

Vital Information



Date _____

Name _____ Soc. # _____

Address _____ City _____ State _____ Zip _____

Email Address _____ Date of Birth _____

Home Ph _____ Business Ph _____ Cell Ph _____

Please indicate the best number to contact you: Home Business Cell

Marital Status: Married Domestic Partner Single Widowed Divorced
Do you have children? Y N

Name of Spouse/Partner _____

Reason for seeking services at Noya Chiropractic?

How were you referred to Noya Chiropractic?

Is there anything about your Nerve System and Spine we should know about? (Previous surgeries)

What is your level of commitment to yourself, your life and wellbeing? High Medium Low

Additional comments:

Life Style History

Briefly describe your nutrition breakfast, lunch and dinner:

What is your daily fluid intake?

What is your average sleep & rest per day?

Do you exercise? What do you do and how often?

Family relationship (i.e. good, stressful, none)

Rank your satisfaction with work. Low 1 2 3 4 5 6 7 8 9 10 High. What type of work do you do?

How often do you vacation?

Do you use recreational drugs or over the counter drugs medication? If yes, please list:

What are your play & relaxation activities?

Any other health related concerns/Issues? Any previous diagnosis?

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS OR SYMPTOMS?

- | | | | | |
|--|-------------------------------------|----------------------------------|---|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Allergies | <input type="checkbox"/> HIV | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Loss of Smell or Taste | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Ringing in Ears | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sweats | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Other |

Name _____

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognize any of these stresses?

C = Child T= teenager A=adult or N = not at all

1. Physical Stress:

EXPLAIN

Work Injuries	C	T	A	N
Poor posture	C	T	A	N
Sitting on your wallet for years	C	T	A	N
Sleeping Position i.e stomach/side	C	T	A	N
Extensive Computer Work	C	T	A	N
Carrying Heavy Purse/Bookbag/Child	C	T	A	N
Repetitive Lifting/Bending	C	T	A	N
Driving for Many Hours	C	T	A	N
Continuous Hours Standing/Sitting	C	T	A	N
Bone fracture/Surgery	C	T	A	N

2. Emotional Stress:

Relationships	C	T	A	N
Career	C	T	A	N
Children	C	T	A	N
Money	C	T	A	N
Fast Paced Life	C	T	A	N
Hold in Feelings	C	T	A	N
Quick Tempered	C	T	A	N
Verbal Abuse	C	T	A	N
Perfectionist	C	T	A	N
Procrastinator	C	T	A	N

