

# Dr. Amy King, Chiropractor

## Vital Information

Legal Name \_\_\_\_\_ Date \_\_\_\_\_

Name I prefer to be called (if different) \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ Pronouns \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_

Circle: Single Married Widowed Separated Divorced Partnered \_\_\_\_\_ years Other

Do you have children? How many/ages? \_\_\_\_\_

Best number to reach you (\_\_\_\_\_) \_\_\_\_\_ Email Address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Relationship \_\_\_\_\_

Best Phone (\_\_\_\_\_) \_\_\_\_\_

What do you do for a living? \_\_\_\_\_

Employer/School: \_\_\_\_\_

How did you hear about Dr. King? \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_ Are you pregnant? Yes No

If yes, estimated due date: \_\_\_\_\_

Is your visit due to an accident or injury? If yes, please explain.

What is the primary reason for your visit today?

Is there anything about your body, spine, or nervous system that we should know? (include any/all surgeries, accidents, head injuries, whiplash, broken bones, or any other traumas)

## **Lifestyle and Health Information**

Have you ever been to a chiropractor? Yes No Last adjustment? \_\_\_\_\_

How many ounces of water do you drink daily? \_\_\_\_\_ oz

Describe your typical diet:

How many hours of sleep/rest do you get? \_\_\_\_\_ Is it restful? Yes No

What do your life activities consist of? (please list: meditation/exercise/gym workouts/acupuncture/massage therapy/body or energy work/etc.) How often?

Work/daily activity: (circle) Sitting Standing Light labor Heavy Labor

Other: \_\_\_\_\_

How many hours do you work per week? \_\_\_\_\_

Please list all physical or emotional stresses due to work or other daily activities:

Health challenges past and present: (please list ANY and ALL current/past health conditions/diagnoses/symptoms)

Chemical stressors, circle and/or list: use of alcohol, drugs, nicotine, caffeine, OTC or prescribed medications, birth control, current/past use of hormone therapy, etc.

What is your average daily stress level? (circle)

(low) 0 1 2 3 4 5 6 7 8 9 10 (high)

What causes you to become stressed?

What is your level of commitment to yourself, your life, and your well-being? (circle)

Low Medium High

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_