



Laura Vassar, D.C.

Welcome!

Your first visit to our center is an opportunity for us to learn 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. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of higher levels of health, and wellness in the future.

Personal Information

Name _____ Today's Date ____/____/____ Gender: M F

Address _____

Number & Street _____ City _____ State _____ Zip _____
Phone (H) _____ (Cell) _____ (Work) _____ Ext. _____

Email Address _____ Birth Date ____/____/____ Age: _____

Single Married/Partnered Widowed Divorced Spouse/Partner's Name _____

of children ____ Names & ages: _____

Whom may we thank for referring you to our office? _____

Do you have health insurance? Yes No

What kind of work do you do? _____

Do you have a primary healthcare advisor? Yes No What type? MD DO Other _____

Have you ever been to a chiropractor before? Yes No Approximate date of last visit ____/____/____

Chiropractor's Name/City/State: _____ Good results? Yes No

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

If yes, what? _____

Please check if you are here due to any of the following: Motor Vehicle Injury Work Injury

Other Injury, please explain _____

Let's Find Out Why You're Here...

What is the main reason for your visit today? _____

When did the problem begin?: _____

Does anything make the problem worse?: _____

Does anything make the problem better?: _____

Since this problem started is it: About the same Getting better Getting worse

Is this interfering with (check all that apply): Work Sleep Daily routine Sports/Exercise/Walking
 Positive mental attitude Hobbies Other: _____

What other activities or events do you enjoy that you aren't able to do because of this problem? _____

Any other health concerns? _____

Please check any of the following problems you have experienced **recently** (within the last month) or have experienced in the **past**:

	Recently	Past		Recently	Past		Recently	Past
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	Acid Reflux	<input type="checkbox"/>	<input type="checkbox"/>	Skin disorders	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	Gallbladder problems	<input type="checkbox"/>	<input type="checkbox"/>	Other neurological problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Liver problems	<input type="checkbox"/>	<input type="checkbox"/>			
Deafness	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	MEN ONLY		
Earache	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Testicular swelling/pain	<input type="checkbox"/>	<input type="checkbox"/>
Buzzing/ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Irritable bowel	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/seizures	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>			
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>	WOMEN ONLY		
Sleep Loss	<input type="checkbox"/>	<input type="checkbox"/>	Inability to control			Painful periods	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	urination/defecation	<input type="checkbox"/>	<input type="checkbox"/>	Irregular cycles	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Sexual difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage	<input type="checkbox"/>	<input type="checkbox"/>
Weight loss/gain	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	Excessive flow	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in the arms/			Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	hands/fingers/toes/legs	<input type="checkbox"/>	<input type="checkbox"/>	Are you pregnant at this time?	Y	N
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Pain in the arms/hands/			Date of last menstrual cycle: _____		
			fingers/toes/legs	<input type="checkbox"/>	<input type="checkbox"/>			

Please list any additional problems not noted above: _____

And How You Got to Where You Are Now...

Research is showing that many of the health challenges that occur later in life originate during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

The Beginning Years

Did your mother smoke or drink alcohol while pregnant with you? Yes No Unsure

Did your mother have a difficult pregnancy with you? Yes No Unsure

Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No Unsure

Was your delivery (**please check any/all that apply**):

At home In a hospital Drug induced C-section Breech Forceps

Difficult Prolonged Cord around the neck Vacuum or suction extraction

Did you have any serious childhood illnesses? Yes No Unsure

Did you have any serious falls/injuries as a child (*i.e. falls down stairs, from a crib or bed, from trees, from horses or recreational vehicles, etc.*)? Yes No Unsure

Did you play youth sports? Yes No Unsure

Did you take/use any drugs (prescribed or not)? Yes No Unsure

Was there prolonged use of medicine such as antibiotics or inhalers? Yes No Unsure

Have you ever been knocked unconscious? Yes No Unsure

Have you ever broken any bones? Yes No Unsure

Did you suffer any emotional stresses/traumas? Yes No Unsure

Were you vaccinated? Yes No Unsure

Were you under regular chiropractic care? Yes No Unsure

Comments: _____

Please list any medications (over the counter and/or prescription) you are taking and what they are for:

Have you ever been involved in **any** accidents (auto, work-related, other) or had serious injuries/traumas?

