



## Welcome to Integrative Healing Dynamics

Name \_\_\_\_\_ Age \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Contact Numbers: Home (\_\_\_\_) \_\_\_\_\_ Mobile (\_\_\_\_) \_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_

Occupation \_\_\_\_\_ Social Security # \_\_\_\_\_ DOB \_\_\_\_\_

Marital Status S M D W Name of Spouse \_\_\_\_\_

Names and Ages of Children \_\_\_\_\_

Have Your Children Received Previous Chiropractic Care? Y N \_\_\_\_\_

Parent's Name (if you are under 18 years of age) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to Integrative Healing Dynamics? \_\_\_\_\_

### REASON FOR SEEKING CHIROPRACTIC CARE

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here

\_\_\_\_\_ **“Wish to have Chiropractic Wellness Services”** and skip to **“Other Data”**.

What concerns do you feel Integrative Healing Dynamics can address for you?

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Is the above concern affecting any of the activities below? (Please circle)

Work: Yes No Recreation/Play: Yes No Sleep: Yes No

Social life: Yes No Walking: Yes No Sitting: Yes No

Exercise: Yes No Eating: Yes No Other: \_\_\_\_\_

WHAT ARE YOUR GOALS FOR THIS PROBLEM ? (Please CHECK ALL that apply):

\_\_\_ pain/symptom relief

\_\_\_ isolate and fix the cause of the problem

\_\_\_ adopting a wellness lifestyle

Are you willing to make changes to your diet and/or lifestyle? \_\_\_ Yes \_\_\_ No

### OTHER DATA

Have you ever received Chiropractic care? Yes No With whom? \_\_\_\_\_

Date of last visit: \_\_\_/\_\_\_/\_\_\_ Reason for ending care? \_\_\_\_\_

Name of current medical doctor: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Date of last medical consultation and result: \_\_\_/\_\_\_/\_\_\_ - \_\_\_\_\_

Do you consult him/her regularly? Yes No If so, why? \_\_\_\_\_

For women: Are you pregnant? Yes No Date of last menstrual period: \_\_\_/\_\_\_/\_\_\_

# Chemical Balance Questionnaire

**Speed** of healing determined by **chemical balance** in the body. Chemical balance is determined, in large, by **what you eat**. Please indicate the amounts of frequencies you partake in the following.

**BE HONEST!**

	<b>Per Day</b>	<b>Per Week</b>
1. Coffee (caff/decaff)	___ cups	___ cups
2. Tea (herbal/regular)	___ cups	___ cups
3. Sugar, sweets, desserts, candy, artificial sweetener	___ times	___ times
4. Salt, salty snacks, chips, etc.	___ servings	___ servings
5. Do you add salt to food at meal time?	___ yes ___ no	___ occasionally
6. Red meat (beef, pork, bacon, ham, etc.)	___ times	___ times
7. Chicken/Fish	___ times	___ times
8. Dairy (milk, cheese, ice cream, etc.)	___ glasses/times	___ glasses/times
9. Water	___ glasses	___ glasses
10. Fresh fruits	___ pieces	___ pieces
11. Fresh vegetables (non-canned)	___ servings	___ servings
12. Alcoholic Beverages	___ servings	___ servings
13. Soft Drinks (caff/decaff)	___ servings	___ servings
14. Smoking	___ packs	___ packs

What is a typical breakfast for you?

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What is a typical lunch for you?

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What is a typical evening meal for you?

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List any vitamins/herbs you are currently taking

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## HEALTH, WELLNESS AND CHIROPRACTIC CARE

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

### HISTORY OF PHYSICAL STRESS (Birth to Present)

**Research indicates that the birth process can cause trauma to a baby's spine and nerve system. Please indicate to the best of your recollection how you were birthed:**

Was your birth: (Circle all that apply)

Drug induced      C section      Breech      Natural      Forceps      Hospital  
Prolonged      Home Birth      Vacuum extraction      Umbilical cord around neck

General Physical Trauma:

**Most traumas occur in the early years (between birth and the early twenty's). It is during those years that your spine and nerve system is growing and most vulnerable. The information below will help us to consider the types of stresses that you have been subjected to.**

Have you had any accidents related to the following? (Circle all that apply and give dates.)

