Eilrich Family Chiropractic & Wellness

Please fill out this form as completely as possible so that we can provide the best possible care.

PERSONAL INFORMATION

Name (First) _____ (MI) _____ (Last) _____
What you prefer to be called_____
Age_____ Date of Birth____/____/_____ Sex___
E-Mail_____
Home Address_____ City_____ State_____
Zip_____
Preferred Contact Phone Number: (_____) _____ (cell, work, home)
Occupation_____ Employer_____
City_____ State_____ Zip_____
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed □ Living With
Emergency Contact_____
Relationship_____ Phone (_____) _____
How did you hear about our office? _____
Would you like to receive appointment reminders via: Email text (*please circle only one*)
Cell phone Carrier for text reminder_____

REASONS FOR SEEKING CHIROPRACTIC CARE

At Eilrich Family Chiropractic & Wellness, we focus on your ability to be healthy. Our goals are to first address the issues that brought you to this office and second, to offer you the opportunity of improved health, wellness and quality of life in the future.

Please briefly describe the main concern that you would like Eilrich Family Chiropractic and Wellness to address for you.

_____
_____

Are these concerns affecting your quality of life? (Please check those applicable to you)
□ Work □ School □ Exercise/Sports □ Driving □ Walking □ Eating □ Sleep □ Sitting □ Love Life
□ Hobby – please list_____
When did the issue start? _____
What brought it on? _____
Have you had this problem before? □ No □ Yes – please explain:

_____
What have you done for this condition that has helped you feel better?

_____

HEALTH CARE PRACTITIONER HISTORY

Other doctors seen for **this condition**: □ Chiropractor □ Medical Doctor
□ Other – please list_____
Special tests done □ No □ Yes _____
Diagnosis_____What was done_____-

_____

YOUR HEALTH PROFILE

The information below will help us to see the types of PHYSICAL, CHEMICAL & EMOTIONAL stresses you have been subjected to and **how they may relate to your present health status.**

GENERAL HISTORY

Please mark all symptoms you have ever had, even if they do not seem related to your current problem.

□ Dizziness	□ Shortness of breath	□ Depression	□ Ulcers
□ Loss of balance	□ Pain in ribs/chest	□ Nervousness	□ Menstrual irregularity
□ Fainting	□ Neck pain/stiffness	□ Tension	□ Menstrual pain
□ Headache	□ Back pain (mid/low)	□ Fever	□ Urinary problems
□ Seizures	□ Pins/Needles in arms/legs	□ Allergies	□ Sinus problems
□ Stroke	□ Numbness in fingers/toes	□ Hot flashes	□ Skin issues
□ Visual disturbances	□ Cold hands/feet	□ Cold sweats	□ Recurrent Colds/Flu
□ Loss of smell	□ Fatigue/Low energy	□ Heart burn	□ Fibromyalgia
□ Buzz/Ring in ears	□ Sleeping problems	□ Heart attack	□ Diabetes
□ Loss of taste	□ Irritability	□ High Cholesterol	□ Stomach upset
□ Cancer _____	□ Nausea	□ Mood swings	□ Overweight
□ Diarrhea/Constipation	□ High Blood Pressure	□ Abnormal Thyroid	□ HIV/AIDS

Please list any other **serious medical condition(s)** you currently have or ever had:

_____

_____

CHEMICAL STRESS

Chemical stress can occur when a substance that is toxic to the body is breathed in, injected, taken by mouth or placed on the skin (I.e. food allergies, drug reactions, exposure to chemicals in the air, etc.).
Please answer the following which will reveal exposures you may have had.
Have you been **exposed to any of the following** on a regular basis (past or present)?
□ Toxic chemicals □ Second hand smoke □ Drug therapy □ Radiation □ Chemotherapy □ Other_____
Do you have **allergies** to any foods? □ No □ Yes If yes, please list_____
Do you **consume** any of the following? □ Caffeine □ Alcohol □ Tobacco □ Over the counter drugs □ Prescribed drugs
Please list all **medications** you are taking and why: (prescription and non-prescription)

_____

_____

Please list all **supplements or vitamins** you are taking:

_____

_____

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

EMOTIONAL STRESS

It is difficult to separate the emotional stress in our life from the physical response that often occurs.
Please indicate if you have experienced any of the emotional stresses below. (Check all that apply)
□ Loss of loved one □ Work or School □ Divorce/Separation □ Financial □ Lifestyle change
□ Self-esteem

QUALITY OF LIFE

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
Do you **exercise** regularly? □ Yes □ No If yes, how often?
_____
Do you follow a **special dietary regime**? □ Yes □ No If yes, what?
_____

ADDITIONAL QUESTIONS

If there is a need for **dietary changes or nutrients**, would you like to be informed? □ Yes □ No
If there is a need for **specific exercises**, would you like to be informed? □ Yes □ No
If there is a need for support in the **emotional/stress area of health**, would you like to be informed? □ Yes □ No
Is there any **specific health topic** you would like more information on?
_____
_____

EXPECTATIONS

I would like to have the following benefits: (check all that apply)
□ Relief of a symptom or problem
□ Relief and Prevention of a symptom or problem
□ Healthier spine and nerve system
□ Best possible health on all levels

COMMUNICATION INFORMATION

So we may meet your levels of expectations, please answer this last question.
Out of the four following options, how would your **best friend** or **significant other** best describe you?
□ Straight to the point □ Social & Outgoing □ Steady & Dependable □ Cautious & Perfectly Accurate

PLEASE READ AND SIGN BELOW

The information I have provided on these forms is correct and accurate to the best of my knowledge. I give Dr. Robert Eilrich permission to render care to me today. The initial visit includes a professional and complete health history/consultation and evaluation.

Signature _____
Date_____

Thank you for choosing our practice! We look forward to helping you.