NETWORK CHIROPRACTIC CENTER OF SEDONA, DR. LORI KRAUSS

VITALITY QUESTIONAIRRE

Name: ____ Date: ________

Address: _____________________________ City: _________ State: _____ Zip: ________

Home Phone________________ Work: __________________ Cell Phone: _______________

Age: ________________ Date of Birth: ____/_____/_____

E-mail____

Employer___________________________Occupation_______________________________

Marital Status: S / M / D / W Name of Spouse/Partner_________________________

Names and Ages of Children____

Emergency Contact________________________________Phone______________________

Who referred you to Network Chiropractic Center_________________________________

Reason for seeking care? How has it affected your life? How long? Severity?

LIFE STYLE:

Briefly describe your average meal:

What is your daily fluid intake? What and how much?

What is your average sleep per day? Time you go to bed & wake up? Quality?

Do you exercise? Type? How often?

Relationships? (family, friends) (good, amazing, supportive, stressful?)

Satisfaction at work: low medium high

Do you presently use or have used in the past any over-the-counter, prescription, or recreational drugs? If so, please list:

Do you use: Tobacco? Coffee or other stimulant? White refined sugary foods

What vitamins, minerals, homeopathics, herbs do you take?

What are your health goals?

HEALTH HISTORY

Have you ever been adjusted by a chiropractor? Y / N When? How long?
Do you consult with a family MD, DO, ND regularly? Y / N If yes, for what?
Has anyone in your family suffered a serious illness (Cancer, Heart, Diabetes)?

Research shows that many health challenges have origins during childhood years, even as early as birth.

Physical Stressors: (Please circle or answer)
Birth: Forceps? C-section? Breech? Vacuum Extraction? Natural? Drugs?
List any injuries, falls, accidents:
List any fractures, surgeries:
Any abuse: physical? sexual?
Non trauma: Sitting on wallet, Purse on one shoulder, Computer for hours, Sleep posture?

Emotional Stressors: (Please circle)
Relationships? Work? Children? Money? Quick Tempered? Hold in feelings? Perfectionist? Procrastinator? Illness or loss of a loved one? Depression? Suicidal thoughts? Anxiety? Fears? PTSD? Abuse?

Chemical Stressors: (Please circle)
Have you been exposed to large amounts of: Industrial pollutants? Cigarettes? Second hand smoke? Junk food? Caffeine? Artificial Sweeteners? Drugs of any kind? Vaccines? Cosmetics and hair dyes? Cleaning solutions? Pesticides? Herbicides? Other?

FOR WOMEN:
Are you pregnant? Y/N Currently nursing? Y/N Birth Control Pills: Y/N
Excessive menstrual flow: Y/N Irregular cycles: Y/N Extreme Cramping: Y/N
Are you going through menopause: Y/N If so, any symptoms:

STRESS HISTORY: (can be your internal habit of stress or external stressors)
Rate your stress levels in the last year. (low) 1 2 3 4 5 6 7 8 9 10 (high)
Rate your stress levels over your lifetime. (low) 1 2 3 4 5 6 7 8 9 10 (high)
Is there anything else that you feel is relevant for the doctor to know about you?

What is your level of commitment to yourself and your Well-Being? High Medium Low

Signature: ________________________________ Date: __________
Consent to treat Minor signed by parent /guardian: ____________________Date: ______