The Life Studio

3020 Bridgeway, Suite 103
Sausalito, CA 94965
415.887.9689
www.thelifestudiosausalito.com

Date ___________________

Name ____

Address ____

City ________________________________ State ____________ Zip _______

Home Phone __________________________ Office Phone ________________

E-mail Address ____

Age _______ Date of Birth __________

Weight ______________Ht____________
Referred______________________________________

Occupation ____ Sex (M) (F)
Married ___ S ___ W ___ D ___ Children____ Name of Spouse _________________

Have you ever had chiropractic care before? __________________________________

For what problem? ____

Were the results satisfactory? Yes______ No_______ N/A_______

Please write the purpose of your visit.

____

____

____

____

____

____

____

How do you believe your problem (pain) began? ______________________________

____

____
____
____

When did you first notice this problem/pain? ______________________________________

Have you ever had this condition before or a similar condition? ___________________

When?
____

What positions or activities aggravate your condition? _____________________________

What positions or activities relieve your condition? ________________________________

Have you ever been treated by a Medical Physician for this ailment?_________________

Where?
____

Describe the type of treatment ____

Diagnosis of previous physician ____

Length of time under care________________________ Results ___________________

Have you ever been in any accidents, auto, fall down stairs, fall from ladder, etc.
(even as a child)?_______________ When?
____
____
____
____
____
_

Have you ever broken any bones? (fractures) ___________ Any dislocations? ________
____
____
____

What operations have you had? ____________________Year ________________
____________________Year ________________
____________________Year ________________

Have you ever had any cosmetic surgery, breast implants, etc.? _______Year _________

Have you had any surgery to replace hip, knee, etc.? ___________Year _____________
Give dates you have had any of the following? (if exact date is unknown, give approximate)

Do you have any health problems not listed above? ______________________________

Do you faint easily? ____

Do you take vitamins? Yes______ No ______

Do you exercise regularly? Yes ________ No ________

Habits: (please check)

Cigarettes ________ Quantity ___________ Coffee? ________ Quantity ____________

Alcohol? ________ Quantity ___________ Tea? ________ Quantity _______________

Have you been treated for any health condition by a physician in the past year? _______
If yes, what condition? ____

Have you lost or gained weight in the past year? ________________________________

Use this space for any additional information you may wish to discuss _____________
____
____

Have you had or do you now have any of the following symptoms which are or have been of significant distress to you? Please indicate with the letter N if you have these conditions now (within the past 12 months) or P if you ever had these conditions in the past.

	Now N	Past P		Now N	Past P
Headaches____ Frequency	____	____	Loss of Balance	____	____
Neck Pain	____	____	Fainting	____	____

Stiff Neck	____	____	Loss of Smell	____	____
Sleeping Problems	____	____	Loss of Taste	____	____
Back Pain	____	____	Diarrhea	____	____
Nervousness	____	____	Feet Cold	____	____
Tension	____	____	Hands Cold	____	____
Irritability	____	____	Arthritis	____	____
Chest Pains	____	____	Muscle Spasms	____	____
Dizziness	____	____	Frequent Colds	____	____
Shoulder/Neck/Arm Pain	____	____	Stomach Upset	____	____
Pins & Needles in Arms	____	____	Constipation	____	____
Pins & Needles in Legs	____	____	Cold Sweats	____	____
Numbness in Fingers	____	____	Fever	____	____
Numbness in Toes	____	____	Sinus Problems	____	____
High Blood Pressure	____	____	Diabetes	____	____
Difficulty Urinating	____	____	Hemorrhoids	____	____
Allergies	____	____	Leg Cramps	____	____
Weakness in Arms	____	____	Colitis	____	____
Weakness in Legs	____	____	Gall Bladder	____	____
Shortness of Breath	____	____	Indigestion	____	____
Fatigue ____		____	____ Belching		____
Depression	____	____	Vomiting	____	____
Lights Bother Eye	____	____	Shoulder Pain	____	____
Loss of Memory	____	____	Swelling Joints	____	____
Ears Ring	____	____	Knee Pain	____	____
Face Flushed	____	____	Hayfever	____	____
Buzzing in Ears	____	____	Menstrual Difficulties	____	____

Do you have vertigo (dizziness)? Yes ________ No ________

Do you pass out easily (faint or loss of consciousness)? Yes ________ No ________

Do you have double vision or have you lost sight in one eye? Yes ________ No ________

Do you have any slurred speech or difficulty with speech? Yes ________ No ________

Do you have indigestion or difficulty swallowing? Yes ________ No ________

Do you have any difficulty walking, with coordination or falling to one side? Yes ________ No ________

