

Welcome To Bolt Chiropractic Family Wellness

Today's Date: ___/___/___ Home Ph. # _____

Work Ph. # _____

Name: _____

What you prefer to be called: _____

Mailing (Street) Address: _____

City: _____ State: _____ Zip Code: _____

Email address (for patient newsletter) _____

Birth Date: ___/___/___ Age: _____ S.S. # _____

How did you learn about our office? _____

Previous Chiropractic Care? ___ Yes ___ No

Approximate Last Visit Date: _____

Marital Status: ___ Single ___ Married ___ Divorced ___ Separated ___ Widowed

Spouse's Name: _____

Names and Ages of Children: _____

Hobbies: _____

Patient's Employer/Business: _____

Occupation: _____

Recent work related injury? ___ Yes ___ No Auto Accident? ___ Yes ___ No

Please check reasons for pursuing chiropractic care:

___ *I'm continuing ongoing care from another chiropractor.*

___ *I'm Interested in wellness and natural health care.*

___ *I'm concerned about my health and I'm looking for answers.*

___ *I have a specific condition that concerns me.*

Explain condition or symptom: _____

___ *I want to improve my immune function.*

___ *I have no idea why I'm here. Please take the time to explain to me what you do.*

In order for us to better understand your current level of health, please check any of the following body signals which you have or have had previously:

___ Dizziness or Fainting ___ Headache ___ Postural Imbalance ___ Arthritis ___

Asthma

___ Short Leg/Orthotics ___ Ear Infection ___ Intestinal Problems ___ Frequent Colds

Sinus Problems High Blood Pressure Bladder Problems Kidney Problems
 PMS Menopausal Symptoms

Check the following conditions that YOU have or have had:

Circle conditions that are common to FAMILY MEMBERS:

AIDS Alcoholism Cancer Diabetes Epilepsy Hyper/Hypothyroidism
 Heart Disease Lung Disease Multiple Sclerosis Scoliosis Stroke
 Ulcers

List Prescription or Over The Counter Medications Now Taken:

Known Allergies:

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation).

Which of these stresses do you recognize?

Please circle when you experienced these stresses:

C (Child), T (Teenager), A (Adult)

Physical/Emotional/Chemical Stress:

Comments:

Birth Trauma	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/Standing		T	A	
Children Stress			A	
Career Stress			A	
Relationship Stress	C	T	A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount:

Poor Diet/Excessive Sugar C T A
Caffeine C T A Amount:

Artificial Sweeteners C T A
Prescription Drugs C T A
Over-The Counter Drugs C T A
(ex. Tylenol, Motrin)

Which do you feel are your primary stresses? _____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxations. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

(Signature)

____/____/____
(Date)