ISLAND CHIROPRACTIC

performance and longevity

Name: _____Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Date of Birth: _____ Preferred Phone: _____
Whom may we thank for referring you? _____
Reason for today's visit:
_____
_____
When did this begin?_____
_____
Has this happened before? Y / N If so, when? _____
Rate pain from 1 (*minimal*) to 10 (*severe, you should be in the hospital*): _____
How have the symptoms changed since they first appeared? _____
_____
Type of pain: Sharp _____ Dull _____ Throbbing _____ Aching _____ Shooting _____
Burning ____ Numbness ____ Other _____
How often do you have this pain?
_____
Does your pain interfere with: Daily Routine _____ Work _____ Recreation _____
Exercise _____ Sleep _____ Other_____
Which of these is difficult to perform?
Sitting ____ Standing ____ Lying Down ____ Walking ____ Bending ____ Twisting ___
Have you sought treatment for this condition elsewhere?_____
If so, describe _____
_____

LIFESTYLE

What do you do to optimize your health on a regular basis?
_____
_____
How many meals do you eat per day? _____ Snacks? _____
Do you eat:
Fresh Fruit_____ Fresh Vegetables _____ Meat _____ Fish _____ Dairy _____
Nuts/Seeds _____ Bread/Pasta/Grains/Cereals _____ Fast Food _____
Coffee/Tea _____ Alcohol _____
How often do you have a bowel movement? _____
How often do you exercise? What types of exercise?
_____
_____
How many hours a night do you sleep? ____ How is your quality of sleep?
_____
In which position do you usually fall asleep?
Back _____ Side_____ Front _____
Is the computer, TV, or radio on when you sleep? Y / N

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How long is your work commute? To Work: _____ From Work: _____
Rate your stress level during a typical day: *Mild* 1 2 3 4 5 6 7 8 9 10 *Severe*
What posture do you tend to assume day to day?
Mostly Standing ___ Mostly Sitting ___ Other _____

HEALTH HISTORY

	DESCRIPTION and DATE
Falls	
Head Injuries	
Broken Bones	
Dislocations	
Surgeries	
Illnesses	
Allergies	
Other	

Current Medications:
_____
_____

Vitamins/Herbs/Minerals/Supplements:
_____
_____

Do you suffer from headaches? Y / N If so, how often? _____

Are you pregnant? Y / N If so, due date: _____

Has a chiropractor treated you in the past? Y / N
If yes, how often were you seen? _____
How long were you treated for? _____

Is there any other health issue you would like to discuss? _____
_____
_____

We do not diagnose or treat disease. Dr. Nicholas Kambourakis is a highly skilled professional trained in identifying locations of the spine where pressure on nerve tissue exists. Our goal is to manually adjust these disturbances in order to remove the interference and thus restore normal transmission if vital nerve impulses from the brain to all cells and tissues of the body. Our goal is to assist your body in attaining proper communication with all cells and tissues for maximum expression of health.

SIGNATURE _____ DATE_____