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**Vitalistic Survey**

Today’s Date Date of Birth Age

Name I like to be called

Address

Cell Phone Work Phone

Email

Occupation

☐ Married ☐ Domestic Partner ☐ Single Name of Partner:

If you have children, please give names and ages:

Are you pregnant or trying to conceive children? ☐ Pregnant ☐ Nursing ☐ N/A

Who can we thank for **referring** you to Pure Light?

Have you seen a chiropractor before? If so, when?

**Emergency contact (name and phone)**

Do you have a specific concern that brings you in? ☐ No, I am interested in having my nervous system assessed to achieve optimal health and wellness ☐ Yes (please explain),

**If yes, please answer the following questions:**

How long have you been experiencing this issue? Days Weeks Months

Where else does the pain go in your body?

How often do you experience this? ☐ Daily ☐ Weekly ☐ Monthly ☐ Comes and goes ☐ Constantly How would you describe the pain/discomfort? ☐ Dull ☐ Achy ☐ Throbbing ☐ Tight/stiff

☐ Burning ☐ Sharp ☐ Other

What makes it feel worse? What makes it feel better?

What have you tried that **has** helped? ☐ Ice ☐ Heat ☐ Massage ☐ Walking/Movement ☐ PT ☐ Chiropractic ☐ Other:

What have you tried that **hasn’t** helped? ☐ Ice ☐ Heat ☐ Massage ☐ Walking/Movement ☐ PT ☐ Chiropractic ☐ Other:

Because Chiropractic involves **bodywork** and **physical touch**, please let us know if you are sensitive to being touched:

**Have you experienced any of the following symptoms?**

**Current (c) Previous (p)**

C P C P

☐ ☐ Allergies ☐ ☐ Carpal Tunnel (numbness in hands/fingers)

☐ ☐ Asthma ☐ ☐ Leg Cramps

☐ ☐ Autoimmune Disorder ☐ ☐ Low/Midback Pain

☐ ☐ Chronic Fatigue ☐ ☐ Neck Pain

☐ ☐ Digestive Issues ☐ ☐ Pins/Needles in front/side of your legs

☐ ☐ Frequent Colds ☐ ☐ Sciatica

☐ ☐ Frequent Infections ☐ ☐ Skin Conditions

☐ ☐ Headaches ☐ ☐ Sleep Problems ☐ Other

**PHYSICAL STRESSES**

Previous hospitalizations/surgeries: ☐ None ☐ Yes

Previous Motor Vehicle Accidents: ☐ None ☐ Yes

Previous Non-Vehicle Accidents/Falls: ☐ None ☐ Yes

Previous Physical or Emotional Diagnosis: ☐ None ☐ Yes

Frequency of exercise/week Cardio:…………………..☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Weight Bearing:……..☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Core Exercise:………..☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Do you stretch after exercise or after other activities of poor posture? ☐ Yes ☐ Sometimes ☐ No

Do you primarily: ☐ Sit ☐ Stand ☐ Perform repetitive tasks ☐ N/A

Hours of sleep: ☐ <6 ☐ 7-9 ☐ 10+ Do you wake refreshed? ☐ Yes ☐ No ☐Sometimes

Age of Mattress (years): ☐ <6 ☐ 7-9 ☐ 10+

Sleep position: ☐ Back ☐ Belly ☐ Side ☐ All

Number of hours spent driving per day: ☐ 0-2 ☐ 3-5 ☐ 6-8

Number of hours spent at a desk or computer per day: ☐ 0-2 ☐ 3-5 ☐ 9+

**CHEMICAL STRESSES**

Number of glasses or ounces of water per day: caffeinated beverages per day

Do you smoke?................☐ No ☐ Yes ☐ I used to for years ☐ Secondhand smoke exposure

Do you drink alcohol?..☐ No ☐ Yes ☐ 0-6 /week ☐ 6-12/week ☐ 12+/week

Any food allergies, sensitivities or intolerances? ☐ No ☐ Yes

Do you eat gluten:?...................................☐ No ☐ Yes ☐ I am trying to eliminate from diet

