inspire life
CHIROPRACTIC CENTER

Welcome!

Your first visit to our center is an opportunity for us to learn all about you and your family. It is time for you to share with us where you are now in your health & life, as well as what you would like to move toward.
And away we go!

Chiropractic Vitality Inventory

Today's Date: _____

Personal Information

Legal Name:_____ Preferred Name:_____

Pronoun: _____ Sex: _____ Gender: _____

Age:_____ Date of Birth:_____

Both Parent's names (if you are under 18): _____

Address: _____ City: _____ State:_____ Zip: _____

Home Phone: (___)_____ Business Phone: (___)_____ Cell Phone: (___)_____

Email Address:

☐ Single ☐ Married ☐ Divorced ☐ Widowed Spouse/Partner: _____

Names & Ages of Children: _____

_____

What kind of work do you do? _____ Self-Employed? ☐ Yes ☐ No

What are your hobbies, interests, & inspirations: _____

_____

How did you hear about us?

☐ Website ☐ Google ☐ Social Media ☐ Event

☐ Referral - Who can we thank for referring you? _____

☐ Other: _____

Let's find out why you're here...

What concerns do you feel Inspire Life Chiropractic Center can address for you? _____

_____

Are these concerns affecting your quality of life? (please circle all that apply)

Work:	Yes	No	Driving:	Yes	No	Sleep:	Yes	No
School:	Yes	No	Walking:	Yes	No	Sitting:	Yes	No
Fitness/Sports:	Yes	No	Eating:	Yes	No	Love Life:	Yes	No

Chiropractic Vitality Inventory

Health Care Practitioner History

Have you ever received Chiropractic care? ☐ Yes ☐ No Name of DC: _____

How long were you under care? _____ days _____ weeks _____ months _____ years

Date of last visit: _____ Why did you stop care? _____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath

☐ Massage Therapist ☐ Psycotherapist ☐ Energy Healer ☐ Dentist

Reason: _____

_____

Female Practice Members

Are you pregnant? ☐ Yes ☐ No

If **pregnant**, Due Date: _____ Name of OBGYN or Midwife: _____

Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other: _____

The primary system in the body which coordinates health is the Nervous System (NS). This system is comprised of three layers. The first layer is the spinal musculature encasing the spinal column. The second layer is the joints of the spine known as the vertebral column designed to surround and protect the delicate NS. The third, most important layer is the communication layer made up of the brain, spinal cord, and nerves. When unmanaged stressors add up over time, it not only affects layers one and two, but creates dysfunction and dis-ease in this vital system, leading to physical, chemical, and emotional causes and effects.

The information below will help us to see the types of PHYSICAL, EMOTIONAL, & CHEMICAL stresses you have been subjected to in your life, how they may relate to your present spinal, nerve & health status, & whether they may have caused neurospinal dysfunction.

Physical Stress: Birth & Infancy

The birth process can traumatize a baby's spine and cause damage to the neural spinal system. Please CHECK where and how you were birthed. (If you do not know, please skip to the next question.)

☐ Home ☐ Natural ☐ Breech ☐ Caesarian section ☐ Forceps

☐ Hospital ☐ Cord around neck ☐ Prolonged labor ☐ Drug induced labor ☐ Suction

Physical Stress: Childhood through Adult

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse

If yes, please list the type of injury & date: _____

_____

Have you ever hurt, broken, fractured, sprained, injured, or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ☐ Yes ☐ No

If yes, please list areas injured & dates of injuries: _____

_____

Have you ever been hospitalized or had surgery? ☐ Yes ☐ No

If yes, state reason & dates: _____

_____

Chiropractic Vitality Inventory

On average, how many hours do you sit per day? ☐ 0-5 ☐ 5-10 ☐ 10-15 ☐ 15+

How would you rate your activity level? ☐ Very Active ☐ Moderately Active ☐ Sedentary

Emotional Stress: Childhood through Adult

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you are currently experiencing (C), have experienced any of the following stressors in the past (P), or anticipate the possiblity of experiencing this stress in the future (F).

	C	P	F
Childhood trauma	☐	☐	☐
Abuse	☐	☐	☐
Loss of loved one	☐	☐	☐
Serious illness (self or loved one)	☐	☐	☐
Lifestyle change	☐	☐	☐
Financial concerns	☐	☐	☐
Work environment	☐	☐	☐
School environment	☐	☐	☐

	C	P	F
Divorce / separation (spouse)	☐	☐	☐
Divorce / separation of parents	☐	☐	☐
Relationships / Friendships	☐	☐	☐
Anger by you or at you	☐	☐	☐
Feeling "not worthy"	☐	☐	☐
Put things off to the last minute	☐	☐	☐
Worry	☐	☐	☐

Chemical Stress: Childhood through Adult

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ☐ Yes ☐ No If yes, did you have a reaction? ☐ Yes ☐ No ☐ Unsure

If yes, were you aware of your other options? ☐ Yes ☐ No

Do you want more information about other options? ☐ Yes ☐ No

Are you currently (C), have you been in the past (P), or do you anticipate future (F) exposure or consumption of any of the following?

