Active Life Chiropractic
1460 E Valley Rd, Suite 136
Basalt, CO 81621

Phone (970)456-7870
Fax (720)367-5056
www.activelifechirocare.com

Patient Health Assessment

General Information

Patient Name:	Date:	
Date of Birth:	Patient Sex: M F	
Patient Address:	City:	Zip:
Home Phone:	Cell Phone:	
E-mail:	Primary Care Physician:	
Patient Occupation:	Employer:	
Emergency Contact:	Relation to Patient:	
Phone:		
Who may we thank for referring you to our office?		

Complaint History

1. Describe your current complaint and how the problem began:____

   ____

   How long have you had this condition? ____

2. How would you describe the pain?

   ▫Sharp ▫Soreness ▫Throbbing ▫Tingling ▫Dull ▫Stiffness

   ▫Spasm ▫Burning ▫Ache ▫Weakness ▫Numbness ▫Shooting

3. How would you rate the intensity of your pain? (Circle the appropriate number)

   0 1 2 3 4 5 6 7 8 9 10
   (No pain) (Moderate pain) (Terrible/unbearable pain)

4. How often is the pain present?

   ▫ Constant (81-100%) ▫ Frequent (51-80%) ▫ Occasional (26-50%) ▫ Intermittent (25% or less)

5. Since your problem began is the pain:

   ▫ Getting worse ▫ Getting better ▫ Staying the same

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6. How did your problem begin? ______________________________

   Explain: ______________________________

   ☐An auto accident ☐Work related accident ☐Other type of accident

   ☐Gradual ☐Sudden ☐No specific reason

7. What makes your problem better? ______________________________

   ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise ☐Lying down ☐Inactivity

8. What makes your problem worse? ______________________________

   ☐Nothing ☐Walking ☐Standing ☐Sitting ☐Moving around/exercise ☐Lying down ☐Inactivity

9. Are you currently taking any medications? ☐Yes ☐No

   If yes, please describe: ______________________________

   ____

10. Were you previously treated for an earlier occurrence of this same condition? ☐Yes ☐No

    If yes, by whom? ☐MD ☐Chiropractor ☐Physical therapist ☐Other

    What were the approximate dates, type of treatment and results? ______________________________

    ____

11. What is your physical activity at work?

    ☐ Mostly sitting ☐ Light manual labor ☐ Moderate manual labor ☐ Heavy manual labor

12. Do you exercise?

    ☐ No regular exercise ☐ 1-2 times a week ☐ 3-4 times a week ☐ Cardio

    ☐ Stretching ☐ Weight Machine ☐ Free Weights ☐ Sports (list type)________________

13. What is your present general stress level?

    ☐ No stress ☐ Minimal stress ☐ Moderate stress ☐ Greatly stressed

14. Is your problem affecting your ability to work or do other routine daily activities?

    ☐ No affect ☐ Need some assistance with daily activities

    ☐ Have some limited physical restrictions, but can function ☐ Cannot work

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Past or Present Symptoms, Conditions or Habits

Below is a listing of symptoms, conditions or habits. Please check the box indicating whether this applies to past or present.

Symptom	Past	Present	Symptom	Past	Present
Neck pain	▫	▫	High blood pressure	▫	▫
Shoulder pain	▫	▫	Heart condition	▫	▫
Arm/elbow pain	▫	▫	Respiratory condition	▫	▫
Hand pain	▫	▫	Digestive problems	▫	▫
Upper back pain	▫	▫	Kidney / bladder problems	▫	▫
Lower back pain	▫	▫	Menstrual problems	▫	▫
Pain in upper leg or hip	▫	▫	Breast soreness / lump	▫	▫
Pain in lower leg or knee	▫	▫	Sinus conditions	▫	▫
Jaw pain	▫	▫	Allergies / Asthma	▫	▫
Swelling / stiffness of joints	▫	▫	Cancer	▫	▫
Headaches	▫	▫	Stroke	▫	▫
Dizziness	▫	▫	Excessive weight loss / gain	▫	▫
Fainting spells	▫	▫	Arthritis	▫	▫
Prostrate condition	▫	▫	Diabetes	▫	▫
Condition of uterus/ ovaries	▫	▫	General prolonged fatigue	▫	▫

Tobacco use:
▫ Past ▫ Present
▫ Occasional ▫ Moderate ▫ Heavy

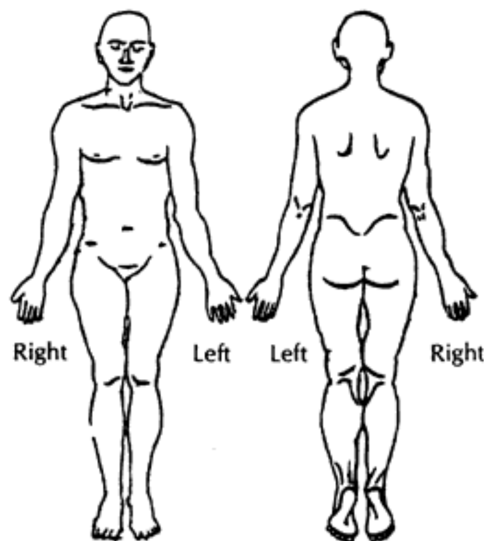
Alcohol use:
▫ Past ▫ Present
▫ Occasional ▫ Moderate ▫ Heavy

Caffeine use:
▫ Past ▫ Present
▫ Occasional ▫ Moderate ▫ Heavy

Pregnancy:
▫ Past ▫ Present

Surgical Procedures - Please list:

Please shade in the figures below where you have pain, or other symptoms.



I have reviewed the information contained on this form with the patient.

Patient name ______________________________

Provider initials________________ Date________________

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INFORMED CONSENT

NATURE AND PURPOSE OF CHIROPRACTIC PROCEDURES
A chiropractic adjustment is the application of a quick precise movement to a specific segmental contact point on the musculoskeletal system. Adjustments are usually performed by hand but may be performed by hand-guided instruments.

You should understand that the chiropractic care, analysis, and screening procedures provided on any occasion are NOT a substitute for your personal medical doctor, a full physical examination and/or a pre-participation physical evaluation. You should understand that all health care procedures including the chiropractic adjustment have some risks associated with them, which may include musculoskeletal sprain/strain, neurological deficits, osseous fracture, and in extremely rare instances, vertebral artery syndrome (stroke). Please ask any questions if you want further understanding of risks and benefits of chiropractic care.

AUTHORIZATION FOR CHIROPRACTIC CARE

I have read the above paragraphs. I understand the nature and purpose of the chiropractic care provided the possible consequences, and the risk that the care may not accomplish the desired objective. I acknowledge that no guarantees have been made to me concerning the results of the care and/or treatment. I authorize Dr. Alesha Willis of Active Life Chiropractic to proceed with chiropractic care and/or treatment from this day and forward.

*Printed name of client:*____

*Signature *:* ___________________________________*Date:* ____________
**Parent or legal guardian must sign if patient is under 18 years of age*