rivulet
CHIROPRACTIC

Vital Information

Date:_____

Name_____ SSN _____-_____-_____
Address_____City_____ Zip _____
Date of Birth_____ Age____ Gender_____ Height_____ Weight_____
Cell Phone_____ Work_____ Home_____
Email Address _____
Best number to contact you: Cell / Work / Home (circle one)
Employer_____ Occupation _____
Status: Married / Domestic Partner / Single / Widowed / Divorced
Name of Spouse/Partner_____ Do you have children? Y/N
If so, what are their names and ages? _____
Who may we thank for referring you? _____

Please write your answers to the following:

What is your reason for seeking services at Rivulet Chiropractic?

Is there anything about your Nervous System and/or Spine that we should know?

Life Story

Name_____ Date_____

Please describe an average daily meal:

Breakfast:

Lunch:

Dinner:

Snacks:

What is your daily fluid intake? What and how much? _____

_____

What is your average sleep/rest per day? _____ Quality? Good Fair Poor

Do you exercise? What do you do and how often?

_____

_____

How are your family relationships? (i.e. good, stressful, none)

_____

_____

What type of work do you do? (i.e. sitting, repetitive, standing, lifting, posture)

_____

_____

How often do you vacation? _____

What are your play and relaxation activities? _____

_____

Do you use recreational drugs, prescription or over-the-counter medications? If yes, please list: _____

_____

Any other health related concerns/challenges? Any previous diagnosis?

_____

_____

Name_____ Date_____

Do you have any of the following symptoms now or in the last 6 months? Please check all that apply.

☐ Headaches
☐ Allergies
☐ HIV
☐ Shortness of Breath
☐ Neck Pain
☐ High Blood Pressure
☐ Chest Pain
☐ Vertigo/Dizziness
☐ Loss of Smell or Taste
☐ Loss of Balance
☐ Low Back Pain
☐ Anxiety
☐ Stomach Problems
☐ Cancer
☐ Ringing in Ears
☐ Nervousness
☐ Fatigue
☐ Sweats
☐ Heart Condition
☐ Depression
☐ Numbness in Arms/Legs
☐ Other _____

Have you had previous Chiropractic Care? Who? _____

Date of last adjustment? _____

How long were you under care? _____

What is your level of commitment to yourself, your life and well-being?

High Medium Low

For Women Only

Are you pregnant?	YES/NO
Are you currently nursing?	YES/NO
Are you taking birth control pills?	YES/NO
Do you have excessive menstrual flow?	YES/NO
Do you experience irregular cycles?	YES/NO
Do you experience extreme cramping?	YES/NO
Do you have breast implants?	YES/NO

Signature _____ Date _____