Susan Miller, D.C.
Vibrant Life Wellness Center
29 River Rd
Newcastle, ME 04553
207-563-6060

Full Name _____ Date_____

Mailing Address _____
(Street) (City, State) (Zip Code)

Home Phone _____ Work Phone _____

Cell Phone _____ E-mail_____

Spouse/Guardian Name _____

Marital Status: M S W D P # Children _____ Age _____ Birthdate _____

Pregnant? _____ Height _____ Weight _____ Occupation _____

Employer's Name and Address _____

Spouse Occupation/Employer _____

Name of person responsible for account _____

Do you have insurance that covers Chiropractic care? Yes_____ No_____

Do you have Medicare Coverage? Yes_____ No _____

WHO MAY WE THANK FOR REFERRING YOU? _____

I. HEALTH CONCERNS

List health concerns according to their severity.	Rate of severity (1= mild / 10= worst imaginable)	Date started, for how long?	If you had the condition before, when?	Did problem begin with an injury?	% of pain is present
1. _____	_____	_____	_____	_____	_____
2. _____	_____	_____	_____	_____	_____
3. _____	_____	_____	_____	_____	_____
4. _____	_____	_____	_____	_____	_____

What have you done for this condition? Was it of benefit?

_____

_____

I do (do not) have a family history of this or similar symptoms (Please explain)

_____

_____

Is this condition interfering with your: work____ sleep_____ daily routine_____ sports/exercise_____ other_____

What activities aggravate your condition? _____

_____

_____

Other doctors seen for this condition: Chiropractor _____ Medical Dr. _____ Dentist _____ Other _____

1. Name/Address _____

When? _____ What did they say was wrong? _____

What did they do? _____ Did it help? _____

2. Name/Address _____

When? _____ What did they say was wrong? _____

What did they do? _____ Did it help? _____

Have you been "forced" or "felt the need" to make any "positive" changes In your life due to this pain, illness, condition, etc? (i.e. eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

_____

_____

If you "get better" or get rid of this "condition" will you go back to your "old ways"? _____

Are you unable to do certain activities that you would like to do because of this pain, illness, condition? (i.d. sports, walk, pick up grandchildren, etc.) If so, what?

_____

_____

What lesson(s) have you taken from your healing process to date?

_____

_____

Have you had any surgery? (Please include all surgery)

1. Type _____ When _____ Doctor _____

2. Type _____ When _____ Doctor _____
3. Type _____ When _____ Doctor _____
4. Type _____ When _____ Doctor _____

Accidents and/or injuries: auto, work, or other (especially those related to your present problems).

1. Type_____ When _____ Hospitalized?_____
2. Type_____ When _____ Hospitalized?_____
3. Type_____ When _____ Hospitalized?_____

Have you ever had x-rays taken? _____ When? _____ Where? _____

Area of Body: _____

Do you wear orthotics or heel lifts? Yes_____ No_____

II. CURRENT MEDICINE(S)

Please list ALL drugs you currently take or have taken in the past 6 months:

(The doctor will give you a printout from the Physician's Desk Reference with important information.)

Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____

Please list all nutritional supplements, vitamins, homeopathic remedies you presently take:

Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____
Name _____ Dosage _____ For what? _____

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?
Yes _____ No _____ Maybe _____

If dietary changes are indicated would you be willing to make changes in your diet?
Yes _____ No _____ Maybe _____

Would you take whole food supplements if indicated?
Yes _____ No _____ Maybe _____

Mark the following conditions you may have had or have now (**-** have had **+** have now)

___ Allergy	___ Diarrhea	___ Measles	___ Rheumatic Fever	___ Alcoholism
___ Eczema	___ Miscarriage	___ Stroke	___ Multiple Sclerosis	___ Anemia
___ HIV (AIDS)	___ Gout	___ Arteriosclerosis	___ Emphysema	___ Mumps
___ Sinus Problems	___ Arthritis	___ Neuritis	___ High Blood Pressure	___ Asthma
___ Nervousness	___ Thyroid Problems	___Ulcers	___Heart Disease	___ Cancer
___Depression	___Convulsions	___ Venereal Disease	___ Malaria	___ Pleurisy
___ Gallbladder Prob.	___ Migraines	___ Headaches	___ Menstrual Cramps	___ Back Pain
___ Epilepsy	___ Irreg. Periods	___ Heart Attack	___ Tuberculosis	___ Diabetes

___ Low Blood Sugar ___ Ringing in Ears ___ Other (please explain) _____

DIET:

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - consume this daily
FD - consume this a few times per day
FW- consume a few times per week
M - consume this monthly
FM- consume a few times per month (less than weekly)
O- Do not consume this

Alcohol		Eggs		Soda
Artificial Sweetner		Fasting		Tobacco
Beef		Fried foods		Weight control diet
Coffee		Fruit		Whole grains
Cooked, canned vegetables		Organic vegetables		
Dairy		Poultry		
Diet Food		Raw vegetables		

The type of diet I usually follow is classified as:_____

General Emotional Trauma:

With each of the following stress situations, please write either **"P"** for past or "**C"** for current

	Mild	Moderate	severe		Mild	Moderate	severe
Childhood Stress				Work stress			
School Stress				Stress of commuting			
Play or recreational				Loss of loved one			
Family Stress				Change in lifestyle			
Personal realationship				Change in vocatiojn			
Stress of being sick				Abuse			

How do you grade your physical health? Excellent_____Good_____Fair_____Poor_____Getting better____Getting worse

How do you grade your emotional/mental health? Excellent___Good___Fair____Poor___Getting better___Getting worse

Is there anything else which may help to better understand you which has not been discussed?
_____
_____
_____
_____

Why are you here at this point in time _____

_____

Print Name_____

Signature_____ Date_____