Automobile    Motorcycle    Bicycle    Sports    Other: \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Have you ever injured your nerve system or spine? (Head, neck, back, pelvis, hips):    Yes    No

If yes, please explain: \_\_\_\_\_

Have you broken any bones or sprained any part of your body?    Yes    No

If yes, please explain: \_\_\_\_\_

Have you ever had surgery or have you been hospitalized?    Yes    No

If yes, please explain: \_\_\_\_\_

### HISTORY OF CHEMICAL STRESSES

**Chemical stresses occur during life due to any substance that is breathed, injected, taken orally, or placed on the skin that is toxic to the body. The following will give us insight into any exposures you may have had.** (Please circle those that apply)

Have you been vaccinated?    Yes    No

Do you currently or have ever taken?

Prescriptions drugs      Over the counter drugs      Recreational drugs

List drugs you are now taking: \_\_\_\_\_

Have you been exposed to or currently exposed to?

Chemicals      Fumes      Dust      Smoke

Do you consume?    Alcohol      Coffee/caffeine      Tobacco

Are your present problems due to an injury? \_\_\_ Yes \_\_\_ No \_\_\_ On the Job \_\_\_ Auto Collision \_\_\_ Personal Injury \_\_\_ Other:

Have you made a report of your accident? \_\_\_ Yes \_\_\_ No \_\_\_ To Employer \_\_\_ Auto Carrier \_\_\_ Other:

Has the accident been reported? \_\_\_ Yes \_\_\_ No \_\_\_ To Employer \_\_\_ Auto Carrier \_\_\_ Other:

**Please enter "2" (Previously), "3" (Presently), in front of all of the following signs and symptoms. Leave blank if not applicable. A Complete History and Undersatnding of your health will facilitate care.**

### **General Symptoms**

- \_\_\_ 784.0 Headache
- \_\_\_ 780.6 Fever
- \_\_\_ 780.99 Chills
- \_\_\_ 780.8 Night Sweats
- \_\_\_ 780.2 Fainting
- \_\_\_ 780.4 Dizziness
- \_\_\_ 780.3 Convulsions
- \_\_\_ 780.52 Loss of sleep
- \_\_\_ 780.7 Fatigue
- \_\_\_ 799.2 Nervousness
- \_\_\_ 783 Loss of weight
- \_\_\_ 782 Numbness or pain in arms/ legs/ hands
- \_\_\_ 995.3 Allergy (What) \_\_\_\_\_
- \_\_\_ 786.07 Wheezing
- \_\_\_ 729.2 Neuralgia

### **Muscles & Joints**

- \_\_\_ 728.9 Weakness
- \_\_\_ 781.0 Twitching
- \_\_\_ 723.5 Stiff Neck
- \_\_\_ 724.5 Backache
- \_\_\_ 719.0 Swollen Joints
- \_\_\_ 781 Tremors
- \_\_\_ 729.5 Foot Trouble
- \_\_\_ 724.79 Painful Tail Bone
- \_\_\_ 724.5 Pain Between Shoulders
- \_\_\_ 737.3 Spinal Curvature

### **Gastro Intestinal**

- \_\_\_ 783 Poor appetite
- \_\_\_ 536.8 Poor Digestion
- \_\_\_ 994.2 Starvation
- \_\_\_ 787.3 Belching or Gas
- \_\_\_ 787.0 Nausea
- \_\_\_ 787.0 Vomiting
- \_\_\_ 578.0 Vomiting blood
- \_\_\_ 536.8 Pain over stomach
- \_\_\_ 564.0 Constipation
- \_\_\_ 787.91 Diarrhea
- \_\_\_ 562.1 Colon Trouble
- \_\_\_ 455.6 Hemorrhoids (Piles)
- \_\_\_ 776.7 Fluid Retention
- \_\_\_ 873.9 Liver Trouble
- \_\_\_ 274 Gout
- \_\_\_ 782.4 Jaundice
- \_\_\_ 575.9 Gall Bladder Trouble

