



vital information

date: \_\_\_\_\_

first name: \_\_\_\_\_ last name: \_\_\_\_\_

address: \_\_\_\_\_ city: \_\_\_\_\_ state: \_\_\_\_\_ zip: \_\_\_\_\_

social security #: \_\_\_\_\_ marital status  married  domestic partner  
 single  widowed  divorced

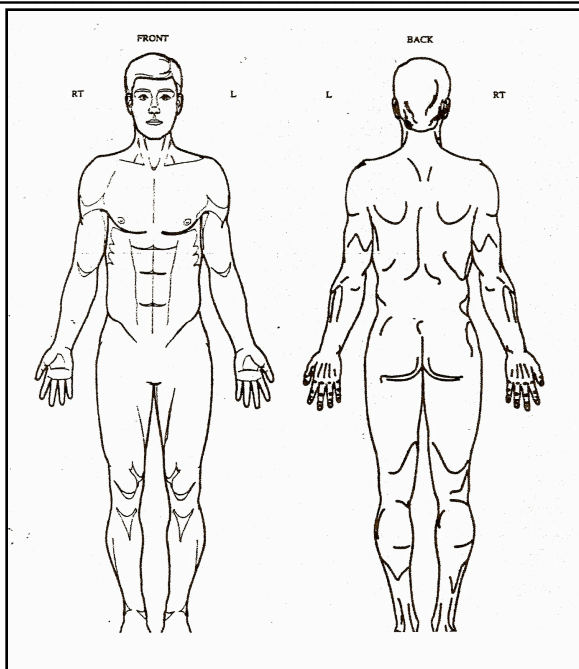
spouse/partner's name: \_\_\_\_\_ your date of birth: \_\_\_\_\_

home phone: \_\_\_\_\_ work phone: \_\_\_\_\_ cell phone: \_\_\_\_\_

email: \_\_\_\_\_ emergency contact name/phone: \_\_\_\_\_

how were you referred to us? \_\_\_\_\_

in your own words tell us what brings you in today? \_\_\_\_\_



using the symbols provided in the pain index, mark the areas on the illustrations below where you are experiencing pain, followed by a number from 1 to 10 indicating the extent of the pain. (1-minor, 10-major)

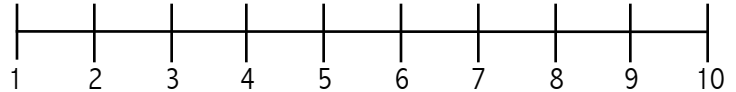
pain index

- D dull nagging pain
- B burning
- S sharp/stabbing
- N numbness/tingling
- M muscle spasm/pulling

for example: if you are experiencing moderately severe burning in back of your neck, you should note a "B8" on the neck of the illustration.

for office use only

on a scale of 1-10, how do you feel now? (1-best, 10-worst)



Do you have any of the following conditions or symptoms?

- |   |   |                                  |  |  |
|---|---|----------------------------------|--|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Allergies                  | <input type="checkbox"/> HIV     | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Neck Pain       |
| <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Chest Pain                 | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Loss of Smell/Taste | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Dizziness                  | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Stomach Problem     | <input type="checkbox"/> Cancer          |
| <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Fatigue                    | <input type="checkbox"/> Sweats  | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Bowel/Bladder Problems | <input type="checkbox"/> Numbness/Pain in Arms/Legs |                                  |  | <input type="checkbox"/> _____           |

Is there anything about your Nerve System and Spine we should know about?  
(Previous Surgeries/Diagnosis)

signature & date: \_\_\_\_\_

# Life Style History

Name: \_\_\_\_\_

The following three areas of stress can cause misaligned vertebra (subluxation). Do you recognize any of these stresses either presently or in the past?

Physical Stress:

- |                                  |                          |       |          |
|----------------------------------|--------------------------|-------|----------|
| Birth Trauma (mother or child)   | <input type="checkbox"/> | _____ | Explain: |
| Physical abuse                   | <input type="checkbox"/> | _____ |          |
| Slips/Falls                      | <input type="checkbox"/> | _____ |          |
| Work injuries                    | <input type="checkbox"/> | _____ |          |
| Poor Posture                     | <input type="checkbox"/> | _____ |          |
| Sitting on your wallet           | <input type="checkbox"/> | _____ |          |
| Sleeping position                | <input type="checkbox"/> | _____ |          |
| Extensive computer work          | <input type="checkbox"/> | _____ |          |
| Carrying heavy purse/bag/child   | <input type="checkbox"/> | _____ |          |
| Repetitive lifting/bending       | <input type="checkbox"/> | _____ |          |
| Driving for long periods of time | <input type="checkbox"/> | _____ |          |
| Sitting/standing for many hours  | <input type="checkbox"/> | _____ |          |
| Bone fracture/surgery            | <input type="checkbox"/> | _____ |          |

Emotional Stress:

