



# WHOLE FAMILY CHIROPRACTIC

Dr. Tye Moe

*Welcome!*

Your first visit to our center is an opportunity for us to learn all about you and your family. It is a time for you to share with us where you are now in your health and life, as well as what you would like to move toward. And away we go!

## Personal Information

Name \_\_\_\_\_ Birth Date \_\_\_/\_\_\_/\_\_\_ Today's Date \_\_\_/\_\_\_/\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Ext. \_\_\_\_\_ (Cell) \_\_\_\_\_

Address \_\_\_\_\_  
Number & Street City State Zip

Email Address \_\_\_\_\_

Single  Married/Partnered  Widowed  Divorced Spouse/Partner's Name \_\_\_\_\_

# of Kids \_\_\_ How many at home? \_\_\_ Names & ages: \_\_\_\_\_

What kind of work do you do? \_\_\_\_\_ Self-employed?  Yes  No

Have you ever been to a chiropractor before?  Yes  No Approximate date of last visit \_\_\_/\_\_\_/\_\_\_

Dr.'s Name/City/State: \_\_\_\_\_ Good results?  Yes  No

Are you under care of any other doctor? Yes/No If Yes, the condition being treated for: \_\_\_\_\_

Please check if you are here for any of the following:  Motor Vehicle Injury  Work Injury  Other Injury

Whom may we thank for referring you to our center? \_\_\_\_\_

Favorite hobbies or interests: \_\_\_\_\_

# Let's Find Out Why You're Here...



Reason for seeking chiropractic care: \_\_\_\_\_

Any other specific concerns? \_\_\_\_\_

List all current medications and conditions being treated: \_\_\_\_\_

List any past surgeries and dates: \_\_\_\_\_

List any past accidents and dates: \_\_\_\_\_

List any injuries you've had: \_\_\_\_\_

Have you ever been under chiropractic maintenance care? \_\_\_\_\_

Do you know what a subluxation is? If yes, please describe: \_\_\_\_\_

## Health Inventory

If you have experienced any of the following, please indicate by writing C (Current), P (Past) or CP (Current and Past).

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Neck pain/stiffness   | <input type="checkbox"/> Loss of balance     | <input type="checkbox"/> Lights bother eyes     |
| <input type="checkbox"/> Sleeping problems  | <input type="checkbox"/> Shoulder pain         | <input type="checkbox"/> Earaches            | <input type="checkbox"/> Cold Sweats            |
| <input type="checkbox"/> Frequent colds     | <input type="checkbox"/> Mid back pain         | <input type="checkbox"/> Ringing in ears     | <input type="checkbox"/> Fever                  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Low back pain         | <input type="checkbox"/> Irritability        | <input type="checkbox"/> Skin Conditions        |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Hip pain              | <input type="checkbox"/> Depression          | <input type="checkbox"/> Urinary problems       |
| <input type="checkbox"/> Digestion problems | <input type="checkbox"/> Joint pain            | <input type="checkbox"/> Nervousness         | <input type="checkbox"/> Mood swings            |
| <input type="checkbox"/> Weakness           | <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Tension             | <input type="checkbox"/> Menstrual irregularity |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Heart problems        | <input type="checkbox"/> Ulcers              | <input type="checkbox"/> Menstrual pain         |
| <input type="checkbox"/> Headaches          | <input type="checkbox"/> Pins/ needles in legs | <input type="checkbox"/> Pin/needles in arms | <input type="checkbox"/> Hot flashes            |
| <input type="checkbox"/> Migraines          | <input type="checkbox"/> Leg/foot pain         | <input type="checkbox"/> Arm/hand pain       | <input type="checkbox"/> Brain fog              |
| <input type="checkbox"/> Nausea             | <input type="checkbox"/> Numbness in toes      | <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Difficulty focusing    |
| <input type="checkbox"/> Fainting           | <input type="checkbox"/> Cold feet             | <input type="checkbox"/> Cold hands          | <input type="checkbox"/> Cancer                 |
| <input type="checkbox"/> Low energy/tired   | <input type="checkbox"/> Anxiety               | <input type="checkbox"/> Sinus congestion    | Other: _____                                    |

# What's Happening in Your Life

Please circle any stresses you have encountered.

## Physical

Slip or fall

Sporting activity

Lifting

Prolonged computer-TV time

Sleeping in a weird position

Manual labor

Housework

Pregnancy

Birth Trauma

Other \_\_\_\_\_

## Mental

Work

Rush-hour traffic

Taxes

Bills

Arguments

Deadlines

Busy schedule

Homework

Exams

Other \_\_\_\_\_

## Chemical

Medications (OTC or prescription)

Nicotine

Alcohol

Soda (regular or diet)

Fast Food

Processed foods

Energy drinks

Sugar

Vaccinations/Immunization

Other \_\_\_\_\_

Do you notice you store your stress in (please circle):

◆ Your neck/shoulders    ◆ Mid-back    ◆ Low-back/pelvis    ◆ Other \_\_\_\_\_

Please rate your GENERAL stress level, 0 to 10 \_\_\_\_\_ At Work/School \_\_\_\_\_ At Home \_\_\_\_\_

# Your Health

Name/Phone of the last doctor who put you on a health development program?

Were you able to stay on the program? \_\_\_\_\_ How long? \_\_\_\_\_ Good results? \_\_\_\_\_

Are you healthier today than you were 5 years ago?  Yes  No  Not Sure

Will you be as happy and healthy as you are today (or BETTER) in 5 years?  Yes  No  Not Sure

If yes, what will you do to make sure you are? \_\_\_\_\_

If no or not sure, what *could* you do to *start* getting happier & healthier? \_\_\_\_\_

What would you like your health to be like 5 years from now? \_\_\_\_\_

## Let's Make Sure We're On the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventative form of *medicine*. Medically-based care specializes in the *diagnosis* and *treatment* of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nerve systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function *is* increased **health, wellness** and an **overall improved quality of life**, we will not diagnose, treat or attempt to cure any specific physical, mental or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a *specific* medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease orientated professional if you feel that our function-based approach will not be sufficient in progressively raising you to the levels of health, wellness and quality of life you desire for yourself and your family.

I, \_\_\_\_\_, have read and understand the above statement and I hereby give permission for Dr. Tye Moe to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Moe to report his findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

*We sincerely thank you for choosing our center and for taking the time to honestly reflect upon and share your current level of health and well being, as well as your goals.*

***We look forward to helping you maximize your experience and expression of health and life!***

