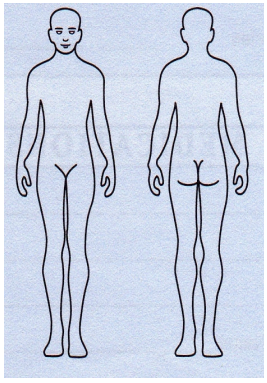
Physical, emotional and chemical STRESSES, common to our contemporary lifestyles, can result in misalignment of the spinal column causing damage to the nerve system. The result is a condition called Vertebral Subluxation. The Chiropractic exam/evaluation is specifically designed to detect Vertebral Subluxations in all phases of their progression. Many common symptoms and conditions are caused by the interference and stress on the nerve system. Please place a (X) on conditions that you are currently suffering from and a (O) on any conditions you have had in the past.

__Arthritis
__Back Curvature
__Mental / Emotional Disorders
__Diabetes
__Swollen or Painful Joints
__Convulsions / Epilepsy
__Skin Problems
__Bruise Easily
__Cancer
__Allergies
__Frequent Colds
__Upper Back Pain / Stiffness
__Excessive Gas
__Constipation / Diarrhea
__Prostate Problems
__Impotence
__Kidney Problems
__Frequent Urination
__Menstrual Problems / PMS
__Menopausal problems

__Headache
__Migraine Headache
__Neck Pain R/L
__Shoulder Pain R/L
__Numbness or Tingling in arms or hands R/L
__Carpal Tunnel Syndrome R/L
__Dizziness
__Ringing in Ears
__Hearing Loss
__Loss of Balance
__Digestive Problems
__Depression
__Attention Disorder
__Anxiety Disorder
__Eating Disorder
__Trouble Concentrating
__Loss of memory
__Ear Infection
__Learning Disability

__Asthma
__Difficult Breathing
__Chest Pain
__Heart Problems
__Heart Attack
__Stroke
__Bruit
__High / Low Blood Pressure
__Varicose Veins
__Liver Trouble
__Gall Bladder Trouble
__Mid Back Pain / Stiffness
__Pain with cough, or strain
__Hip Pain
__Low Back Pain / Stiffness
__Sciatica
__Numbness or Tingling in legs or feet R/L
__Muscle Tightness
__Trouble sleeping

Primary Health Concern:_____



○ Please indicate the location of your pain or discomfort on the diagram
○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
○Please indicate quality of the pain:
□Dull □Burning □Numb □Stabbing □Tingling □Cramping
○Does this pain radiate or travel? □No □Yes
If yes, please indicate on diagram
○Please indicate the severity of the pain on a scale from 1-10 (1 minor pain 10 major pain) 1-----2----3----4-----5-----6-----7-----8-----9-----10
○What makes this pain or condition better? _____Worse?_____
○What have you done to treat this problem? _____

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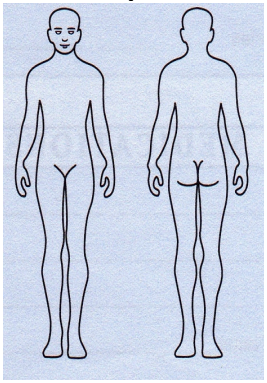
Secondary Health Concern:_____



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○When did this problem start? _____
○Have you ever had this problem before? □No □Yes If yes, when_____
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⎕Dull⎕Burning⎕Numb⎕Stabbing⎕Tingling⎕Cramping
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