

Sozo Chiropractic & Wellness, LLC

409 W. Wall St. ~ Grapevine, TX 76051 ~ 469-223-8836 ~ www.sozochiro.com

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

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Employer: _____

Email Address: _____ ←Please print clearly

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?

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 value are your problems currently affecting? (X all that apply)

- | | |
|--|---|
| <input type="radio"/> Work | <input type="radio"/> Playing with your Children |
| <input type="radio"/> Gardening | <input type="radio"/> Playing with your Grandchildren |
| <input type="radio"/> Cooking | <input type="radio"/> Energy to be active |
| <input type="radio"/> Walking | <input type="radio"/> Concentration |
| <input type="radio"/> Creativity | <input type="radio"/> Breathing |
| <input type="radio"/> Physical Health | <input type="radio"/> Quality Sleep |
| <input type="radio"/> Golf | <input type="radio"/> More Balanced Posture |
| <input type="radio"/> Fishing | <input type="radio"/> Emotional well being |
| <input type="radio"/> Hunting | <input type="radio"/> Strength |
| <input type="radio"/> Household Chores | <input type="radio"/> Endurance |
| <input type="radio"/> Feeling Normal | <input type="radio"/> Steady Hand Movement |
| <input type="radio"/> Exercise | <input type="radio"/> Freedom from Pain |
| <input type="radio"/> Lifting Weights | <input type="radio"/> Reduce or Elimination from Pain |
| <input type="radio"/> Tolerance with your children | <input type="radio"/> Resistance to Disease |
| <input type="radio"/> Tolerance with your spouse | <input type="radio"/> 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 experienced 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 pregnant? Yes No

Date of last period: _____

Is there anything preventing you from doing what it takes to get well?

Time Money Family Obligations Travel Distance Other: _____

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: _____

Help us get to know you a little bit better...

What are your hobbies? _____

Favorite food or place to eat? _____

What activities do you enjoy doing with your family/friends? _____

Print Name: _____

Signature: _____

Date: _____