Do you have nausea or vomiting? Yes ________ No ________

Do you have numbness on one side of your face or body? Yes ________ No ________

Do you have any visual disturbances or rapid eye movement? Yes ________ No ________

Do you have or have you ever had difficulty in arranging
words properly? Yes _______ No _______
Do you have a headache or head pain that is unlike any
you have had before? Yes _______ No _______
Do you have headaches for hours or days? Yes _______ No _______
Do you have a history of stroke in your family? Yes _______ No _______
Do you have chest pain? Yes _______ No _______
Do you have any change in bowel or bladder habits? Yes _______ No _______
Do you have a sore that does not heal? Yes _______ No _______
Do you have any unusual bleeding or discharge? Yes _______ No _______
Do you have any thickening in your breasts or elsewhere? Yes _______ No _______
Do you have a change in any wart or mole? Yes _______ No _______
Do you have a nagging cough or hoarseness? Yes _______ No _______
Do you have night sweats? Yes _______ No _______
Do you have pain in neck, jaw or face? Yes _______ No _______
Do you have a drooping eyelid or change in your pupils? Yes _______ No _______
Do you have any ringing in your ears? Yes _______ No _______
Do you take birth control pills? Yes _______ No _______
What prescription medication are you taking if any?

- [ ] High blood pressure medication
- [ ] Blood thinners
- [ ] Herb, vitamins, or over the counter products
- [ ] Other

Have you ever had cancer? Yes ____ No ____
Does you pain ever wake you from a sound sleep? Yes ____ No ____
Are you losing weight now without trying? Yes ____ No ____
Are you coughing up blood or noticing it in your stools or urine? Yes ____ No ____
Have you had any loss of bladder or bowel control? Yes ____ No ____
Have you lost consciousness or had double vision recently? Yes ____ No ____
Are you seeing any other doctor now for any reason? Yes ____ No ____
Note: ____
Are you taking any medication or over-the-counter drugs? Yes ____ No ____
Please indicate type (aspirin, etc.)

Social History

SMOKER _______ Yes or _____ No, If Yes, how many packs ________________
ALCOHOL _______ Yes or _____ No, If Yes, how much ______________________

Family History

Did you mother or father have any of the following:
Put an M for mother, F for father, and B for both.

( ) High Blood Pressure ( ) Ulcer or Stomach Problems
( ) Heart Attack ( ) Stroke (Please indicate age when stroke occurred,
( ) Emphysema Mother _______ Father _______)
( ) Seizure-Convulsions ( ) Arthritis-Rheumatism
( ) HIV Positive ( ) Mental Illness
( ) Asthma ( ) Thyroid Disease
( ) Diabetes ( ) Circulation Problems
( ) Kidney Disease ( ) Cancer

Comments: ____
____
____
____
____
____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING

Mark the areas on this body where you feel the described sensations.
Use the appropriate symbols. Mark areas of radiation.
Include all affected areas.

Numbness Pins & Needles Burning Aching Stabbing

- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /
- - - - -	00000	xxxxx	*****	/ / / / /

Please mark on the pain scale from Zero to 10 the pain you feel with this condition.
10 being the worst pain you have felt with this condition.

Pain Chart

Neck-Shoulder-Arm-Pain
On a scale of zero to 10, I rate my discomfort as follows:
(____________________)
0 10
no pain severe pain

Mid Back Pain
On a scale of zero to 10, I rate my discomfort as follows:
(____________________)
0 10
no pain severe pain

Low Back and Leg Pain
On a scale of zero to 10, I rate my discomfort as follows:
(____________________)
0 10
no pain severe pain

Date: ________________________ Signature ___________________________

Informed Consent

Medical doctors, chiropractic doctors, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment.

I _________________________________, do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues. Physical therapy and exercises may also be used.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
<u>Soreness</u>: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
<u>Dizziness</u>: Temporary symptoms like dizziness and nausea can occur but are relatively rare.
<u>Fractures/Joint Injury</u>: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
<u>Stroke</u>: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightening. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.

Treatment Results

I understand that there are beneficial effects associated with treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.

I realize that the practice of medicine, including chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree to the performance of these procedures by my doctor.

Alternative Treatments Available

Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bedrest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for joint stability or serious disk rupture. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Nontreatment: I understand the potential risks of refusing or neglecting care may include increases pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. Any questions I have had regarding these procedures have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

To attest to my consent to these procedures, I hereby affix my signature to this authorization for treatment.

____ Signature of Patient

____ Signature of witness

____ Date and time