"Since 1982"
CRUZ Life CENTER
Natural Health Care Solutions for Your Life
· LASER THERAPY
· CHIROPRACTIC
· HEALTH COACHING

Please Print: Date: _____

Name: _____ Date of Birth: _____

Telephone: Home: _____ Cell: _____

Address: _____

E-Mail: _____

Spouse Name/Support Person: _____Number of Children: ___ Social Security Number:_____

Occupation: _____Where Employed: _____Hours of work per week:_____

Who can we thank for referring you to our office: _____

Where did you hear about us: Newspaper Sign Internet Radio

What symptoms caused you to come to the office? _____

_____

What caused this? _____

When did this start? _____ How long do symptoms last? _____

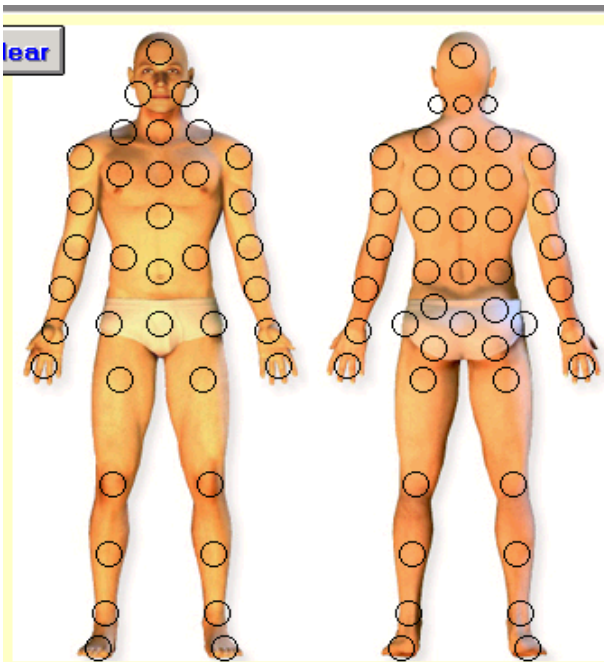
How bad is this? (Circle the one that applies) **Mild, Moderate, Severe, Intolerable**

Has your condition gotten: (Circle the one that applies) **WORSE SAME BETTER**

Please circle what intensity level is your pain at its worse? **Lowest 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 – 10 Highest**

Circle the word or words that best describe any pain. **Cramping, Aching, Dull, Sharp, Shooting, Bright, Lightening like, Diffuse, Throbbing, Deep, Nagging, Burning, Stinging, Pressure like**

Please indicate on chart where you are experiencing any pain or discomfort:



How often does the symptom occur? (Circle the one that applies)

Occasional, Frequent, Constant

Does any pain travel to any other area? _____

What makes this better? _____

What makes this worse? _____

What else have you done to treat this? _____

Have you seen a chiropractor before? **YES NO When:** _____

You	Parent	Heart disease or stroke	You	Parent	Food Allergies
You	Parent	High blood pressure	You	Parent	Neuromuscular disease
You	Parent	High triglycerides	You	Parent	Arteriosclerosis
You	Parent	Cancer	You	Parent	Gall bladder disease
You	Parent	Lung/ pulmonary disease	You	Parent	Diabetes mellitus
You	Parent	Kidney disorder	You	Parent	Anorexia / Bulimia
You	Parent	Osteoporosis	You	Parent	Compulsive overeating
You	Parent	Ulcer	You	Parent	Anemia
You	Parent	Gastrointestinal disease	You	Parent	Arthritis
You	Parent	Diarrhea / Constipation	You	Parent	Alcohol Abuse
You	Parent	Depression / Anxiety	You	Parent	Addictive Habits
You	Parent	Weight issues	You	Parent	Mental Health Issues

Family History?

Do you sleep well?_____ Do you wake up at night?_____ What times?_____

To urinate?_____ What time do you generally get up in the morning?_____

Constipation/ Diarrhea?_____ Explain:_____

What blood type are you?_____ What is your ancestry?_____

Women: Are your periods regular? _____How many days is the flow?_____How frequent?_____

Painful or symptomatic?_____ Please explain:_____

Are there any healers, helpers, or therapies with which you are involved? _____

What role does exercise play in your life? _____

Do you have warts, athletes foot, toe fungus, psoriasis or any viruses/infections? _____

Do you drink, alcohol, coffee, sodas, smoke, or have any addictions?_____

What percentage of your food is home cooked?_____Where do you get the rest of it?_____

Serious illness/ hospitalizations / injuries? _____

What is your energy level on scale of 1 – 10: ___What do you do to increase your energy? _____

Please check the one choice that most closely describes your current goals for health/wellbeing.

- □ **I am only concerned about relief of a particular symptom.**
- □ **I am only concerned about relief of a particular symptom, and preventing its return.**
- □ **I want optimum health and wellbeing on every level available to me.**

Females: Is there a chance you may be pregnant **Yes** **No**

Do you have a pacemaker or any metal pins or plates in your body?

Yes Where?_____

No

Please list all types of medications & vitamins you take & for what reason.

_____ _____ _____

_____ _____ _____

_____ _____ _____

WE ACCEPT PAYMENT BY CASH, CHECK, CREDIT CARD, AND CARE CREDIT

I understand that all services are to be paid in full at the time of service.

I certify that the information that I have given here is true and accurate to the best of my knowledge.

Signed_____ Date_____