



LUMINOUS
CHIROPRACTIC

Light up your life.

Name: _____ Home Phone: _____

Address: _____

City, State, Zip: _____ Cell Service Provider:

E-Mail Address: _____

Birth Date: _____ Age: _____ SSN#:

Occupation: _____ Employer: _____

Marital Status: M S W Spouse/Partner Name: _____ Number of
Children _____

MY PURPOSE FOR TODAY'S APPOINTMENT:

- I'm here for an evaluation. I'm a healthy person and I'm interested in maximizing my health and preventing future problems.
- I'm here for an evaluation because I'm having health challenges and I'm looking for a natural health solution.
- I'm here for an evaluation. I'm curious to know if my spine is healthy and to see if I have any problems that I am not aware about.
- I'm here for an evaluation because I'm curious to learn more about Chiropractic Care.
- I'm here for an evaluation only.
- Other:

IF THE DOCTOR FEELS THAT THEY CAN HELP YOU:

Please select that one that best applies to you



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- I am willing to follow the doctor's recommendations because I strongly value my health.
- I am willing to receive care if payment plans are available.
- I am willing to receive care but only if my insurance pays for all of it.
- I am not interested in receiving any care I just want to see what the office is all about.

1. Research shows that your spine should be checked regularly. How many times have you visited a chiropractor in your lifetime?
2. When was your last complete spinal examination including x-rays?
3. Have you ever been told that you have a spinal curvature, spinal arthritis, or inherited spinal problem?
4. Spinal misalignments cause decay and degeneration which may result in grinding or cracking noises. Do you ever hear noises or feel grinding when you move your head or neck? YES or NO
5. Spinal misalignments can make you feel like you need to twist, stretch, or crack your neck or back. DO you ever feel the need to crack or pop your neck or lower spine? YES or NO
6. Poor posture leads to poor health and often indicates a spinal problem. How would you rate your posture?
Poor – 1 2 3 4 5 6 7 8 9 10- Excellent
7. Stress can cause or accelerate spinal damage. Rate your stress level over the last 90 days.
Excellent – 1 2 3 4 5 6 7 8 9 10- Poor
8. Please list any health symptoms or health complaints you are currently experiencing.



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9. Prescription medication may cause various side effects, hide the severity of health problems and hinder the body's ability to heal. Please list your current medications and why you are taking them.

10. Auto and work related injuries can cause serious spinal problems. Is this visit related to an accident or injury? YES or NO

11. Spinal health is especially important during pregnancy. Is there a chance you could be pregnant? YES or NO

12. Have you ever been diagnosed with cancer? YES or NO

The above information is true and accurate to the best of my knowledge.

Patient Signature: _____

Date: _____

CONDITION	Self	Father	Mother	Spouse	Brother s	Sisters	Children
Arthritis							
Asthma							
Acid Reflux							
Back Trouble							
Cholesterol							
Cancer							
Constipation							



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HEALTH HISTORY OF FAMILY MEMBERS							
Diabetes							
Spine / Disc							
Name: _____							
Problems							
Date: _____							
The purpose of this form is to assist the doctors by providing past health history information for their review.							
Emphysema							
Fibromyalgia							
Headaches							
Heart Trouble							
High Blood Pressure							
Kidney Trouble							
Migraine							
Nervousness							
Leg/Foot Pain							
Arm/ Hand Pain							
Pinched Nerve							
Neck Pain							
Stomach Trouble							