Omer Chiropractic
Lifestyle Center
"Creating Healthier Tomorrows"

Welcome to Omer Chiropractic Lifestyle Center. Thank you for choosing our office for your chiropractic care. We are committed to providing you with the highest quality of chiropractic care available.
Following your paperwork, the doctor will discuss your health history and perform an examination. The acceptance of your case will be based on the examination and diagnostic findings. If you ever have any questions regarding your chiropractic care, please don't hesitate to ask us. We look forward to a long, healthy relationship with you and your family.

Today's date:____________________

Name: ________________________________Preferred name (if different): ______________ SS#:_____________

Email Address: _____________________________ Date of Birth: ________________ Age: _____ Gender: M / F

Address: ___________________________________ City/ State/ Zip: ____________________________________

Home Phone: ____________ Cell Phone:_____________ Employer: _______________ Work Phone:____________

Check One: □ Single □ Married □ Widowed □ Divorced □ Separated # of Children: _____________

Spouse Name: _______________________________________ Phone: ____________________________________

Name of emergency contact: _____________________________ Phone: ____________________________________

How did you hear about our office? (Whom may we thank for referring you to us?): _____________________________

List your problems or complaints according to severity:	Date started, or for how long?	If you had the condition before, when?	Did problem begin with an injury?
1. ____________________	__________	________________	____________
2. ____________________	__________	________________	____________
3. ____________________	__________	________________	____________

Previous accidents and/or injuries: auto, work related, or other (especially those related to your present condition).

1. Type: ______________________________ When: ________________________ Hospitalized? □ yes □ no
2. Type: ______________________________ When: ________________________ Hospitalized? □ yes □ no
3. Type: ______________________________ When: ________________________ Hospitalized? □ yes □ no

NOTE: If you have RECENTLY been involved in an accident or injury, please inform a staff member so they may bring you our accident report form.

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

1. Type: ______________________________ When: ________________________ Doctor: _____________
2. Type: ______________________________ When: ________________________ Doctor: _____________
3. Type: ______________________________ When: ________________________ Doctor: _____________

Have you had any x-rays taken?

When? _________________ Where? ____________________ Area of Body: ____________________

Have you been under chiropractic care before? ☐ Yes ☐ No Date of your last visit: ____________________

If so, Chiropractor's name: ____

FEMALES ONLY: Date of last menstrual period?____________ Are you pregnant? ☐ Yes ☐ No ☐ Maybe

PERSONAL HISTORY:

Any medical conditions you have been diagnosed with?________________________________

Medications: ____

Allergies: ____

WHY CHIROPRACTIC??? People seek chiropractic care for a variety of reasons. Some want symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health and wellness possible with chiropractic care (Wellness Care). Your Doctor will weigh your needs and desires when recommending your treatment.

Please check the type of care desired so we may be guided by your wishes whenever possible.

☐ Relief Care ☐ Corrective Care ☐ Wellness Care ☐ Check here if you want the Doctor to select the type of care appropriate for your condition

Our office policy requires payment in full for all services rendered at the time of the visit. We do not file your insurance, however we will provide you with all the necessary information to submit it yourself. We invite you to discuss any questions regarding our services. The best health services are based on a friendly, mutual understanding between the provider (our office) and the patient (you).

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my health status.

Signature: ________________________________ Date: ________________

Guardian Signature (if minor) : ____

LIFESTYLE ASSESSMENT

We are all innately programmed for wellness. In order to express optimal health one needs only to supply the necessary quality ingredients (purity) in the right amounts (sufficiency). Interferences to wellness can be created by not having enough of something essential (deficiency) or too much of something harmful (toxicity). We have created this questionnaire to assess your levels of deficiency and toxicity in the areas of nutrition, movement, and thought. Please answer honestly and in detail so that we may best guide you to your most vibrant level of health!

EATING WELL "You are what you eat"

***Deficiency*:**

Whole, natural foods - Do you eat 8-10 servings of fruits and vegetables/day? Yes ☐ No☐
If not how many? ________ Fruits _________ Vegetables

Omega-3's - Are you taking essential fatty acids? Yes☐ No☐
W hat is the source? __________________ Quantity?______________

Pure water – are you drinking an adequate amount (½ oz of water per pound of body weight/day)? Yes ☐ No☐
How much water do you drink?________________________

***Toxicity*:**

Do you drink alcohol? If so, how many drinks of alcohol do you intake per week?________ Yes ☐ No☐

Do you smoke cigarettes? If so, how many packs/week?_______For how many years?______ Yes ☐ No☐

Do you eat/crave junk food? (Please circle all that apply) Fast food, processed food, sweets Yes ☐ No☐

MOVING WELL "Movement is life, and Chiropractic delivers!"

***Deficiency*:**

Do you follow a regular aerobic exercise program (At least 30 minutes/day)? Yes ☐ No☐

Do you perform postural exercises for your spine daily? Yes ☐No ☐

Do you follow a strength training program, 2-3 X/week involving all major muscle groups? Yes ☐No ☐

***Toxicity*:**

Have you ever been involved in a car accident? If so when? ______________________________ Yes ☐No☐
Describe____

How many hours, on average, do you sit daily?_________________________ At a computer? Yes ☐No☐

Have you had any major injuries (sports, etc.)? If so, when?______________________________ Yes ☐No ☐
Describe____

THINKING WELL "Our thoughts create our world"

Deficiency:

Do you have daily stress reduction strategies? Yes ☐No☐

Do you have a strong support network of friends and family? Yes ☐No ☐

Toxicity:

Do you engage in negative self talk (self-critical, perfectionist tendencies)? Yes ☐No ☐

Do you have chronic stress in your life? If so, what? ______________________________ Yes ☐No ☐

Rate the level of stress in your work life. Low ☐ Moderate ☐ High☐ Severe☐

Rate the level of stress in your personal life. Low ☐ Moderate ☐ High ☐ Severe ☐

IMPORTANT!! Please tell us what you MOST want out of your experience here - what is/are your goal(s)?
____

How will we know that your goals are being met?
____