

Your Life Review –

Wollen Family Chiropractic

Box 1

Begin Here

If you have enjoyed regular chiropractic wellness care (weekly), please go to box 2.

If this is for pain based care, please go to box 3 and complete the information questionnaire.

Box 2

Welcome to our Office

If you have already experienced the tremendous benefits of regular Chiropractic adjustments and wish to continue the chiropractic wellness experience, welcome to our office and together let's keep the world healthy.

GO TO BOX 4.

Box 3

Current Health Challenge Information

Describe the pain: sharp dull travels constant

Since the onset is the pain: worse better the same on & off

Is there anything that makes it worse: standing sitting lying motion

Are any of your systems involved: digestive cardiovascular respiratory
elimination reproductive

Does the pain cause you to: lose sleep be short tempered miss work
miss play lose focus

Any other facts about your current problem or pain: _____

Box 4 Please check all your warning signs even if not seemingly related to your complaint.

1 <input type="checkbox"/> frequent colds <input type="checkbox"/> anxiety <input type="checkbox"/> cold hands/feet <input type="checkbox"/> ulcers <input type="checkbox"/> bowel problems <input type="checkbox"/> restless sleep <input type="checkbox"/> nervousness <input type="checkbox"/> high BP <input type="checkbox"/> tight muscles <input type="checkbox"/> accelerated aging <input type="checkbox"/> heart palpitations <input type="checkbox"/> poor expressions of emotions	2 <input type="checkbox"/> ADD <input type="checkbox"/> hypoglycemia <input type="checkbox"/> poor concentration <input type="checkbox"/> cognitive worry <input type="checkbox"/> irritability <input type="checkbox"/> impulsivity <input type="checkbox"/> distraction <input type="checkbox"/> low energy <input type="checkbox"/> disorganization <input type="checkbox"/> incontinence <input type="checkbox"/> muddledness <input type="checkbox"/> poor awakening <input type="checkbox"/> low pain threshold	3 <input type="checkbox"/> headaches <input type="checkbox"/> seizures <input type="checkbox"/> narcolepsy <input type="checkbox"/> PMS <input type="checkbox"/> sleep walking <input type="checkbox"/> hot flashes <input type="checkbox"/> allergies <input type="checkbox"/> bi polar disorders <input type="checkbox"/> eating disorders <input type="checkbox"/> bed wetting <input type="checkbox"/> mood swings <input type="checkbox"/> panic attacks	4 <input type="checkbox"/> fevers <input type="checkbox"/> fatigue <input type="checkbox"/> MS <input type="checkbox"/> Epstein-Barr syndrome <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> depression <input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Chronic fatigue syndrome <input type="checkbox"/> Auto-immune system disorders
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Box 5

Injury History

Hospital birth: yes no Play any sports? yes no What sports: _____

Ever broken a bone? _____ Did you: fall as a child? yes no Ever been knocked out? yes no

Ever been in any motor vehicle accidents? (please note type and year, even if not apparently injured) _____

Any surgeries? _____

History of illness:

List current medications: _____

Box 6

Agreements

The statements made on this form are accurate, to the best of my recollection, and I agree to allow this office to do an examination of me for further evaluation.

SIGNATURE _____

DATE _____