	C	P	F
Toxic Chemicals	☐	☐	☐
Second-hand smoke	☐	☐	☐
Drug therapy	☐	☐	☐
Radiation	☐	☐	☐
Chemotherapy	☐	☐	☐
Environmental pollution	☐	☐	☐
Artificial sweetners	☐	☐	☐
Bad diet (white flour & sugar)	☐	☐	☐
Eat fast foods	☐	☐	☐

	C	P	F
Eat processed foods	☐	☐	☐
Coffee / Caffeine	☐	☐	☐
Alcohol	☐	☐	☐
Tobacco	☐	☐	☐
Over-the-counter drugs	☐	☐	☐
Prescribed drugs	☐	☐	☐
Recreational drugs	☐	☐	☐
Other: _____	☐	☐	☐
Other: _____	☐	☐	☐

	C	P	F
Food Sensitivities	☐	☐	☐
Allergies: Dairy	☐	☐	☐
Wheat	☐	☐	☐
Eggs	☐	☐	☐
Nuts	☐	☐	☐
Other foods: _____	☐	☐	☐
Seasonal	☐	☐	☐
Other: _____	☐	☐	☐
Other: _____	☐	☐	☐

Please list all medications (prescribed & over the counter): _____

_____

_____

Note: It is imperative that you list all medications & drugs as they may have an influence on your care.

Chiropractic Vitality Inventory

If you have experienced any of the following, please indicate by checking C (current), P (past), or CP (current & past).

	C	P	CP		C	P	CP		C	P	CP
Fatigue	☐	☐	☐	Neck pain / stiffness	☐	☐	☐	Loss of balance	☐	☐	☐
Sleeping problems	☐	☐	☐	Shoulder pain	☐	☐	☐	Earaches	☐	☐	☐
Frequent colds	☐	☐	☐	Mid-back pain	☐	☐	☐	Ringing in the ears	☐	☐	☐
Asthma	☐	☐	☐	Low-back pain	☐	☐	☐	Irritability	☐	☐	☐
Allergies	☐	☐	☐	Hip pain	☐	☐	☐	Depression	☐	☐	☐
Digestion problems	☐	☐	☐	Joint pain	☐	☐	☐	Nervousness	☐	☐	☐
Weakness	☐	☐	☐	Chest pain	☐	☐	☐	Tension	☐	☐	☐
Dizziness	☐	☐	☐	Heart problems	☐	☐	☐	Ulcers	☐	☐	☐
Headaches	☐	☐	☐	Pins/needles in legs	☐	☐	☐	Pins / needles in arms	☐	☐	☐
Migraines	☐	☐	☐	Leg / Foot pain	☐	☐	☐	Arm / hand pain	☐	☐	☐
Nausea	☐	☐	☐	Numbness in toes	☐	☐	☐	Numbness in fingers	☐	☐	☐
Fainting	☐	☐	☐	Cold feet	☐	☐	☐	Cold hands	☐	☐	☐
Low energy / tired	☐	☐	☐	Anxiety	☐	☐	☐	Sinus congestion	☐	☐	☐
Lights bother eyes	☐	☐	☐	Skin Conditions	☐	☐	☐	Menstrual irregularity	☐	☐	☐
Cold sweats	☐	☐	☐	Urinary problems	☐	☐	☐	Menstrual pain	☐	☐	☐
Fever	☐	☐	☐	Mood swings	☐	☐	☐	Hot flashes	☐	☐	☐
Brain fog	☐	☐	☐	Difficulty focusing	☐	☐	☐	Cancer	☐	☐	☐

Quality of Life

Do you notice you store your stress in: (please check all that apply)

☐ Your Neck & Shoulders ☐ Your Mid-back ☐ Your Low-back & Pelvis ☐ Other

Please rate your GENERAL stress level, 0-10. At Work / School: _____ At Home: _____

How do you think you handle your stress? _____

_____

How do you grade your physical health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How do you grade your emotional / mental health?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How do you rate your sexual health / intimacy?	☐ Excellent	☐ Good	☐ Fair	☐ Poor
How do you rate your overall "quality of life?"	☐ Excellent	☐ Good	☐ Fair	☐ Poor

Do you exercise regularly? If yes, how often? _____

Do you take supplements? If yes, please list: _____

_____

What would you like to gain at Inspire Life?

☐ Resolution & Prevention of a symptom or problem

☐ Healthier spine & Nervous system

☐ Continual progression in health & life

☐ Other: _____

Let's Make Sure We're on the Same Page...

When an individual or family seeks and is accepted into a program of **function-based** chiropractic care, it is essential for all parties to be working toward the same objectives. We have only one goal, and it is important that everyone understands both our objective and the methods we will use to move consistently toward that objective.

Your care in our center is not a substitute or alternative for, nor is it a preventive form of medicine. Medically-based care specializes in the ***diagnosis*** and ***treatment*** of specific symptoms, illness and disease. Our function-based chiropractic care specializes solely in helping people of all ages ensure that their spines and nervous systems are functioning as optimally as possible. This in turn allows their bodies to work the best they possibly can.

So while the natural result of optimal function is increased **health**, **wellness**, and an **overall improved quality of life**, we will not diagnose, treat, or attempt to cure any specific physical, mental, or emotional ailment, nor will we give advice about specific medical conditions or treatments.

If you are seeking care for the removal of a ***specific*** medical symptom or condition, we suggest you seek additional help from a symptom, illness, and disease oriented professional if you feel that our functional-based approach will not be sufficient in progressively raising you to the levels of health, wellness, and quality of life you desire for yourself and your family.

I,_____, have read and understand the above statement and I hereby give permission for Dr. Mel Krug to continue with my child's and/or my initial consultation and assessment. I also agree to return at a later date to allow Dr. Krug to report her findings and recommendations to me. By agreeing to this, I am in no way obligated to follow the advice given to me in the report of findings.

Signature:_____ Date: _____

We sincerely thank you for choosing our center & for taking the time to honestly reflect upon & share your current level of health & well being, as well as your goals.

We look forward to helping you maximize your experience & expression of health & life!