



Welcome

Your first visit to our office 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. You may also find your ideas about who you are and your true health and life potentials expanding as you take your first step with us on your joyous journey toward ever-higher levels of health, wellness and wholeness.

Personal Information

Today's Date ____/____/____

Name _____ Birth Date ____/____/____

Address _____
Number & Street City State Zip

Phone (H) _____ (W) _____ (Cell) _____

E-Mail _____ What is the best way to reach you? Home Work Cell

Single Married Widowed Divorced Spouse/Partner's Name _____

of Kids _____ How many at home? _____ Names and Ages: _____

Your Employer _____ Occupation _____ Years On Job _____

Please describe your work duties (i.e. computer, lifting, standing, etc) _____

Do you have a primary healthcare advisor? Yes No Approx. date of last visit ____/____/____

Have you ever been told you have any problems/defects in your spine or nerve system? Yes No

If yes, what? _____

Who can we thank for referring you to our office? _____

WHAT BRINGS YOU TO OUR OFFICE?

- Wellness Care
 Work Injury
 Auto Accident
 Acute/Chronic Problem(s)

Primary Concern: _____

Date it began: _____ Gradual Sudden Progressive over time

What gives it relief?: _____ What aggravates it?: _____

Type of Pain: Sharp Dull Ache Burn Throb

Constant (100% of the time) Frequent (75%) Intermittent (50%) Occasional (25%)

Does it radiate into your: Arm L R Leg L R Does not radiate

Pain Intensity: (No Pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (unbearable pain)
(Please Circle)

Secondary Concern: _____

Date it began: _____ Gradual Sudden Progressive over time

What gives it relief?: _____ What aggravates it?: _____

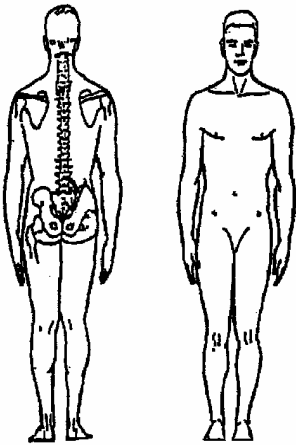
Type of Pain: Sharp Dull Ache Burn Throb

Constant (100% of the time) Frequent (75%) Intermittent (50%) Occasional (25%)

Does it radiate into your: Arm L R Leg L R Does not radiate

Pain Intensity: (No Pain) 0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10 (unbearable pain)
(Please Circle)

Any other concerns?: _____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact **location** of your pain on the diagram. Also describe the **type** and **frequency** of your pain, as well as any activity which brings on or aggravates the pain. For example; dull, sharp, consistent, off & on, when standing, when sitting, etc.....

P= Pain

N= Numbness

T= Tingling

B= Burning

A= Acute/New Problem

C= Chronic Pain

If your condition was due to an accident: Date of accident? _____

Type of accident? Auto _____ Work/On Job _____ At Home _____ Other _____

Have you ever been in an auto accident?

Past Year _____ Past 5 Years _____ Over 5 Years _____ Never _____

The following three areas of stress can cause a spinal misalignment (subluxation), nerve interference and a decreased quality of life. Please indicate any item that you recognize as a stress in your life (past or present).

C= Child T= Teenager A= Adult N= Not at all

Physical Stress

	C	T	A	N	EXPLAIN
Birth Trauma (as mother or child)	C	T	A	N	_____
Slips/Falls	C	T	A	N	_____
Car Accidents	C	T	A	N	_____
Sports Injuries	C	T	A	N	_____
Work Injuries	C	T	A	N	_____
Physical Abuse	C	T	A	N	_____
Poor Posture	C	T	A	N	_____
Sitting on your wallet	C	T	A	N	_____
Sleeping Position (stomach, side)	C	T	A	N	_____
Extensive Computer Work	C	T	A	N	_____
Carrying Heavy Purse/Backpack/Child	C	T	A	N	_____
Repetitive Lifting/Bending	C	T	A	N	_____
Driving for many hours	C	T	A	N	_____
Continuous hours standing/sitting	C	T	A	N	_____
Bone fracture/surgery	C	T	A	N	_____

Emotional Stress

	C	T	A	N	EXPLAIN
Relationship	C	T	A	N	_____
Career	C	T	A	N	_____
Children	C	T	A	N	_____
Money	C	T	A	N	_____
Fast Paced Life	C	T	A	N	_____
Holding in Feelings	C	T	A	N	_____
Quick Tempered	C	T	A	N	_____
Verbal/Emotional Abuse	C	T	A	N	_____
Perfectionist	C	T	A	N	_____
Procrastinator	C	T	A	N	_____
Sickness or Loss of Loved One	C	T	A	N	_____

Chemical Stress

	C	T	A	N	EXPLAIN
Vaccinations/Immunizations	C	T	A	N	_____
Environment (i.e. pollution)	C	T	A	N	_____
Smoker (Amount & for how long)	C	T	A	N	_____
Second Hand Smoke	C	T	A	N	_____
Poor Diet	C	T	A	N	_____
Caffeine (Amount)	C	T	A	N	_____
Artificial Sweeteners	C	T	A	N	_____
Prescription Drugs	C	T	A	N	_____
Over-The-Counter Drugs (i.e. Advil)	C	T	A	N	_____

Recreational Drugs	C	T	A	N	_____
Alcohol (Amount & how often)	C	T	A	N	_____

Please indicate with a * the area(s) that you would consider the greatest stress in your life.

What other things have you done/are currently doing to improve your life and health?

(Please circle all that apply)

Massage	Acupuncture	Yoga	Pilates	Homeopathy
Vitamins/supplements	Meditation/Prayer	Herbs	Physical Therapy	
Exercise (Type & How often)	_____	Organic Foods	Cleanse/Detox	
Other	_____			

Chiropractor, Who? _____ Date of Last Adjustment _____

Frequency of Visits _____ times per week / month

Duration of Care _____ weeks / months / years

Did you enjoy your experience? Yes No _____

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? _____

How committed are you to actively participating in moving yourself toward greater levels of happiness, peace, excitement, health, wellness and wholeness? (Circle your answer)

Not at all 1 2 3 4 5 6 7 8 9 10 **100% Committed**



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

When an individual or family seeks, and is accepted into, a program of **wholeness** or **Life-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 Life-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 a fuller expression of Life Energy in their bodies.

So, while a natural result of a higher expression of Life Energy is **increased health, wellness and an overall expansion of your well-being**, 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 the additional help from a symptom, illness, and disease specialist if you feel that our wholeness-based approach will not be sufficient in progressively raising you to the levels of health, wellness and wholeness you desire for your self and your family.

I, _____, have read and understand the above statement and I hereby give permission for Dr. Greg Parsons and/or Dr. Jodi Parsons and Thrive Chiropractic Studio to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to attend an orientation and allow Dr. Parsons to report his/her findings and recommendations to me immediately following the orientation. By agreeing to this, I am in no way obligated to follow the advice given to me in the orientation and 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!