BE NOW CHIROPRACTIC

Nutrition & Wellness Studio
2122 N Craycroft Rd, Ste 104, Tucson, AZ 85712
520-484-3471

Mission Statement: Be Now Chiropractic provides chiropractic care with the loving intention of removing nervous system subluxations, while providing nutrition and wellness strategies in order for each practice member to live the most beneficial life possible on all levels of Being, free of nervous system interference.

Name _____ Home Phone _____

Address _____ Cell Phone _____

City, State, Zip _____ Work Phone _____

Birth date _____ Age _____

Occupation _____ Employer _____

Marital Status Single Married Divorced Widowed Spouse/Partner _____

# of Children _____ Email _____

Parent/Guardian if Under 18 _____

By my signature, I hereby authorize and consent to the chiropractic evaluation and care of my child.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Phone _____ Cell _____

Emergency Contact:
Name _____ Phone _____ Relationship _____

Whom may we thank for referring you to us? _____

If not through referral, how did you hear about us? _____

Name of Local primary physician _____ May we contact them? _____

The technique used in this practice focuses on wellness-based chiropractic care. This means that we do not adjust based on symptoms, complaints, and/or pain. The adjustments are based solely on our assessment of nervous system interference.

However, you may still have a primary complaint, and it is beneficial to track its progress as you undergo wellness-based chiropractic care.

Please identify your chief complaint below. If you do not have one, please indicate "NA" for not applicable.

Please indicate your **primary complaint**: _____

Date Started _____ How is it now: ☐ Same ☐ Better ☐ Worse

Pain? Please describe: ☐ Sharp ☐ Dull ☐ Constant ☐ Comes and Goes ☐ Travels

What makes the condition better? _____

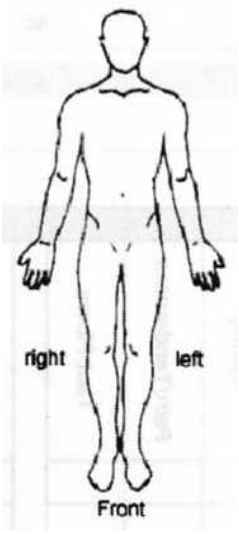
What makes the condition worse? _____

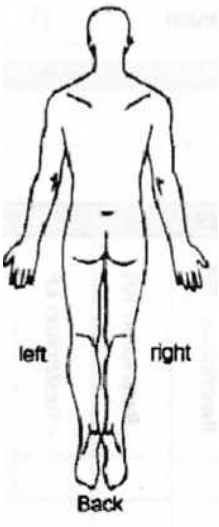
Is condition worse during certain times of the day? _____

Is this condition interfering with: ☐ Work ☐ Sleep ☐ Routine Other: _____

Other Doctors seen for this complaint and results? _____

Please mark with an “X” where you feel any pain, tingling, numbness, or muscle spasm:





Please indicate if you experience any of the following:

- ☐ Unexplained weight loss
- ☐ Night sweats
- ☐ Deep, boring bone pain
- ☐ Pain that wakes you up at night
- ☐ History of cancer
- ☐ Change in bowel or bladder habits
- ☐ Difficulty urinating
- ☐ Difficulty swallowing/chewing
- ☐ Difficulty speaking
- ☐ Loss of vision
- ☐ Slurring of words
- ☐ Worsening headaches
- ☐ Numbness or tingling
- ☐ Weakness of muscles
- ☐ Diabetes
- ☐ Recent infection

Health History-Subluxations can cause malfunction in any part of the body. Please mark any items you currently experience (N for now) or have experienced in the past (P for past).

N	P		N	P		N	P	
☐	☐	Headaches/Migraines	☐	☐	Asthma/Difficulty Breathing	☐	☐	Numbness/Tingling in Legs
☐	☐	Dizziness	☐	☐	Allergies/Sinus Issues	☐	☐	Low Back Pain
☐	☐	Fainting/Seizures	☐	☐	Heart/Blood Pressure Issues	☐	☐	Arthritis/Joint Pain
☐	☐	Insomnia	☐	☐	Upper Back Pain	☐	☐	Female/Male Issues
☐	☐	Earaches/Hearing Problems	☐	☐	Mid Back Pain	☐	☐	Cancer
☐	☐	Neck Pain	☐	☐	Digestive Issues/Liver/Gall Bladder	☐	☐	Diabetes
☐	☐	Shoulder/Arm/Hand Pain	☐	☐	Hip Pain	☐	☐	Osteoporosis
☐	☐	Numbness/Tingling in Arms	☐	☐	Leg/Foot Pain	☐	☐	Depression/Psychological
☐	☐	Frequent Colds				☐	☐	Other:

If you have experienced any of the following, please explain:

Accidents/Injuries/Fractures: _____

Hospitalizations/Surgeries; _____

Please indicate your family history:

Heart Disease	Arthritis	Cancer	Diabetes	Other
☐	☐	☐	☐	☐

Other: _____

Please list all of the medications you are taking including over the counter medications, herbs & vitamins, and nutritional supplements. If none please write: None

Name	Dose	Frequency	Name	Dose	Frequency

Please describe your diet: _____

Please describe your exercise routine: _____

Do you drink alcoholic beverages? If so, how many per day, per week, or per month? _____

Have you ever smoked? If so, how many packs per week and for how long? _____

Do you use recreational drugs? If so, please indicate which ones and how often. _____

How committed are you to reclaiming your health?

10% **20%** **30%** **40%** **50%** **60%** **70%** **80%** **90%** **100%**

Please check all that you would like to discuss with the Doctor:

☐ Weight Loss ☐ Anti-Inflammatory Protocol ☐ Exercise Program

Do you have any other health goals, thoughts, or concerns? _____

Patient Signature _____ Date _____