



Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is time for you to share with us where you are now in your health & life, as well as what you would like to move toward.

And away we go!

Chiropractic Vitality Inventory

Today's Date: _____

Personal Information

Legal Name: _____ Preferred Name: _____

Pronoun: _____ Sex: _____

Age: _____ Date of Birth: _____

Both Parent's names (if you are under 18): _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Business Phone: (____) _____ Cell Phone: (____) _____

Email Address: _____

Single Married Divorced Widowed Spouse/Partner: _____

Names & Ages of Children: _____

What kind of work do you do? _____ Self-Employed? Yes No

What are your hobbies, interests, & inspirations: _____

How did you hear about us?

Website Google Social Media Event

Referral - Who can we thank for referring you? _____

Other: _____

Let's find out why you're here...

What are the main concerns that brings you in today? When did these concerns start? _____

Are these concerns affecting your quality of life? (please circle all that apply)

Work: Yes No Driving: Yes No Sleep: Yes No

School: Yes No Walking: Yes No Sitting: Yes No

Fitness/Sports: Yes No Eating: Yes No Scale of 1-10, how would you rate the discomfort?

Not bad 1 2 3 4 5 6 7 8 9 10 The worst

Health Care Practitioner History

Have you ever received Chiropractic care? Yes No Name of DC: _____

How long were you under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

- Medical Physician Naturopath Acupuncturist Homeopath
 Massage Therapist Psychotherapist Physical Therapist Dentist

Reason: _____

Have you tried anything else to address your concern? _____

Female Practice Members

Are you pregnant? Yes No

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife: _____

Where will you be birthing your baby? Hospital Home Birthing Center Other: _____

The primary system in the body which coordinates health is the Nervous System (NS). This system is comprised of three layers. The first layer is the spinal musculature encasing the spinal column. The second layer is the joints of the spine known as the vertebral column designed to surround and protect the delicate NS. The third, most important layer is the communication layer made up of the brain, spinal cord, and nerves. When unmanaged stressors add up over time, it not only affects layers one and two, but creates dysfunction and dis-ease in this vital system, leading to physical, chemical, and emotional causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve & health status, & whether they may have caused neurospinal dysfunction.

Is there anything that makes your condition better/ worse? _____

Physical Stress: Childhood through Adult

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (check all that apply)

- Automobile Motorcycle Bicycle Sports Playground Abuse

If yes, please list the type of injury & date: _____

Have you ever hurt, broken, fractured, sprained, injured, or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? Yes No

If yes, please list areas injured & dates of injuries: _____

Have you ever been hospitalized or had surgery? Yes No

If yes, state reason & dates: _____

Chiropractic Vitality Inventory

On average, how many hours do you sit per day? 0-5 5-10 10-15 15+

How would you rate your activity level? Very Active Moderately Active Sedentary

Emotional Stress: Childhood through Adult

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you are currently experiencing (C), have experienced any of the following stressors in the past (P), or anticipate the possibility of experiencing this stress in the future (F).

	C	P	F		C	P	F
Childhood trauma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Divorce / separation (spouse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Divorce / separation of parents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Relationships / Friendships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious illness (self or loved one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anger by you or at you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifestyle change	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Feeling "not worthy"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Financial concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Put things off to the last minute	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Chemical Stress: Childhood through Adult

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Are you currently (C), have you been in the past (P), or do you anticipate future (F) exposure or consumption of any of the following?

	C	P	F		C	P	F		C	P	F
Toxic Chemicals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eat processed foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Sensitivities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Second-hand smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Coffee / Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergies: Dairy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Wheat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Radiation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eggs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Over-the-counter drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nuts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental pollution	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Prescribed drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other foods: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bad diet (white flour & sugar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat fast foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list all medications (prescribed & over the counter): _____

Note: It is imperative that you list all medications & drugs as they may have an influence on your care.

Chiropractic Vitality Inventory

If you have experienced any of the following, please indicate by checking C (current), P (past), or CP (current & past).

	C	P	CP		C	P	CP		C	P	CP
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck pain / stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleeping problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shoulder pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Earaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequent colds	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mid-back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Low-back pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Irritability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hip pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digestion problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins/needles in legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pins / needles in arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Leg / Foot pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arm / hand pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in toes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in fingers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fainting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Low energy / tired	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lights bother eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Conditions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual irregularity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Urinary problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brain fog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty focusing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Quality of Life

Do you notice you store your stress in: (please check all that apply)

- Your Neck & Shoulders Your Mid-back Your Low-back & Pelvis Other

Please rate your GENERAL stress level, 0-10. At Work / School: _____ At Home: _____

How do you think you handle your stress? _____

How do you grade your physical health? Excellent Good Fair Poor

How do you grade your emotional / mental health? Excellent Good Fair Poor

How do you rate your overall "quality of life?" Excellent Good Fair Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

What would you like to gain at Two Rivers Chiropractic?

- Resolution & Prevention of a symptom or problem
- Healthier spine & Nervous system
- Continual progression in health & life
- Other: _____

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

When an individual or family seeks and is accepted into a program of **function-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 preventive form of medicine. Medically-based care specializes in the **diagnosis** and **treatment** of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nervous systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function is increased **health, wellness**, and an **overall improved quality of life**, 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 additional help from a symptom, illness, and disease oriented professional if you feel that our functional-based approach will not be sufficient in progressively raising you to the levels of health, wellness, and quality of life you desire for yourself and your family.

I, _____, have read and understand the above statement and I hereby give permission for **Two Rivers Chiropractic to continue with my, or my child's new patient exam.**

Signature: _____ Date: _____

We sincerely thank you for choosing our center & for taking the time to honestly reflect upon & share your current level of health & well being, as well as your goals.

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