Inspire Me Chiropractic Studio & Health Spa
Phone: 678.819.2556 1503 Johnson Ferry Rd, Suite 100
www.inspiremenaturally.com Marietta, GA 30062

# Comprehensive Health Profile / History

**Please do your best to fill out everything on this intake form. It is important that we understand past and current stressors that may have affected and could possibly continue to affect you physically, emotionally, mentally, chemically, and spiritually. It is important for us to know the following information, even if you feel it does not apply to the reason you came in for care. Please know that we value your time and aim only to provide you the best care possible. Thank you for choosing Inspire Me Natural Health Solutions!*

**Name**: _____ **Sex**: Male / Female
First Middle Last
**Address**: _____
Street City State Zip Code
**Home Phone**: _____ **Cell Phone**: _____ **E-Mail**: _____
***For Inspire Me office use only. We will never share your information with outside parties.**
**Date of Birth**: ___/___/___ **Age**: ____ **Weight**: _____ **Height**: _____
**Occupation**: _____
**Employer**: _____ **Work Phone**: _____
**Duties/ Habits**: ___ sit more than 1 hour ___ carry equipment/tools on your body (i.e. utility belt)
___ repetitively bend or twist ___ cradle the phone shoulder to ear (which side? L or R)
___ Repetitively type ___ drive on the job (car or other) ___ lift more than 10 lbs repetitively

**Married/Life Partner?** Yes___ No___ **Significant Other's Name: _____ DOB**___/___/____
**Children('s) Name(s) and Age(s): _____**

**Emergency contact**: Name_____ Phone _____ Relation_____

**How did you discover our office and the professional services we offer? _____**
_____
***If female***, do you suspect or know that you are pregnant? Y N If yes, please fill out a Pregnancy Profile form.
Do you have any **current health concerns or major medical conditions**?
_____
_____

***Please answer the following questions about your <u>chief concern</u>.***
Please describe your main reason for seeking chiropractic care_____
When did this situation or concern first begin? _____
Is this related to an ___ auto accident ___ injury on the job ___ other injury (_____)
Date of most recent flare-up: _____
Have you had this or something similar before? Y N If yes, when? _____
What did you do about it then? _____

Have you done anything for or gotten any advice or treatment for this issue? ___Yes ___ No
Explain: _____
Result: _____

What activities aggravate your condition/pain? _____
_____
What activities alleviate your condition/pain? _____
_____
Is the condition worse during certain times of the day? Y N If yes, when? _____

## Previous Chiropractic Care

Have you been to a chiropractor before? Yes No
Duration of care: _____ Reason for visit: _____
Result: _____Are you still going? Yes No
Were you pleased? Yes No Technique used: _____
When was your last adjustment? _____
Does your family currently receive chiropractic care? Yes No
If no, have they in the past? Yes No

## Your Health Concerns or Symptoms and How They May Affect Your Life

| Yes | No | Present | Participant Comment | Doctor's Comment |
|---|---|---|---|---|
| ☐ | ☐ | Did/do you smoke? When? | _____ | _____ |
| ☐ | ☐ | Did/do you drink alcohol? Amount? | _____ | _____ |
| ☐ | ☐ | Do you eat healthy foods/? follow a certain diet? | _____ | _____ |
| ☐ | ☐ | Have you been in <u>any</u> accidents? | _____ | _____ |
| ☐ | ☐ | Hobbies/Sports injuries? | _____ | _____ |
| ☐ | ☐ | Have you had surgery and/or organs removed/replaced? | _____ | _____ |
| ☐ | ☐ | Any issues with teeth, eyes, or hearing? | _____ | _____ |
| ☐ | ☐ | Regular exercise? (type & frequency) | _____ | _____ |
| | | **(Childhood )** | | |
| ☐ | ☐ | Major Illnesses/allergies? | _____ | _____ |
| ☐ | ☐ | Accidents/falls? | _____ | _____ |
| ☐ | ☐ | Surgery? | _____ | _____ |

Inspire Me Chiropractic Studio & Health Spa
Phone: 678.819.2556 1503 Johnson Ferry Rd, Suite 100
www.inspiremenaturally.com Marietta, GA 30062

**Check each you have and indicate if you experienced in the past or have now.**

| | | |
|---|---|---|
| ___Headaches | ___Menstrual Problems | ___Numbness/ tingling |
| ___Allergies | ___Hormonal changes | ___Neurological disorders |
| ___Sinus Problems | ___Diabetes | ___Arthritis (OA/ RA) |
| ___Asthma | ___Stroke | ___Changes in bowel or bladder habits |
| ___Jaw trouble/ TMJ | ___High Blood pressure | ___Concussion/ Head injury |
| ___Stress/ anxiety | ___Low blood pressure | ___Frequent infections |
| ___Sleep problems | ___High cholesterol | ___Respiratory disease |
| ___Fatigue | ___Heart disease | ___Surgery |
| ___Weight Changes | ___Cold hands | ___Cancer |
| ___Digestive issues | ___Cold feet | ___HIV or AIDS |

Other: _____

**Family history** of any of those listed? Y N Which and who? _____
_____

**Vitamins or supplements** you are ***currently*** taking and your reason for taking them: _____
_____

**Medications** you are ***currently*** taking (including prescription, non-prescription, and birth control) and your reason for taking them:_____
_____

Is there **anything else** which may help us to understand you, your history, or your needs which have not been discussed on this survey? Please explain: _____
_____
_____

** Remember, health is a process. Past and present choices affect this process. Thank you for taking the time to provide us with the information we need to best help you achieve your health goals. Congratulations on taking an active step toward health and thank you for giving us the opportunity to participate in this process.*

Signature: _____ Date: _____

Inspire Me Chiropractic Studio & Health Spa
Phone: 678.819.2556 1503 Johnson Ferry Rd, Suite 100
www.inspiremenaturally.com Marietta, GA 30062

## Informed Consent to Chiropractic Treatment

**Health:** Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity. Therefore, symptoms are NOT a valid measure of health.

**Chiropractic:** Chiropractic is a science, art and philosophy that concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) and how that relationship affects the restoration and preservation of health. It is a preventative approach to health care that uses natural and safe methods to restore normal function without using medication or surgery. It identifies interference in the communication between the brain and the rest of the body and restores proper function creating a balanced healthy system.

**Chiropractor:** A chiropractor has a doctorate degree with four years of graduate study. He or she must pass four National Board exams in order to receive a license to practice chiropractic. The goal of the chiropractor is the detection of and specific adjusting of subluxation only. We do not offer to diagnose or treat any condition.

**Subluxation:** Subluxation is the physical manifestation of an un-integrated life experience. When one or more of the 24 vertebrae of the spinal column are misaligned, the system as a whole is affected: structurally, chemically, and tonally. This results in interferences to nerve system function, leading to tightened muscles and taught ligaments, therefore leading to a decrease in the body's overall, healthy performance. Subluxations are corrected and/or reduced by an adjustment.

**Adjustment:** An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation. An adjustment can only be performed by a licensed Doctor of Chiropractic. Our chiropractic method of correction is by specific adjustments of the spine and related structural components. Adjustments are usually done by hand but may be performed by handheld instruments or specialized tables.

**Risks of Remaining Untreated:** Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and introduce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

**Need for Referral:** If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

*I have read and understand all of the above statements. I hereby affix my signature to this authorization for treatment.

_____ _____

Print Name Signature Date

### Consent to evaluate a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive treatment.