MB
PCN
MC
MA

FLOWER OF LIFE
CHIROPRACTIC

ADULT NEW MEMBER HEALTH SURVEY

Name_____ Sex: M ❑ F ❑ Pronouns_____ DOB_____/_____/_____ Age_____

E-mail_____@_____.com Phone _____

Address_____ City_____ State_____ zip _____

Partner's Name _____ Pronouns_____ Phone _____

Names of Child(ren) & Age(s)_____

How did you find our office? _____

Your genes are not your destiny; your environment determines what genes are turned on and how they express. Your biography becomes your biology.

We are going to ask you a variety of questions that give us more information about your past and present experiences. These experiences affect your physiology and directly affect your physical, mental, emotional and spiritual wellbeing. These experiences fall into four categories; physical (trauma), mental/emotional/spiritual (thoughts), electronic waves (technology), and chemical (toxins). If any experience was too much for your system to handle it can lock into your body as a tonal shift (tension) which can lead to a variety of symptoms. Please fill out the intake to the best of your ability. Your health survey is a key to the puzzle. No detail is too small.

YOUR ARRIVAL - *Your story starts with your conception, gestation and most importantly, your birth. The birth process can be very stressful on the birthing person's body but also on baby's.*

While in utero did your mother: ☐ Drink ☐Smoke ☐ On Medication ☐ Use Drugs ☐ High stress ☐ Accident

Was your birth: ☐ Vaginal without assistance ☐ Vaginal with Assistance (☐ Forceps ☐ Vacuum Extraction

☐ C- Section ☐ Induced labor ☐ Medications given _____

Where were you born? _____Any complications? _____

CHEMICAL STRESS- *Anything you inhale, ingest, or absorb*

Are you currently taking/ have you taken birth control? How long? Type?_____

Current Medications (Name, Dose & Taken Since) : _____

_____

Previous Medications & Vaccines (Name & When / how long taken) _____

_____

Do You: ☐ Drink Alcohol _____x/ week ☐ Use Drugs ☐Smoke _____packs/ week

☐ Drink Soda ____x/week ☐ Eat Packaged Food ☐ Use Air Purifier

☐Coffee _____ per day ☐ Eat Organic _____% ☐ Use Water Filter

☐_____oz of water per day ☐ Eat Non GMO ☐ Use Shower Filter

Current Diet: ☐ Vegetarian ☐ Pescatarian ☐ Vegan ☐ Keto ☐ Paleo ☐ Dairy-free ☐ Soy-Free ☐ Gluten-Free

☐ Other ☐ Chicken ☐ Fish _____x/ week ☐ Red Meat _____x/ week

What do your typical meals look like?

Breakfast: _____

Lunch: _____

Dinner: _____

EMOTIONAL/MENTAL STRESS: These stresses have a major affect on how our body processes and feels.

Occupation _____ Do you enjoy what you do: ☐ Y ☐ N ☐ S

Have you ever experienced the following?

☐ Mental Abuse ☐ Physical Abuse ☐ Sexual Abuse ☐ Major move ☐ Loss of a loved one

☐ Rapid life change ☐ Career change ☐ Being far from family/friends ☐ Financial Concern

☐ Divorce/ Separation ☐ Loss of Child ☐ Care provider for child/children ☐ Care Provider for parent

Please Explain: _____

_____

PHYSICAL- *Thinking all the way back to your childhood, have you had any of the following?*

Surgery (& year performed) : _____

Accidents: _____

Falls: _____

Sports/ Exercise (past & present): _____

Duties/Habits: ☐ Sit more than an hour ☐ Carry equipment or tools on your body ☐ Repetitive bend or twist

☐ Cradle the phone to ear L or R ☐ Drive on the Job ☐ Lift more than 10 lbs. repeatedly

Have you had a Breast Augmentation / Reduction / Removal? ☐ Y ☐ N (Please circle) Year(s)_____

Number of Previous Pregnancies: _____ Have you had a miscarriage or abortion? ☐ Y ☐ N When? _____

Type of birth(s): ☐ Vaginal ☐ Cesarean (☐ planned - why?_____) _____wks gestation

Birth Intervention(s): ☐ Induction: (☐ Membrane Sweep ☐ Cytotec ☐ Ptocin ☐ Foley Balloon) Why? _____

☐ Medication ☐ Antibiotics ☐ Epidural ☐ Ruptured membranes ☐ Ptocin ☐ Episiotomy ☐ Forceps / Vacuum

How long did you labor at home? _____ Hours Laboring _____ Time pushing _____

Did You: ☐ Delay Cord Clamp ☐ Skin to Skin right away ☐ Hemorrhage ☐ Baby was separated for _____ time

☐ Complications with baby after birth ☐ Difficulty Delivering Placenta ☐ Baby latched right after delivery

☐ Tearing ☐ Slow recovery ☐ Postpartum Blues ☐ Breastfeed - How Long? _____

Please provide a timeline of laboring/ birthing / Postpartum: _____

_____

_____

My Birth Experience was… _____

Are you Currently: ☐ Consciously Pre-Conceiving ☐ Conceiving ☐ Pregnant Guess (due) Date: _____

Conscious Conception? ☐ Y ☐ N Fertility Issues? ☐ Y ☐ N Fertility Measures Taken? ☐ Y ☐ N

Share Fertility Journey: _____

Third trimester presentation: ☐ Head Down ☐ Transverse Lie ☐ Breech ☐ Posterior Lie

Do you have: ☐ OBGYN ☐ Midwife ☐ Doula ☐ Lactation Consultant ☐ Postpartum Doula/ Baby Nurse

Have you experienced any of the following during this pregnancy: ☐ Morning Sickness/Vomiting/Nausea

☐ Sciatic Pain ☐ Heartburn ☐ Bladder/ Kidney Infection ☐ Difficulty Sleeping ☐ Constipation

☐ Low back Pain ☐ Headaches ☐ Pregnant with Multiples ☐ Gestational Diabetes ☐ Indigestion

☐ Pubic bone Pain ☐ Varicose Veins ☐ Placental Dysfunction ☐ High Blood Pressure ☐ Hemorrhoids

CURRENT HEALTH CONCERNS

What is the reason for this reservation?_____

*Above each listed concern, please denote your current discomfort level on a scale of 1-10.

