Health Intake Form

Advanced Spine and Posture Center

123 E. Drake Rd.

Fort Collins, CO. 80525

Name: ____Date:___________________________

Address: ______________________________City:______________State:___Zip:_______________

Home Ph: _________________Work Ph: ___________________Cell Ph:______________________

Best Number to contact you: Home Work Cell Social Security #________________________________

Email Address: ____

Birth Date: _______________Age: _____Sex: M F circle one: single married partnered widowed divorced separated

Occupation & Employer: ____________________________ # of hours worked per week: __________

Significant Other's Name: ________________________Significant Other's Occupation: _____________

Name and Ages of Kids: ____

Who can we thank for referring you to our office: ____

Main reason for consulting our office today: ____

Any information about your Nerve System and Spine we should know: ____________________________________

What is your level of commitment to yourself, your life and wellbeing? __High __Medium __Low

Have you ever sought the services for this or any other health concern from the following?

__Massage therapist __Acupuncturist ___Naturopath ___Yoga Studio ___Physical Therapist

___Personal ___Nutrionalist ___Rolfer _____Pilates ___Other_________

___Chiropractic

Have you been adjusted by a chiropractor before? ___Yes ___ No

Office: ___________________Date of last Adjustment: _______________________________

Frequency of Care: ___________________ x per week/month Duration of care: ______ weeks/months/years

-What is your daily fluid intake: Coffee____/week Alcohol___/week Water____/day Soda_____/week

- Sleep/Rest Habits: Daytime naps: Y N Hours a night:_______/hrs Do you wake up refreshed? Y N

- Are you interested in improving your physical agilities? Y N Are you concerned with weight loss? Y N

- Exercise Habits: (please describe what you do and how often)

-What type of work do you do? ____Satisfied/Enjoy your work? Y N

-Do you use prescription, over the counter and/or recreational drugs/medications? Y N (If yes, please list)

-What are your current play and relaxation activities?

Check any of the symptoms or conditions below that you experience?

__Headaches	__Carpal Tunnel	__Asthma	__Digestive Problems
__Neck Pain	__Problem Sleeping	__Vertigo	__Pain Between Shoulder Blades
__Mid-Back Pain	__Ringing in Ears	__Cancer	__Shortness of Breath
__Low-Back Pain	__Loss of Balance	__Allergies	__ Tension across Top of Shoulders
__Sciatic Pain	__High Blood Pressure	__Dizziness	__Numbness in Arms/Legs
__Leg or Hip Pain	__Weight Trouble	__Depression	
__Shoulder/Arm Pain	__Low Energy/Fatigued	__Other____	

Which one of the above symptoms is worst? ________________________ How long have you had it? __________________________

When it is at its worst, how does it feel? ____

The following 3 areas can contribute to nerve interference and diminished quality of life. Circle the areas that apply to you and when.

C=Child T=Teenager A=Adult N=Not at all (circle one in each category)

Physical Stress		**Emotional Stress**		**Chemical Stress**	
Birth Stress	C T A N	Relationships	C T A N	Environmental	C T A N
Slip/fall	C T A N	Career	C T A N	Smoker	C T A N
Car Accident	C T A N	Family	C T A N	Second Hand Smoke	C T A N
Sports Injury	C T A N	Money	C T A N	Caffeine	C T A N
Physical Abuse	C T A N	Fast paced life	C T A N	Artificial Sweeteners	C T A N
Work Injury	C T A N	Holds in Feelings	C T A N	Prescription Drugs	C T A N
Poor Posture	C T A N	Quick Tempered	C T A N	Recreational Drugs	C T A N
Sitting on Wallet	C T A N	Perfectionist	C T A N	Self Medicate	C T A N
Stomach Sleeper	C T A N	Procrastinator	C T A N	Poor Diet	C T A N
Computer Work	C T A N	Loss of loved one	C T A N		

Repetitive lift/bending C T A N

Prolonged Driving C T A N

Prolonged Standing C T A N

Prolonged Sitting C T A N

Surgery/Broken Bones C T A N

Lack of Physical Activity C T A N

Excess Physical Activity C T A N

- What do you feel is the primary stressor in your life?

- Rate(circle) your combined overall level of stress from all sources listed above:

No Stress—1—2—3—4—5—6—7—8—9—10—High Stress

Terms of Service

When a person seeks chiropractic health care and we accept someone for such care, it is essential for both to be working towards the same objective. Chiropractic has only one goal, to detect and correct/reduce the vertebral subluxation. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Insurance: Advance Spine and Posture Center as a courtesy check will check patient's insurance benefits and will bill insurance for any who want care and have Chiropractic coverage. However, patient acknowledges that they are responsible for payment of services and any unpaid amounts not covered by their insurance carrier.

ADJUSTMENTS: An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method is by specific adjustments of the spine.

HEALTH: A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate wisdom/ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area. Regardless of what disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **Our only practice objective** is to eliminate a major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. If a lifetime of a better functioning body is what you want for you, your family, and friends then welcome, you are in the right place.

I,(Printed name)________________________________(Signature)_______________________________undertake any care with the understanding of and agreement with, the above explanation. ______________________(Date)

Consent to evaluate and adjust a minor and/or child: I, ______________________________ (Print name) being the parent or legal guardian of ____________________________(Print name) give permission for my child to receive any care.