Sozo Chiropractic & Wellness, LLC

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Sozo (sode'-zo): To save a suffering one from disease; to make well, heal, restore to health.

Date: _____ Date of Birth: _____ Age: _____
Name: _____
Address: _____ Apt. #: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Home Phone: _____
Work Phone: _____ Employer: _____
Email Address: _____ ←**Please print clearly** *(Very, very important! For office closings, office newsletters, receipts, essential notifications, schedule changes, bulletins, etc…)*
Best way to Contact: Home # Cell # Work # Email
Emergency Contact Name: _____
Phone: _____ Relation: _____
Marital Status: Single Married Divorced Widowed In a Relationship
Spouse Name: _____
If you have children, how many? _____
List names and ages of children: _____
_____
We are a referral based office. Whom do we have the pleasure of thanking for referring you?
_____
What are your hobbies? _____

Chiropractic is not about a treatment or cure for disease.
Chiropractic is for the removal of interference to the nervous system (subluxation) and restoration of function and communication within the body so that your body may express its fullest potential for life and healing.
Subluxation affects your LIFE and HEALTH.

Subluxations are painless and people should be checked regularly for subluxations from the moment they are born.

How can we serve you? ____ I have no Complaints. I am here for a Subluxation check up.
When were you last checked for subluxations? _____
By whom? _____
How long under care? _____ Last visit date? _____
Reason for stopping care? _____

_____ Check here if you have never seen a Chiropractor before.

Subluxations cause poor sleep, low energy, reduced healing capacity and much more.

What activities or parts of your life that you <u>value</u>, are the problems you are experiencing affecting?
(X all that apply)

- O **Gardening**
- O **Cooking**
- O **Walking**
- O **Being a better Artist**
- O **Creativity**
- O **Physical Health**
- O **Relationships with family and friends**
- O **Golf**
- O **Tennis**
- O **Fishing**
- O **Hunting**
- O **Bocce Ball**
- O **Taking out the Garbage**
- O **Feeling Normal**
- O **Have More Vitality**
- O **Exercise**
- O **Work**
- O **Lifting Weights**
- O **Tolerance with your children**
- O **Tolerance with your spouse**
- O **Playing with your Children**
- O **Playing with your Grandchildren**
- O **Enjoying a day at the beach**
- O **Energy to be active**
- O **Concentration**
- O **Breathing**
- O **Deep Relaxation**
- O **Quality Sleep**
- O **More Balanced Posture**
- O **Emotional well being**
- O **Strength**
- O **Endurance**
- O **Reflexes**
- O **Reaction Times**
- O **Steady Hand Movement**
- O **Freedom from Pain**
- O **Reduce or Elimination from Pain**
- O **Resistance to Disease**
- O **Earning potential**
- O **Overall health improvement**

What are you currently experiencing? _____

_____

How long have you been aware of this problem? _____

Have you seen anyone else for this issue? Yes No
If yes, who? When? Outcome?_____

Has anything/anyone helped? Yes No
If yes, who or what? _____

Have you ever been treated for a similar problem? If yes, please describe. Yes No

_____

Unable to handle everyday stress is a contributor to subluxation:

What do you do for a living? _____ Hrs/wk? _____
Do you have more than one job? No Yes _____ Hrs/wk? _____
How would you rate your stress level at work? _____
How would you rate your stress level at home? _____

Improper lifestyle habits can also contribute to subluxations.

Do you exercise? No Yes _____
Do you use any tobacco products? No Yes When did you quit? _____
Do you drink alcoholic beverages? No Yes How often? _____
Do you drink coffee/tea? No Yes How often? _____
Do you drink soda/diet soda? No Yes How often? _____
Do you use artificial sweeteners? No Yes How often? _____
Do you have special dietary restrictions? No Yes _____
Have you ever been diagnosed with an STD or VD? No Yes _____

Traumas can cause subluxations.

Please list all operations or surgeries you've had, including dates: _____

_____

Please list any hospitalizations you've had, including dates: _____
Have you had any recent infections, colds or flu? No Yes _____
ANY previous or recent motor vehicle accidents and when? _____

_____

ANY other major traumas, injuries, sports injuries, falls, etc. and when? _____

_____

ANY broken bones, sprained ankles, shoulder injuries, etc. with dates: _____

_____

ANY other symptoms or health issues you would like to discuss? _____

_____

Illnesses can cause or be caused by subluxations.

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? No Yes
Explain: _____

Have you ever been diagnosed with a heart condition, blood vessel condition, high blood pressure, etc?
No Yes: _____

Have you ever had a stroke or heart attack? No Yes: _____

Neurological, Autoimmune or Glandular problem or disease? Explain, include prior testing and diagnosis:

_____

Even when properly prescribed, medications are the leading cause of death in America and a leading cause of subluxation. Please list ALL medications, prescribed and/or over the counter:

_____

_____

Have you experience any change in bowel or bladder function, loss of control, or lack of sensation in that area?
No Yes: _____

Females: Is there ANY possibility that you could be be pregnant? Yes No
Date of last period: _____

Pregnant Patients

Have you had any previous pregnancies? No Yes _____
Have you had past cesareans? No Yes _____
Have you had a previous D&C? No Yes _____
Did you have any health problems during previous pregnancies? No Yes _____

_____

Name of your obstetrician: _____
Name of your midwife/doula: _____
Where do you plan to have your baby? _____
What symptoms of pregnancy have you already experienced? _____
List any additional comments/concerns: _____

Is there anything preventing you from doing what it takes to get well?
Time Money Family Obligations Travel Distance Other: _____

Print Name: _____
Signature: _____ Date: _____