Yes No

Please List

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Have you had any surgery? (Please include **ALL** surgeries):

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Type: _____ Approximate Date: _____

Current Lifestyle

Please **circle the number** that rates your habits and answer the questions that follow.

Eating habits: Very poor 1 2 3 4 5 6 7 8 9 10 Excellent

Do you use artificial sweeteners (Splenda, Aspartame, Nutrasweet, Sugar free food/drinks)? Yes No

Please list any nutritional supplements you take: _____

How much *plain* water do you drink per day? _____

Please list types of other beverages you drink and the # per day (coffee, tea, juice, diet/regular soda, energy drinks) _____

Sleep Quality: Very poor 1 2 3 4 5 6 7 8 9 10 Excellent

Average hours of sleep per night: _____

Position(s) you usually sleep in: _____

Exercise habits: Very poor 1 2 3 4 5 6 7 8 9 10 Excellent

Do you do any regular or structured exercise? Yes No

If yes, what kind and how often? _____

Do you play any adult sports? Yes No (If yes, please list) _____

General health: Very poor 1 2 3 4 5 6 7 8 9 10 Excellent

Do you smoke/chew? No Yes Packs/day _____ Former When did you quit? _____

Number of alcoholic drinks per week _____

Do you have a personal history of drug/alcohol abuse? Yes No

Occupation: _____ Hours sitting: _____ Hours standing: _____

Do you feel your job involves physical labour that is (please circle) light moderate heavy

Mind-set: Very poor 1 2 3 4 5 6 7 8 9 10 Excellent

Do you take time to relax or meditate regularly? Yes No

If yes, how do you do this: _____

How often?: _____ For how long?: _____

Do you do anything specific on a regular basis to encourage a positive mental attitude?

If yes, please list what you do: _____

Please rate your **stress levels** associated with each category on a scale of 1-10 (**1=low stress, 10=high stress**):

_____ Personal relationships (spouse/significant other, family, friends, etc.)

_____ Business or work relationships

_____ Your job itself

_____ Finances

_____ Your health

_____ Uncertainty of the future

_____ Other (please explain) _____

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

When an individual or family seeks chiropractic health care and is accepted into a program of chiropractic care, **it is essential** that you understand **the objectives of our care**.

Chiropractors provide a unique service that other health care providers do not offer: the location and correction or reduction of **vertebral subluxations** (spinal nerve stress) in your body.

A **vertebral subluxation** is a misalignment or distortion of your spinal column or related structures that can affect your brain, nervous system and overall body function. Subluxations can cause pain, dis-ease and/or loss of proper body function.

Chiropractors spend years studying how to locate, analyze and correct vertebral subluxation. We use specialized techniques to facilitate your body's correction of vertebral subluxation. Chiropractor's do this by using what's called an **adjustment**.

An **adjustment** is a specific, intentional and gentle impulse into your spine or related structures to restore normal biomechanics. This takes the pressure off and restores normal tension in your nervous system. When your spine and nervous system are free from the deep stress of vertebral subluxations, you function more efficiently and your natural healing ability, your inborn healer, will better communicate through your body.

We do not offer to medically diagnose or treat any disease, symptom or condition. No matter what condition(s) you may have been diagnosed with and no matter what symptom(s) your body is expressing, you always need a body free from subluxations. If, during the course of our chiropractic examination, we encounter unusual findings that are out of the scope of chiropractic practice, we will let you know of them. You may then decide whether you wish to investigate further and discuss your healthcare options with other healthcare professionals. We will cooperate with you and with them regarding your healthcare goals.

To summarize: the purpose of chiropractic care is not to treat diseases or conditions, nor to suppress symptoms, nor to perform surgery, but rather to help your body function better by removing spinal nerve stress (subluxations). Therefore, we do not prescribe surgery or medications, nor do we offer advice regarding treatment prescribed by others.

Our objective is to reduce or correct a major interference to the expression of your physical/emotional health and healing—vertebral subluxations—so that your natural healing ability and your inborn healer may function without this severe form of stress.

I, (please print name) _____, have read and understand the above statement and I hereby give permission for Dr. Laura Vassar to continue with my and/or my minor child's (please print child's name if applicable) _____ initial consultation and assessment. I also agree to return at a later date to allow Dr. Vassar to report her findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signed _____ Date ____/____/____
(Patient or Parent/guardian's signature)

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. We look forward to helping you maximize your experience and expression of health and life!