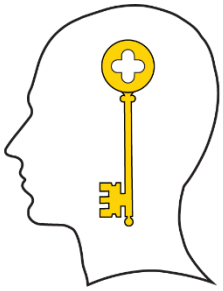

Restoring L.I.F.E.

Name: _____ Date: ____ /____ /____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (____) _____ DOB: ___ /___ /___ Age: _____ Gender: ____

Email: _____ Marital Status: S M D W

# of Children: _____ Occupation: _____

Emergency Contact:

Name:_____ Phone number:_____

Who referred you or how did you hear about us? _____

What do you know about us? _____

Please circle all the professionals seen (past and present):

Medical Doctor Chiropractor Osteopath Physical Therapist

Psychotherapist Counselor Other: _____

Primary Doctor: _____

Please describe your major concerns that bring you to Restoring L.I.F.E.?

_____

_____

Please List the medications/prescriptions you are currently taking:

_____

_____

Please List any and all supplements you are taking:

_____

_____

Please list any and all surgeries:

_____

_____

When was the last time you recall falling or hitting your head?

_____

When was the last time you were in a car accident or had a fall or sports injury?

_____

What are some of the things that your health or condition is keeping you from doing? _____

What are you hoping this care will help you with/to do? _____

_____

I exercise _____ days a week.

I enjoy doing _____ for exercise.

How much water do you drink each day? _____ cups/oz

Do you drink coffee? If so, how much? _____

Do you consume any other caffeinated beverages? If so, what kinds and how much? _____

Do you consume alcohol? If so, how often? _____

Do you use tobacco products? If so, which type and how much? _____

My daily diet consists of: _____

List any known allergies: _____

How many hours of sleep do you get each night on average?: _____

Do you have any digestive issues? _____ if so, which of the following are you experiencing?

constipation diarrhea acid reflux heart burn poor appetite

Nausea vomiting other: _____

Are you interested in having a life coach? Yes No

Circle any of the following symptoms you may be experiencing.

Anxiety	Depression	Chills
Dizziness	Fainting	Fatigue/weakness
Fever	Forgetfulness	Headaches/migraines
Double vision	Dry eyes	Eye pain
Hearing problems	Ringing in the ears	Loss of smell
Nose bleeds	Sinus pressure/pain	Change/loss of taste
Shortness of breath/asthma	Cough	Pneumonia
Swelling	High/low blood pressure	Irregular heart beat
Itching	Abdominal pain	Constipation/diarrhea
Acid reflux	Indigestion	Frequent urination
Menstrual cramps	Night Sweats	Sleeping difficulties
Loss of sleep	Memory loss	Ear pain/discharge
Sweats	Gas	Nose pain
Facial numbness or swelling	Joint pain	Hoarseness
Glasses/contacts	Abnormal weight gain	Chest pain
Nasal discharge	Numbness	Nausea
Difficulty swallowing	Weight changes	Heart burn

Frequent colds	Enlarged/swollen glands	Stiffness

Check the following boxes that relate to your past health history.

Cancer	Heart disease/attack	Tuberculosis	Alzheimer's
Diabetes	Multiple Sclerosis	Parkinson's	High blood pressure
Seizures	Osteoporosis	Stroke	Arthritis

Other: _____

Are you or could you be pregnant? Yes No

If yes, when are you due? _____

How many children do you have? _____