



# 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.

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

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

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### 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)

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

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\*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?

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Do you follow a **special dietary regime**?  Yes  No If yes, what?

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### 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?
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- 

### 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.**