THRIVAL MODE

FAMILY | CHIROPRACTIC | HEALTH

T123___/___

Name_____________________________________Date___/___/___Age____Male/Female
Address___________________________________City_______________State____Zip_____
Phone: Home___________________ Cell______________________ Date of Birth___/___/___
Email Address____
Occupation_________________________________ Employer's Name__________________________
Single/ Married/ Divorced/ Widowed   Spouse's Name__________________________________
Number of Children_____   Names, Ages & Gender _______________________________________
____
Who may we thank for referring you? ____

LIST YOUR HEALTH CONCERNS BELOW

Health Concerns: List according to severity	Rate of Severity 1=mild 10=unbearable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	Are symptoms constant or intermittent?
1.______________	______________	______________	______________	______________	______________
2.______________	______________	______________	______________	______________	______________
3.______________	______________	______________	______________	______________	______________
4. ______________	______________	______________	______________	______________	______________
5.______________	______________	______________	______________	______________	______________

WHAT ARE YOUR HEALTH GOALS?

____
____
____
____

HAVE YOU EVER SEEN OTHER DOCTORS FOR THESE CONDITIONS?   YES / NO
CHIROPRACTOR? _____________________MEDICAL DOCTOR? ___________OTHER___________
WHO AND WHEN? ____
LIST ALL SURGICAL OPERATIONS AND YEAR ____
LIST ALL Over the Counter & PRESCRIPTION MEDICATIONS YOU ARE ON ____________________
____
WHEN WAS YOUR LAST AUTO ACCIDENT____
HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE?   YES / NO
IF YOU HAVE, DR. & DATE____
HAVE YOU EVER BEEN KNOCKED UNCONCIOUS?   YES / NO
IF YES, PLEASE DESCRIBE____
OTHER TRAUMA____
____

Review of Systems (Check all that apply)

Name______________________

Date________________________

Constitutional

- ☐ Fever
- ☐ Chills
- ☐ Feeling Poorly
- ☐ Feeling Tired
- ☐ Recent weight gain ___lbs
- ☐ Recent weight loss ___lbs

Eyes

- ☐ Blurry Vision
- ☐ Glaucoma
- ☐ Ear Infections
- ☐ Dry Eyes
- ☐ Red Eyes

ENT

- ☐ Ringing in the ears
- ☐ Throat Clearing
- ☐ Soar Throat
- ☐ Hoarseness
- ☐ Mouth Sores

Cardiovascular

- ☐ Heart Rate is Slow
- ☐ Heart Rate is Fast
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Lower Extremity Edema

Respiratory

- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Cough
- ☐ Shortness of Breath On Exertion
- ☐ Spitting up Blood

Genitourinary

- ☐ Dysuria
- ☐ Incontinence
- ☐ Testicular Pain
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Abnormal Vaginal Bleeding
- ☐ Genital Lesions

Heme/Lymph

- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Swollen Glands

Musculoskeletal

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- ☐ Muscle Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Joint Stiffness

Integumentary

- ☐ Skin Rash
- ☐ Skin Wound
- ☐ Itching
- ☐ Jaundice

Neurological

- ☐ Confusion
- ☐ Numbness
- ☐ Dizziness
- ☐ Fainting
- ☐ Headaches

Psychiatric

- ☐ Suicidal
- ☐ Depression
- ☐ Anxiety
- ☐ Sleep Disturbances

Endocrine

- ☐ Heat/Cold Intolerance
- ☐ Excessive Thirst
- ☐ Excessive Urination

Gastrointestinal

- ☐ Poor Appetite
- ☐ Difficulty Swallowing
- ☐ Heartburn
- ☐ Diarrhea
- ☐ Rectal Bleeding
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloating
- ☐ Abdominal Pain
- ☐ Black Tarry Stools
- ☐ Regurgitation
- ☐ Constipation
- ☐ Change in Normal Bowel Functi

FAMILY HEALTH HISTORY

THIS FORM IS TO ASSIST THE DOCTORS BY PROVIDING PAST HEALTH HISTORY INFORMATION FOR THEIR REVIEW.

____ ____________________

PLEASE PRINT YOUR NAME HERE DATE

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					

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Level of Commitment

Questionnaire

We assist individuals and families in reaching their health goals. So, whether your interest is reduced pain or you are committed to optimal function and true health, we are here to simplify the process. Please share with us your level of commitment to your health. This will assist us in understanding your personal situation and will help guide the doctors in creating your care recommendations. Please Mark the box that is appropriate for you with an 'x'.

RELIEF

☐ *I am not committed to my overall health. I only have interest in managing my aches and pains. I realize that symptoms are the last thing to show up and the first thing to leave, so the progression of this process (the cause) will most likely continue.*

CORRECTION

☐ *I want to go beyond my aches and pains and begin to stabilize. I want to stop this process from progressing. I want to restore and heal. I want to address and correct the underlying cause of my health concerns.*

Wellness

☐ *I am not experiencing any health concerns. I want to utilize chiropractic care as a means of prevention. I understand the benefits of regular chiropractic care and want it to be a part of my wellness portfolio. I want to be proactive in my health!*

DOCTOR'S CHOICE

☐ *I want the doctor to make the best recommendation for my care based on my subjective concerns and the objective information collected during my examination. I need help and am looking for the doctors to guide my journey.*

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