CHIROPRACTIC INTAKE & HISTORY

LUX VITAE

PATIENT INFORMATION

Patient Name _____
LAST NAME
_____
FIRST NAME MIDDLE INITIAL

Address _____

City_____Province_____

Home Phone _____

Cell Phone _____

Email _____

Sex O M O F Age _____ Birthday_____

O Married O Widowed O Single O Minor

O Separated O Divorced O Partnered

Employer/School_____

Occupation_____

Spouse's Name_____

Spouse's Employer_____

Spouse's Occupation_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____

Contact Number_____

Who may we thank for referring you _____

HOW CAN WE HELP YOU?

What brings you in today? _____

_____

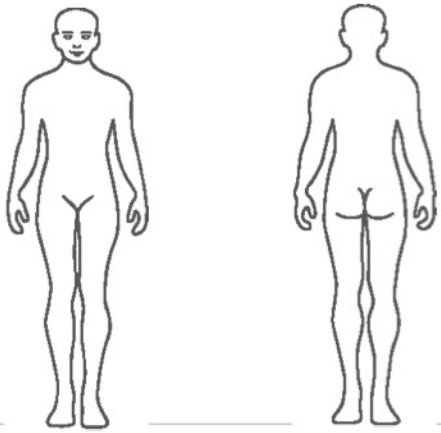
If you are already experiencing a symptom, what is it? _____

How bad is it? How intense are your symptoms? (circle)

1 2 3 4 5 6 7 8 9 10

No Symptom Intense symptom

Please circle areas to the right where you have pain or other symptoms:



What does it feel like? (check where appropriate)

O Numbness
O Tingling
O Stiffness
O Dull
O Aching
O Cramping
O Nagging
O Sharp
O Shooting
O Burning
O Throbbing
O Stabbing
O Swelling
O Other _____

IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	O	O	O	O	Energy	O	O	O	O
Exercise	O	O	O	O	Attitude	O	O	O	O
Recreation	O	O	O	O	Patience	O	O	O	O
Relationships	O	O	O	O	Productivity	O	O	O	O
Sleep	O	O	O	O	Creativity	O	O	O	O
Self-Care	O	O	O	O	Other _____	O	O	O	O

How committed are you to correcting this issue?

1 2 3 4 5 6 7 8 9 10

Not Committed Very Committed

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM

DISEASE	POOR HEALTH	NEUTRAL	GOOD HEALTH	OPTIMAL HEALTH
Multiple medications Poor quality of life Potential becomes limited Body has limited function	Symptoms Drug therapy Surgery Losing normal function	No symptoms Nutrition inconsistent Exercise sporadic Health not a high priority	Regular exercise Good nutrition Wellness education Minimal nerve interference	100% function Continuous development Active participation Wellness lifestyle

On the arrow diagram above:

A. What number do you think represents your health today?_____

B. In what direction is your health currently headed?_____

What are your health goals?

IMMEDIATE_____

SHORT TERM_____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Childrens' ages?_____

Childrens' health concerns?_____

Are you currently pregnant? O No O Yes, I am due_____

Number of past pregnancies?_____

Health concerns regarding this pregnancy?_____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- O AIDS/HIV
- O Alcoholism
- O Anxiety
- O Arteriosclerosis
- O Arthritis
- O Asthma/Allergies
- O Back Pain
- O Cardiovascular Issues
- O Cancer
- O Circulation Issues
- O Childhood Illness
- O Depression
- O Diabetes
- O Digestive Issues (Constipation/Diarrhea/GERO/IBS)
- O Elbow/Wrist/Hand Issues
- O Endocrine Issues (Thyroid)
- O Foot/Ankle Issues
- O Gout
- O Headaches /Migraines
- O Heart Disease
- O Hepatitis
- O Hip Issues
- O Immune Issues
- O Lymphatic Issues
- O Multiple Sclerosis
- O Neck Pain
- O Reproductive Issues
- O Ringing Ears
- O Scoliosis
- O Shoulder Issues
- O Stroke
- O TMJ Issues
- O Urinary Issues
- O Osteoporosis
- O Other _____

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)	MEDICATIONS (list)	SUPPLEMENTS (list)

Waiver and Release of Liability

In consideration of the risk of injury while participating in care (referred to the "Activity") from Lux Vitae Wellness I, _____ hereby knowingly and voluntarily enter into this waiver and release of liability and hereby waive any and all rights, claims or causes of action of any kind whatsoever arising out of my participation in care and do hereby release and forever discharge Lux Vitae Wellness and Dr. Lauren Schreiber for any physical, economical or emotional loss, that I may suffer as a direct result of my participation in the the company's care, including traveling to and from an event related to this Activity.

I understand and recognize that the care and exercise therapy may include but are not limited to, manipulative therapies to all of the joints of the body, active release deep tissue massage technique and instrument assisted soft tissue manipulation to the soft tissues of the body, static and dynamic stretches to the joints and soft tissues of body.

I am voluntarily participating in the aforementioned activity and I am participating in the activity entirely at my own risk. I am aware of the risks associated with traveling to and from as well as participating in this Activity, which may include, but are not limited to, physical or psychological injury, pain, suffering, illness, disfigurement, temporary or permanent disability (including paralysis), economic or emotional loss and death. I understand that these injuries or outcomes may arise from my own or others' negligence, conditions related to travel, or the condition of the Activity location(s). I assume all related risks, both known or unknown to me, of my participation in this Activity, including travel to, from and during this Activity. I hereby release Lux Vitae Wellness and their directors, affiliates, managers, members, agents, attorneys, staff, volunteers, heirs, representatives, predecessors, successors, and assigns.

I acknowledge that I have carefully read this "waiver and release" and fully understand that it is a release of liability. I expressly agree to release and discharge Lux Vitae Wellness and Dr. Lauren Schreiber from any and all claims or causes of action and I agree to voluntarily give up or waive any right that I otherwise have to bring any legal action against Lux Vitae Wellness.

In the event that any damage to equipment or facilities occurs as a result of my willful actions, neglect or recklessness, I acknowledge and agree to be held liable for any and all costs associated with any actions of neglect or recklessness.

In the event that an provision contained within this Release of Liability shall be deemed to be several or invalid, or if any term, condition, phrase or portion of this agreement shall be deterred to be unlawful or otherwise unforeseeable, the remainder of this agreement shall remain in full force and effect, so long as the clause severed does not affect the intent of the parties. If a court should find that any provision of this agreement to be invalid or unenforceable, but that by limiting said provision it would be become valid and enforceable, then said provision shall be deemed to be written, construed and enforced as so limited.

_____ _____

Patient's Signature Date

_____ _____

Parent/ Guardian Signature Date

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