"Since 1982"
CRUZ Life CENTER
Natural Health Care Solutions for Your Life
· LASER THERAPY
· CHIROPRACTIC
· HEALTH COACHING

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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:	**Date:**
Address: Street City State Zip	
Home phone:	**Work phone:**
Cell phone:	**Email address:**
Best time/place to contact you:	
Date of birth:	**Age:**
No. of children:	**Pregnant?** Yes ☐ No ☐
Height:	**Weight:**
Marital status: M S W D	**Spouse/guardian name:**
Occupation:	
Employer:	
Name of person responsible for account:	
Do you have Medicare coverage? Yes ☐ No ☐ SS#: _____	

Who may we thank for referring you? _____

How Can We Help You with your Health Concerns?

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Does it radiate anywhere? If so, indicate all areas of pain on the picture below.

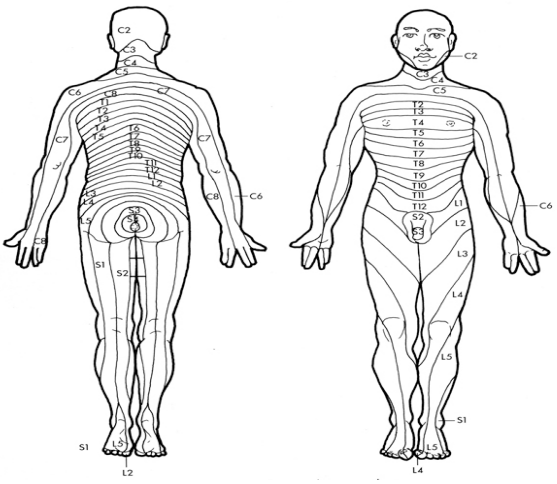
Is your pain dull? _____

Or is your pain sharp? _____

Both sharp and dull at times. _____

Since the problem started is it: About the same □;
Getting better? □ Getting worse? □

What have you done for this condition? Was it of benefit?



What activities aggravate your condition?

What makes it better?

Other doctors you have seen for this condition:

“Limited Scope” Chiropractor (focuses mainly on neck and back pain)	□
“Wellness” Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	□
Medical Doctor	□
Other (please describe)	

If applicable, what did the other doctors tell you the problem was?

Is this condition interfering with any of the following?

Work □	Sleep □	Daily routine □	Sports/exercise □	Other □ (please explain):

General Health History
Often times, accumulation of life’s stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Please list any surgeries you have had and approximate date or year.

Please list any traumatic injuries you have had such as car or work accidents and falls:

Do you wear orthotics or heel lifts? Yes □ No □

Current Medicines and Supplements
Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take and why:

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes □ No □ Maybe □
If dietary changes are indicated would you be willing to make changes in your diet?	Yes □ No □ Maybe □
If specific exercises or stretching would help would you consider adding them to your program?	Yes □ No □ Maybe □
If reducing stress would help you would you like to know ways to reduce stress?	Yes □ No □ Maybe □

Stressors
Because accumulation of stress affects our health and ability to heal please let us know if you are currently feeling stressed in any of these areas below. Circle yes or no.

1. Physical stress (falls, accidents, work postures, etc.) **YES** **NO**

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.) **YES** **NO**

3. Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.) **YES** **NO**

Is there anything else which may help to better understand you which has not been discussed?

_____ I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature: _____

Date: _____