NETWORK CHIROPRACTIC CENTER

VITALITY QUESTIONAIRRE

Name:_____ Date:_____

Address:_____City:_____State:_____Zip:____

Home Phone:_____ Work:_____ Cell Phone:_____

Age:_____ Date of Birth: ____/_____/_____ Social Sec. #:_____

E-mail:_____

Employer:_____Occupation:_____

Marital Status: S/M/D/W Name of Spouse/Partner:_____

Names and Ages of Children:_____

Emergency Contact:_____ Phone:_____

Who referred you to Network Chiropractic Center?_____

Reason for seeking services? How has it affected your life? How long? Severity?

LIFE STYLE:

Briefly describe your average meal:

What is your daily fluid intake? What and how much?

What is your average sleep per day? Time you go to bed & wake up? Quality?

Do you exercise? Type? How often?

Relationships? (family, friends) (good, amazing, supportive, stressful?)

Satisfaction at work: low medium high

Do you presently use or have used in the past any over-the-counter, prescription, or recreational drugs? If so, please list:

Do you use: Tobacco? Coffee or other stimulant? White refined sugary foods

What vitamins, minerals, homeopathics, herbs do you take?

What are your health goals?

What is your level of commitment to yourself and your Well-Being? High Medium Low

HEALTH HISTORY

Have you ever been adjusted by a chiropractor? Y/N When? How long?

Do you consult with a family MD, DO, ND regularly? Y/N If yes, for what ?

Has anyone in your family suffered a serious illness (Cancer, Heart, Diabetes)?

Research shows that many health challenges have origins during childhood years, even as early as birth.

Physical Stressors: (Please circle or answer)

Birth: Forceps? C-section? Breech? Vacuum Extraction? Natural? Drugs?

List any injuries, falls, accidents:

List any fractures, surgeries:

Any abuse: physical? sexual?

Non trauma: Sitting on wallet, Purse on one shoulder, Computer for hours, Sleep posture?

Emotional Stressors: (Please circle)

Relationships? Work? Children? Money? Quick Tempered? Hold in feelings? Perfectionist? Procrastinator? Illness or loss of a loved one? Depression? Suicidal thoughts? Anxiety? Fears? PTSD? Abuse?

Chemical Stressors: (Please circle)

Have you been exposed to large amounts of : Industrial pollutants? Cigarettes? Second hand smoke? Junk food? Caffeine? Artificial Sweeteners? Drugs of any kind? Vaccines? Cosmetics and hair dyes? Cleaning solutions? Pesticides? Herbicides? Other?

FOR WOMEN:

Are you pregnant? Y/N Currently nursing? Y/N On Birth Control Pills: Y/N

Excessive menstrual flow: Y/N Irregular cycles: Y/N Extreme Cramping: Y/N

Are you going through menopause: Y/N If so, any symptoms:

STRESS HISTORY: (can be your internal habit of stress or external stressors)

Rate your stress levels in the last year. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress levels over your lifetime. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Is there anything else that you feel is relevant for the doctor to know about you?

Signature: _____ Date:_____

Consent to treat Minor signed by parent/guardian: _____Date: _____