### **Cardio-Vascular**

- \_\_\_ 785.0 Rapid Heart
- \_\_\_ 427.89 Slow Heart
- \_\_\_ 401.9 High Blood Pressure
- \_\_\_ 458.9 Low Blood Pressure
- \_\_\_ 786.51 Pain over heart
- \_\_\_ 719.07 Swelling Ankles
- \_\_\_ 459.9 Poor circulation

- \_\_\_ 454.9 Varicose veins
- \_\_\_ 436 Strokes
- \_\_\_ 785.1 Palpitations

### **Eye/Ear/Nose/Throat**

- \_\_\_ 368.9 Poor Vision
- \_\_\_ 378.0 Crossed Eyes
- \_\_\_ 379.91 Pain in Eyes
- \_\_\_ 389.9 Deafness
- \_\_\_ 388.70 Earache
- \_\_\_ 388.30 Ear Noises
- \_\_\_ 388.60 Ear Discharges
- \_\_\_ 478.1 Nasal Obstruction
- \_\_\_ 784.7 Nose Bleeds
- \_\_\_ 462 Sore Throat
- \_\_\_ 784.49 Hoarseness
- \_\_\_ 477.9 Hay Fever
- \_\_\_ 493.9 Asthma
- \_\_\_ 460 Frequent Colds
- \_\_\_ 240.9 Enlarged Thyroid
- \_\_\_ 463 Tonsillitis
- \_\_\_ 473 Sinus Trouble

### **Skin or Allergies**

- \_\_\_ 680 Skin Eruption
- \_\_\_ 698.9 Itching
- \_\_\_ 924.9 Bruising easily
- \_\_\_ 701.1 Dryness
- \_\_\_ 680.9 Boils
- \_\_\_ 782 Sensitive Skin
- \_\_\_ 708.9 Hives or Allergy
- \_\_\_ 692.9 Eczema

### **Respiratory**

- \_\_\_ 786.2 Chronic Cough
- \_\_\_ 786.3 Spitting Blood
- \_\_\_ 786.4 Splitting Phlegm
- \_\_\_ 786.50 Chest Pain
- \_\_\_ 786.09 Difficulty Breathing

### **Genito-Urinary**

- \_\_\_ 788.4 Frequent Urination
- \_\_\_ 788.1 Painful Urination
- \_\_\_ 599.7 Blood in Urine
- \_\_\_ 590 Kidney Infection
- \_\_\_ 788.3 Bed Wetting
- \_\_\_ 788.3 Inability to control urine
- \_\_\_ 601.9 Prostate Trouble

### **For Women Only**

- \_\_\_ 625.3 Painful Periods
- \_\_\_ 626.2 Excessive Flow
- \_\_\_ 626.4 Irregular Cycles
- \_\_\_ 627.2 Hot Flashes
- \_\_\_ 625.3 Cramps or Backaches
- \_\_\_ 623.5 Vaginal Discharge

HISTORY OF EMOTIONAL STRESSES

**It is difficult to separate the emotional stress in our lives from the physical response that often occurs. Please indicate if you have ever experienced any of the emotional stresses below:** (Please circle those that apply)

Childhood trauma	Yes No	Loss of loved one	Yes No	Illness	Yes No
Relationships	Yes No	Family	Yes No	Work or School	Yes No
Divorce/Separation	Yes No	Financial	Yes No	Abuse	Yes No
Lifestyle change	Yes No	Parental Divorce	Yes No	Other	Yes No

QUALITY OF LIFE (Please circle those that apply)

How do you grade your physical health?	Good	Fair	Poor
How do you grade your emotional/mental health?	Good	Fair	Poor
How do you rate your overall "quality of life"?	Good	Fair	Poor

\_\_\_ Check if you wish to receive our weekly E-Health Tip. Email: \_\_\_\_\_

*The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:*

Signature \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent (for minor): \_\_\_\_\_

Date \_\_\_\_\_

**Thank you for choosing Integrative Healing Dynamics. We are looking forward to helping you develop a healthier spine and nervous system!**