LIFE EMPOWERED CHIROPRACTIC HEALTH PROFILE

Name: _____ Today's Date: _____

Age: _____ Male: ____ Female: _____ Date of Birth: ____/____/_____

Address: _____City: _____State: _____Zip: _____

Email: _____Cell Phone: _____

May we include you in our weekly text4health text messages? Yes No (you can stop anytime)

Occupation: _____Employer: _____

Single / Married / Divorced / Widowed Spouse's name: _____ # of children: _____

Names, Ages & Gender of Children: _____

_____

Who may we thank for referring you? _____

LIST YOUR HEALTH CONCERNS BELOW

Health concerns according to severity	Severity on Scale of 1-10	When did the episode begin?	If you had the condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?

CIRCLE ALL CURRENT PROBLEMS YOU HAVE:

Dizziness	Throat Issues	Bladder Problems	Lupus
Headaches	Thyroid Problems	Irritable Bowel	Fibromyalgia
Vertigo	Asthma	Infertility	Chest Pain
Ear Infections	Ulcers	Numbness in Feet	Arm Pain
Nausea	Numbness in Hand	Low Back Pain	ADD/ADHD
TMJ	Disc Problems	Hip Pain	Knee Pain
Neck Pain	Menstrual Disorders	Shoulder Pain	Chronic sinusitis
Epilepsy	Heart Disorders	Liver Disease	Other: _____
Migraines	Digestive Issues	Chronic Fatigue	_____
Anxiety	Kidney Problems	Gastric Reflux	_____

CIRCLE ANY CONDITION YOU HAVE NOW/HAVE HAD

Stroke Cancer Heart Disease Seizures Spinal Bone Fracture Scoliosis Diabetes

ALL SURGICAL OPERATIONS AND YEARS: _____

_____

LIST ALL OVER THE COUNTER AND PRESCRIPTION MEDICATIONS YOU ARE ON

....

....

....

WHEN WAS YOUR LAST AUTO ACCIDENT? _____

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? **Y N** IF SO, WHO DID YOU SEE AND WHEN? _____

HAVE YOU EVER BEEN KNOCKED UNCONCIOUS? _____

FRACTURED A BONE? _____

IF YES, PLEASE DESCRIBE: _____

OTHER TRAUMA? _____

DO YOU VIEW YOUR HEALTH AS AN INVESTMENT OR AS AN EXPENSE? _____

HOW COMMITTED ARE YOU TO LIVING A HEALTHIER LIFESTYLE ON A SCALE OF 1-10 WITH 10 BEING THE HEALTHIEST LIFE POSSIBLE? _____

HOW WOULD YOUR LIFE CHANGE IF YOU DIDN'T HAVE THE HEALTH CONDITIONS INDICATED ON THIS FORM?

_____

_____

WRITTEN CONSENT FOR A MINOR CHILD

NAME OF PRACTICE MEMBER WHO IS A MINOR CHILD: _____

I authorize Dr. Tom Cahoon or other employees at Life Empowered Chiropractic, to perform diagnostic procedures, render chiropractic care and other therapies, and perform chiropractic adjustments on my minor child.

AS OF THIS DATE, I HAVE THE LEGAL RIGHT TO SELECT AND AUTHORIZE HEALTH CARE SERVICES FOR MY MINOR CHILD. IF MY AUTHORITY TO SELECT AND AUTHORIZE IS REVOKED OR ALTERED, I WILL IMMEDIATELY NOTIFY LIFE EMPOWERED CHIROPRACTIC

GUARDIAN SIGNATURE _____ DATE ____/____/_____

GUARDIAN RELATION TO MINOR CHILD _____

WITNESS _____ DATE ____ / ____ / _____

Please Share the Following:

1. How often do you exercise? _____ For how long? _____
2. What type of exercise do you perform? _____
3. Please share a typical day of eating for you including times and quantity:

Breakfast _____ Lunch _____

Dinner _____ Snacks _____

4. What time do you usually eat last? _____
5. What time do you typically go to bed? _____
6. How many ounces of water do you drink a day? _____
    a. Source? _____
7. How many cups of coffee do you drink per day? _____
8. What do you put in your coffee? _____
9. How many alcoholic beverages do you consume? _____
    a. Each day? _____ b. Week? _____ c. Month? _____
10. What else do you drink daily? _____
11. Do you smoke cigarettes? _____
    a. How many packs a day? _____ b. Week? _____
12. Do you consume any types of drugs? _____
    a. If so, what and how often? _____
13. Do you meditate? _____
    a. How often and for how long? _____
14. Do you engage in any type of personal development programs? _____
    a. If so, please explain the type, frequency, and duration? _____
15. Do you now, or have you ever seen a counselor? _____
16. On a scale of 1-10, rate your stress levels: _____

    (1 being no stress and 10 being severe)

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTOR BY PROVIDING PAST HEALTH INFORMATION FOR THEIR REVIEW

CONDITION	SPOUSE	SON	DAUGHTER	MOTHER	FATHER
ARM PAIN					
ARTHRITIS					
ASTHMA					
ADD/ADHD					
ALLERGIES					
BACK TROUBLE					
BED WETTING					
CANCER					
CARPAL TUNNEL					
DECEASED					
DIABETES					
DIGESTIVE PROBLEMS					
DISC PROBLEMS					
EAR INFECTIONS					
FIBROMYALGIA					
HEADACHES					
HEARTBURN					
HIGH BLOOD PRESSURE					
HIP PAIN					
LEG PAIN					
MENSTRUAL DISORDER					
MIGRAINES					
NECK PAIN					
SCOLIOSIS					
SHOULDER PAIN					
SINUS TROUBLE					
TMJ					

NAME: _____

DATE: _____

CHIROPRACTIC CONSENT FORM

To the patient: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you: it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various brain-based therapies on me (or the patient named below, for whom I am legally responsible) by Dr. Tom Cahoon and associated health providers who now or will care for me at Life Empowered Chiropractic.

I understand and I am informed that, in the practice of chiropractic, there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of care which the doctor feels at the time, based on the facts then known, in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the care received.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I understand that I am consenting to the care plan and chiropractic care at my own risk. I intend this consent form to cover the entire course of care for my present condition and for any future condition(s) for which I seek care.

PRINTED NAME _____

SIGNATURE _____

DATE SIGNED _____