Online ☐
Ref ☐
C.I. ☐
Event ☐

INTEGRITY CHIROPRACTIC and WELLNESS
Healthcare Solutions for the Whole Family

Client Information

First Name _____ Last Name _____ Date _____

Address _____ City _____

Zip _____ Home Phone _____ Cell Phone _____

Age _____ Date of Birth ____/____/____ Email _____

Marital Status (circle) Married Single Widowed Divorced Referred by _____

Name of Spouse _____ Do you have children? ☐ Yes ☐ No

# of children _____ Ages of children _____

Emergency Contact _____ Contact Number _____ Relationship _____

PERSONAL HEALTH HISTORY

Reason for seeking services at Integrity Chiropractic and Wellness (Chief concern) _____

_____

Is this due to an ☐ Auto Accident ☐ Worker's comp ☐ Neither

Since this started it is ☐ the same ☐ getting better ☐ getting worse

This impacts your ☐ work ☐ family time ☐ leisure ☐ sleep ☐ athletics ☐ other _____

_____

Name of Doctor(s) _____

Medications you currently take ☐ NSAID (Advil, etc) ☐ Statins ☐ Blood Pressure ☐ Pain Killers

☐ Muscle Relaxers ☐ Allergy ☐ Anti-Depressants ☐ Cold Medications ☐ Hormones

☐ Other _____

COMMITMENT TO WELLNESS

Wellness is an active process of becoming aware of and making choices toward a healthy and fulfilling life.
"A state of complete physical, mental, and social well-being, and not merely the absence of disease or infirmity." The World Health Organization

Please mark the scale with the following indicators

'X' = current level of health 'O' = your desired level

Very Challenged Challenged Transition Good Excellent

What is your current level of commitment to yourself, your life, and well-being? (Circle)

No Commitment 1 2 3 4 5 6 7 8 9 10

What changes would you most like to experience with care in this office?

☐ Symptom Relief/Temporary Relief ☐ Restore Health ☐ Maximum Correction

☐ Wellness & Prevention ☐ Improved Performance

☐ Other _____

Since the nervous system controls EVERYTHING in your body it is quite likely that your current health challenges are related to the problems you are seeking care for in our office. What other specific goals might you have?

☐ Better sleep ☐ More energy ☐ Keep up with children/grandchildren

☐ More joy & ease ☐ Cease medication ☐ Reach full potential

☐ Other goals not listed _____

HISTORY OF INJURY/REPETITIVE STRESSES

How many auto accidents (including fender benders) have you had? _____

What sports are/were you involved in? _____

Broken a bone? If so, which ones? _____

Other injuries _____

Do you ☐ Sit >4 hours/day ☐ Drive >2 hours/day ☐ Perform Repetitive Tasks

Surgeries? If so, when and for what conditions? _____

_____

CHIROPRACTIC HISTORY

Have you ever received Chiropractic care? ☐ Yes ☐ No Approx. how long ago? _____

Reason for previous care _____ Name of Chiropractor _____

What care plan was given including at-home exercises? _____

_____

Did you follow the care plan? ☐ Yes ☐ No If not, why? _____

Are your family members under Chiropractic care? ☐ Yes ☐ No If yes, who? _____

HELP US SERVE YOU BETTER

Anything else we should know so we can better serve you? _____

_____