- |                               |                          |       |
|-------------------------------|--------------------------|-------|
| Relationships                 | <input type="checkbox"/> | _____ |
| Career                        | <input type="checkbox"/> | _____ |
| Children                      | <input type="checkbox"/> | _____ |
| Money                         | <input type="checkbox"/> | _____ |
| Busy lifestyle                | <input type="checkbox"/> | _____ |
| Quick tempered                | <input type="checkbox"/> | _____ |
| Verbal abuse                  | <input type="checkbox"/> | _____ |
| Hold in feelings              | <input type="checkbox"/> | _____ |
| Perfectionist                 | <input type="checkbox"/> | _____ |
| Depression/Nervousness        | <input type="checkbox"/> | _____ |
| Sickness or loss of loved one | <input type="checkbox"/> | _____ |

Chemical Stress:

- |                         |                          |       |
|-------------------------|--------------------------|-------|
| Smoker (amount)         | <input type="checkbox"/> | _____ |
| Second hand smoke       | <input type="checkbox"/> | _____ |
| Poor diet               | <input type="checkbox"/> | _____ |
| Caffeine (amount)       | <input type="checkbox"/> | _____ |
| Artificial sweeteners   | <input type="checkbox"/> | _____ |
| Prescription drugs      | <input type="checkbox"/> | _____ |
| Over-the-counter drugs  | <input type="checkbox"/> | _____ |
| Recreational drugs      | <input type="checkbox"/> | _____ |
| Environmental pollution | <input type="checkbox"/> | _____ |

Briefly describe your nutrition. What do you normally eat for breakfast, lunch and dinner?
What is your daily water, soda and other fluid intake?
How much sleep do you get per night? Do you sleep through the night?
Do you exercise? What do you do and how often?
Describe your family relationships? (great, stressful, none)
Rank your satisfaction with work: (Low 1, High 10) What type of work do you do?
How often do you vacation?
Do you use recreational drugs or over-the-counter medication? If yes, please list:
What do you do for fun or to relax?
Any other health related concerns or issues you feel we should know about?

What do you feel is your primary stress?

What is your level of commitment to yourself, your life and well-being?      High                      Medium                      Low

Additional comments:

signature & date: \_\_\_\_\_

Welcome to Midtown Life Studio!

Thank you for choosing Midtown Life Studio for your chiropractic care. We are committed to serving you an exceptional chiropractic experience! At Midtown Life Studio you will receive the highest quality of chiropractic care available, so that you can enjoy an active and healthy life. If you ever have any questions, please don't hesitate to ask! All of your questions, even the ones you haven't thought of yet, will be answered during your second visit. We look forward to a long, healthy relationship with you!

Terms of Acceptance

The practice of chiropractic at Midtown Life Studio consists of:

- 1. Analysis of the spine for the purpose of locating vertebral subluxations (spinal misalignments causing nerve interference).
2. Adjustments of the spine for the purpose of correcting vertebral subluxations.
3. Education and encouragement of our people to become aware of and responsible to their well-being.
4. Empowerment of our people as to the inherent healing capabilities of the human body.

Our intention is to provide you with the best care we can offer as outlined above. We do not offer care with the intent of "treating" or "curing" disease or conditions. If during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

I understand and agree to receive care at Midtown Life Studio for myself/my family as outlined in this "Terms of Acceptance".

Name (Please Print): \_\_\_\_\_ Sign: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

SS# \_\_\_\_\_ Date of Birth \_\_\_\_\_

Authorization

THE PERSON IDENTIFIED ABOVE AUTHORIZES Dr. Greg C. Graham and Midtown Life Studio, TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

SPECIFIC AUTHORIZATIONS:

- I give permission to Midtown Life Studio to use my address, phone number, and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about health care or other health related information.
•If Midtown Life Studio contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
•I give Midtown Life Studio permission to adjust me in an open room where others are also being adjusted. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the Chiropractor at any time in private, the Chiropractor will provide a room for these conversations.
•By signing this form you are giving Midtown Life Studio permission to use and disclose your Protected Health Information in accordance with the directives listed above.

The use of this format is intended to make your experience at Midtown Life Studio more efficient and productive and enhance your access to quality Chiropractic Care and health information. This authorization will remain in effect for the duration of my care at Midtown Life Studio plus 7 years or until revoked by me.

RIGHT TO REVOKE AUTHORIZATION

You have the right to revoke this AUTHORIZATION in writing at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your AUTHORIZATION.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to Midtown Life Studio. The written notice must contain the following information: Your name, Social Security number, and date of birth; A clear statement of your intent to revoke this AUTHORIZATION; The date of your request; and your signature. The revocation is not effective until it is received by Midtown Life Studio.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, Midtown Life Studio will not refuse to provide care.

You have the right to inspect/copy the Protected Health Information to be used/disclosed. A copy of this signed form will be provided to you upon request.

Print Name of Patient \_\_\_\_\_ Signature of Patient \_\_\_\_\_

Date \_\_\_\_\_ Signature of Personal Representative \_\_\_\_\_