Is this discomfort level typical? If not, please describe the typical discomfort level: _____

When did this begin?_____ Have you had this before? _____

Why do you think this is occurring?_____

Is there any other issue/secondary condition that you believe is related to this?_____

Have you gotten any other advice or treatment for this issue? (if yes than from who and what was result)

_____

What activities aggravate your condition? _____

What activities relieve your condition? _____

Is the condition worse during certain times of the day? ☐ Y ☐ N If yes, when? _____

Does it affect: ☐ Mood, patience, attitude ☐ Sleep ☐ exercise or play ☐ day-to-day activities ☐ Ability to work

☐ decision making ☐ relationship or intimacy

What are your healthcare goals? _____

SECONDARY CONDITIONS- Please mark any secondary condition (symptom/diagnosis) that you currently have or have had in the past. Secondary conditions are a result of your body compensating or adapting to your environment.

Past	Now		Past	Now	
☐	☐	ADD/ADHD	☐	☐	Herniated Disc
☐	☐	Anemia	☐	☐	High Blood Pressure
☐	☐	Asthma/ Respiratory Issues	☐	☐	Insomnia / Sleep Issues
☐	☐	Arthritis	☐	☐	Knee / Ankle / Hip Issues
☐	☐	Athletic Injuries	☐	☐	Mastitis
☐	☐	Autoimmune Disorder	☐	☐	Menstrual Problems / Pain
☐	☐	Back Pain	☐	☐	Multiple Sclerosis / ALS
☐	☐	Bowel/Bladder Changes	☐	☐	Neck Pain
☐	☐	Cancer	☐	☐	Numbness / Tingling
☐	☐	Concussion/ Head Injury	☐	☐	Reproductive Organ Issue
☐	☐	Dental / Jaw issues / Braces	☐	☐	Scoliosis
☐	☐	Depression	☐	☐	Skin Condition
☐	☐	Diabetes	☐	☐	Sinus Problem / Allergies
☐	☐	Digestive Issues	☐	☐	Stroke
☐	☐	Dizziness / Vertigo	☐	☐	Surgery
☐	☐	Ear / Hearing Issues	☐	☐	Thyroid Disorder
☐	☐	Eye / Vision Issues	☐	☐	Urinary Tract Infections
☐	☐	Frequent Cold / Flu	☐	☐	Weight Changes
☐	☐	Fatigue / Brain Fog	☐	☐	Wrist / Elbow / Shoulder
☐	☐	Headaches	☐	☐	Other _____

HEALTHCARE TEAM (PRIMARY CARE, THERAPISTS, SPECIALISTS etc)

Provider Name	Provider Type	Last Visit	Reason	Result

Patient Signature _____ Date _____

ADULT ASSESSMENT

Name_____ Asmt #_____ Date___/____/___ Cat_____ Score_____%

Scan: Thermal _____ EMG _____ HRV _____ ____

Structural Assessment: (Photo Taken) ____

Pregnancy UT Angle: _____ ____

Fakuta: Ft forward(-1)_____ Shift (-1) L R Turn:(-3) L R _____ ____

Scales: L _____ R _____ (every 5lbs=-1) ____

ROM: ____

	L:
Flexion: 50 N M S Mo S (D S R)	Flexion: 25 N M S Mo S (D S R)
Extension:60 N M S Mo S (D S R)	Extension:30 N M S Mo S (D S R)
L Rotation:80 N M S Mo S (D S R)	L Rotation: 30 N M S Mo S (D S R)
R Rotation:80 N M S Mo S (D S R)	R Rotation:30 N M S Mo S (D S R)
L Lateral: 45 N M S Mo S (D S R)	L Lateral: 25 N M S Mo S (D S R)
R Lateral: 45 N M S Mo S (D S R)	R Lateral: 25 N M S Mo S (D S R)

Primitive Reflexes: Rooting + - Palmer - + Gallant - + Babinski - + ATNR - + ____

Leg Length: L R 0 ⅛ ¼ ½ ¾ 1 (10,8,7,5,3,0) ____

Heel Tension: **L:** N D I **R:** N D I (10,7,5,3,0) ____

Leg Leg: L R B M Mo S BP (10,7,5,3) ____

Sacral DuralPump: **O**: P L A **S:** P L A (0,5,7,10) ____

Soft TissueSubluxations: 1 2 3 4 5 6 (3,7,10) ____

Disconnections:_____ (-1 per) ____

Osseous Subluxations:_____ (-2 per) ____

Protocol:Blocking: Cat1 Cat2 Cat3 Webster: L R Cranial ____

OrthopedicTests:

Cervicalcompression _____

Cervicaldistraction _____

S houlderdpessr _____

SLR **+ -** _____

K EMP **+ -** _____

Valsalva **+ -** _____

Other_____

= ____/____

Doctor: Dr. Erin **Dr. James** **Dr. Jamie** **Dr. Laura** **Dr. Justyna**

Notes:

_____

_____

_____

_____

_____