Restoring Life chiropractic

Dr.'s Eric & Lauren Alvarado
your family's vitalistic chiropractors

Name: ___________________________________ Social Security Number: ____________________
Age: _____ Date of Birth: ____________ ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated
Address: _________________________________ City: ________________ State/Zip: ____________
Home Phone: _______________ Cell Phone: _______________ Office Phone: _______________
Please provide your cell phone provider in order to participate in our automatic appointment reminder system (ATT, Verizon, TMobile): ____
E-mail: _________________________________ Occupation: _________________________________
Spouse's Name: _________________________ Spouse's Occupation: ________________________
Name/Ages of Children: ____
Emergency Contact Name/Relation/Phone Number: _______________________________________

Most of the people in our practice hear about us through testimonies from their friends & family.
Who can we thank for referring you to our office? _____________________________________
Have you previously received chiropractic care? ☐ Yes ☐ No When: ________
How was your experience: ____

What are your reasons for seeking services at Restoring Life Chiropractic?

Do you use over the counter medication or recreational drugs? If so please list:

Have you experienced any previous traumas to your body such as surgeries, accidents, and/or other injuries? Females please list all birth experiences regardless of the type of birth.

Do you use any tobacco products? ☐ Yes ☐ No Packs per day: ____ Years you have smoked: ____
Do you exercise? ☐ Yes ☐ No Frequency & Type of Exercise: ______________________________
Do you drink alcohol? ☐ Yes ☐ No How much per week: __________________________________

Have you ever been diagnosed as having or suffered from?

☐ Broken or Fractured Bones	☐ Osteoarthritis	☐ Alcoholism	☐ Loss of Bowel/Bladder
☐ Circulatory Problems	☐ Pace Maker	☐ Drug Addiction	
☐ Rheumatoid Arthritis	☐ Stroke	☐ HIV Positive	
☐ Seizures	☐ Cancer	☐ Congenital Disease	

It is important to know certain things about your family history. Please check if applicable & indicate whether the family member is your Father, Mother, Brother, Sister.

☐ Diabetes	☐ Cancer	☐ Liver Disease	☐ Lung Disease	☐ Stroke
☐ Heart Disease	☐ Mental Illness	☐ Arthritis	☐ Kidney Disease	☐ Asthma
☐ Other				

Since your Nervous System controls everything in your body it is quite likely that your current health challenges are related to the reasons you are seeking care for in our office. Please mark the following challenges you have had, CURRENT or PAST:

☐ High/Low Blood Pressure	☐ Menstrual Pain	☐ Buzz/Ringing in Ears
☐ Headaches	☐ Acid Reflux	☐ Numbness in Arms/Fingers
☐ Ulcers	☐ Loss of Balance	☐ Numbness in Legs/Toes
☐ Fatigue	☐ Tension Across Shoulders	☐ Sleeping Problems
☐ Neck Pain	☐ Dizziness	☐ Lights Bother Eyes
☐ Back Pain	☐ Irritability	☐ Menstrual Irregularity
☐ Cold Hands	☐ Constipation	☐ Knee Pain
☐ Stomach Upset	☐ Asthma	☐ Pain Between Shoulder Blades
☐ Depression	☐ Arm Tingling	☐ Digestive Problems

How do these challenges cause you to act:
☐ Moody ☐ Irritable ☐ Interrupts Sleep ☐ Restricts Daily Activities ☐ Other: _________

How do these challenges bother you at work:
☐ Decision Making ☐ Exhausted at the End of the Day ☐ Decreased Productivity
☐ Poor Attitude ☐ Unable to Work Long Hours ☐ Other: _____________________________

How do these challenges hinder your life:
☐ Loss of patience with spouse or children ☐ Hinders ability to participate in exercise/sports
☐ Restricted Household Duties ☐ Interferes with ability to participate in hobbies
☐ Other: ____

As a society we are 50th in the world in health care. At Restoring Life Chiropractic we take pride in helping people attain their optimum health and wellness. With that being said we need an honest assessment of your current level of health. So please place an "X" on the scale below, indicating your level of health and wellness at this time. Then circle on the diagram, showing us the desired location of your health and wellness.

☐ Very Challenged	☐ Challenged	☐ Transition	☐ Good	☐ Excellent
0-50	50-75	75-100	100-125	125+

What is your level of commitment to yourself, your life, and your Well-Being?

☐ High	☐ Medium	☐ Low

Please read the following information about Vitalistic Chiropractic.

People see Chiropractors for a variety of reasons. Many enter chiropractic care under a belief system that chiropractic serves as a natural remedy for various symptoms and/or conditions and soon discover there is much more to chiropractic. Vitalistic Chiropractic focuses on your body's ability to heal regardless of your symptoms, condition, and/or diagnosis. You will notice throughout your care that we do not focus on symptoms, sickness, and disease. Our primary focus is on health, healing, and well-being.

We do not provide relief care for symptoms. We provide restorative care; restoring the nervous system to its full potential so that your body may heal from the inside out. The doctor will suggest the appropriate care based on the current state of your central nervous system.

FEMALE PATIENTS ONLY: X-rays may be used as a tool in the diagnosis process. Please let us know if you may be pregnant.

☐ I am pregnant ☐ I am not pregnant ☐ I may be pregnant	☐ I may be pregnant and would like to have a pregnancy test before proceeding with x-rays.	☐ LMP date: __________

I authorize the doctor to release all information necessary to communicate with personal physicians and other health care providers. I understand that I am responsible for all costs of chiropractic care. The statements made on this form are accurate to the best of my knowledge.

Privacy Act/HIPPA Compliance: I consent to the use of my protected health information by Restoring Life Chiropractic for the purpose of analyzing, diagnosing, treatment, obtaining payment for my health care bills and/or coordination of care.

X ________________________________ ____________________________ _________________

Signature of Patient　　　Printed Name of Patient　　　Date