



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?

<input type="checkbox"/> Broken or Fractured Bones	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Loss of Bowel/Bladder
<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Drug Addiction	
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> HIV Positive	
<input type="checkbox"/> Seizures	<input type="checkbox"/> Cancer	<input type="checkbox"/> 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.

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Asthma
<input type="checkbox"/> 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:

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

<input type="checkbox"/> Very Challenged 0-50	<input type="checkbox"/> Challenged 50-75	<input type="checkbox"/> Transition 75-100	<input type="checkbox"/> Good 100-125	<input type="checkbox"/> Excellent 125+
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What is your level of commitment to yourself, your life, and your Well-Being?

<input type="checkbox"/> High	<input type="checkbox"/> Medium	<input type="checkbox"/> Low
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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.

<input type="checkbox"/> I am pregnant	<input type="checkbox"/> I may be pregnant and would like to have a pregnancy test before proceeding with x-rays.	<input type="checkbox"/> LMP date: _____
<input type="checkbox"/> I am not pregnant		
<input type="checkbox"/> I may be pregnant		

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**