# ALIGNMENT FOR LIFE • Dr. Christina Clapham

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## WELCOME TO OUR OFFICE

## New Client Information Form

Date_____

Last Name _____ First Name _____ Care Card PHN# _____

Birth date (M/D/Y) _____ Age _____ Female ____Male ____ Occupation_____

Address _____ City _____ Postal Code _____

Email Address _____ Do you consent to us sending you information by email? Y N

Home Phone _____ Work Phone _____ Marital Status S M D W Sep. Com. Law

Names/ages of children_____ Name of Spouse_____

Name and number of Emergency Contact _____

How did you find out about our office? Whom may we thank? _____

## Current Health Conditions

Reason for consulting the office: _____

Is this condition interfering with your ____ work _____ sleep _____ daily routine?

How long have you had this condition? _____ Have you had similar problems in the past? _____

What activities aggravate your condition? _____

Does anything relieve your conditions?_____

When does it bother you most? (morning, evening, sitting, etc) _____

Is it constant? _____ Does this pain radiate? _____ To what parts of the body? _____

How long does it generally last? _____

Other Doctors/Practitioners seen for this condition?_____

Treatments received: _____

List any medications you take and for what conditions? _____

_____

Please tell us what you MOST want out of your experience here • what is/are your goal(s)? _____

_____

Have you been under chiropractic care before? _____Yes ____No

What is the date of your last visit? _____ Was your experience positive, negative or neutral? _____

Why? _____

On the scales below, please use the numbers that represent your overall pain or discomfort.

Rate your pain right **now**

no pain unbearable pain

1_____10

Rate your pain at its **best** in the past week

no pain unbearable pain

1_____10

Rate your **average** pain in the past week

no pain unbearable pain

1_____10

Rate your **worst** pain in the past week

no pain unbearable pain

1_____10

## Health History

Major surgery/operation: _____

Major accidents or illnesses: _____

Hospitalization/other than above: _____

Any family conditions or historical problems: _____

Did you suffer any other traumas (physical or emotional): _____

## Stress History

The following three areas of stress can cause interference in the communication of your nervous system. Thoughts (Emotional reactions), Traumas (Physical accidents/injuries/physical activities), Toxins (chemical, what we eat, drink, breathe, etc.) These can cause misaligned vertebra (subluxations) and memory stress that can be interfering with your ability to live your life to your fullest potential.

Please rank your current levels of stress in each area on a scale of 1-10 (1, no stress to 10, high levels of stress).

Physical: _____ Emotional: _____ Chemical: _____

## CURRENT AND PAST BODY SIGNALS INDICATING UNDERLYING DYSFUNCTION

***Please indicate which of the following body signals apply (use "C" for current and "P" for previous):***

| | | | |
|---|---|---|---|
| ___Scalp disorders | ___Sinus Trouble | ___Urinary Concerns | ___Pins & Needles of Legs |
| ___Pain in Head | ___Ear Disorders | ___Bed Wetting | ___Knee Trouble |
| ___Soreness in Neck | ___Hay Fever | ___Pins & Needles of Hands | ___Foot or Ankle Concerns |
| ___Shoulder Stiffness | ___Recurrent Sore | ___Loss of Grip | ___Pins & Needles of Feet |
| ___Shoulder Tension | ___Throat | ___Wrist or Hand Pain | ___Menstrual Concerns |
| ___Arm Pain | ___Asthma | ___Mid Back Pain | ___Menopausal Concerns |
| ___Elbow Pain | ___Chronic Cough | ___Mid Back Tension | ___Lack of Concentration |
| ___Loss of Arm Power | ___Stomach Tension | ___Pain in Ribs | ___Poor Memory |
| ___Eye Disorders | ___Digestive | ___Low Back Pain | ___Loss of Potency |
| ___Loss of Taste | ___Malfunction | ___Low Back Weakness | ___Immune System |
| ___Headaches | ___Nausea | ___Low Back Stiffness | ___Tension Chronic |
| ___Nervousness | ___Allergies | ___Hip Pain or Stiffness | ___Irritability Chronic |
| ___Insomnia | ___Vomiting | ___Buttock Pain | ___Fatigue Chronic |
| ___Dizziness | ___Constipation | ___Leg Pain | ___Loss of Balance |
| ___Loss of Smell | ___Diarrhea | ___Leg Cramps | ___Ringing in Ears |

Please draw the location of your pain or discomfort on the images below. Use the symbols shown to represent the type(s) of pain you are experiencing.

D=Dull S=Stabbing/Sharp C=Cramping

B=Burning T= Tingling (pins & needles) N=Numb