Dairy...............................☐ No ☐ Yes ☐ I am trying to eliminate from diet

Refined sugars............☐ No ☐ Yes ☐ I am trying to eliminate from diet

Processed food...........☐ No ☐ Yes ☐ I am trying to eliminate from diet

Fast food:......................☐ No ☐ Yes ☐ I am trying to eliminate from diet

Do you take a probiotic daily...............☐ No ☐ Yes ☐ I am interested in learning about Probiotics

Vitamin D………………☐ No ☐ Yes ☐ I am interested in learning about Vitamin D

Omega 3 Oils………….☐ No ☐ Yes ☐ I am interested in learning about Omega 3’s

Multi-Vitamin………...☐ No ☐ Yes ☐ I am interested in learning about Vitamins

Other supplements or homeopathics:

Daily medications/purpose:

**EMOTIONAL STRESSES**

What do you feel is the primary stress in your life?

Rate your current level of personal stress in your life………….☐ None ☐ Low ☐ Moderate ☐ High

Relationship stress…………………………☐ None ☐ Low ☐ Moderate ☐ High

Health stress…………………………………..☐ None ☐ Low ☐ Moderate ☐ High

Family stress…………………………………..☐ None ☐ Low ☐ Moderate ☐ High

Career stress…………………………………..☐ None ☐ Low ☐ Moderate ☐ High

Have you experienced any of the following?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Please check all that apply: | Child | Teen | Adult | Now |
| Financial Stress | ☐ | ☐ | ☐ | ☐ |
| Fast-Paced Life | ☐ | ☐ | ☐ | ☐ |
| Family difficulty | ☐ | ☐ | ☐ | ☐ |
| Difficulty expressing feelings | ☐ | ☐ | ☐ | ☐ |
| Abuse | ☐ | ☐ | ☐ | ☐ |
| Perfectionism | ☐ | ☐ | ☐ | ☐ |
| Procrastination | ☐ | ☐ | ☐ | ☐ |
| Quick-Temper | ☐ | ☐ | ☐ | ☐ |
| Relationship issues | ☐ | ☐ | ☐ | ☐ |

Is there anything else that you would like to tell us?

**Pure Light Chiropractic Cancellation Policy**

As a result of our busy schedule, Pure Light Chiropractic will be charging a $20 fee for appointments cancelled in less than 24 hours. We understand emergencies, so please know we try to be as flexible as possible.

I agree to the cancellation policy and understand that Pure Light Chiropractic will securely store my credit card to process the fee.

(Signature) (Date)

**Terms of Acceptance**

When a person seeks chiropractic health care and we accept a person for such care, it is essential for both to be working towards the same objective.

Chiropractic has only one goal. It is important that each person understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

**Adjustment**: An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation. Our chiropractic method of correction is through specific adjustments of the spine.

**Health:** A state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.

**Vertebral Subluxation**: A misalignment of one or more of the 24 vertebrae in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body’s innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of a chiropractic spinal evaluation, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. **OUR PRACTICE OBJECTIVE** is to eliminate a major interference to the expression of the body’s innate wisdom. Our only method is specific adjusting to correct vertebral subluxations.

I, have read and fully understand the above statements. (Print name)

All questions regarding the Chiropractor’s objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

(Signature) (Date)

**Consent for Posture Picture**

Pure Light Chiropractic would like to take a picture of you for evaluation purposes only. We will not share said

picture with anyone without your consent.

Yes, I agree to a picture of my likeness taken by Pure Light Chiropractic Staff for evaluation purposes.

No, I do not agree to a picture.

**Consent to evaluate and adjust a minor**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ being the parent or legal guardian of

Have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

(Signature) (Date)

**HIPPA ACKNOWLEDGMENT**

**Please initial the following:**

I acknowledge that Laine Morales, D.C. has provided me with a written copy of the Notice of

Privacy Practices and that I have been afforded the opportunity to read the Notice of Privacy and ask questions.