

Ahwatukee *Life!* Center

FAMILY CHIROPRACTIC • QUENTON N. MORLEY B.Sc., D.C.

4855 E Warner Rd • Suite A23 • Phoenix • Arizona • ☎(480) 893-3437 • 📠(480)893-9192

www.AhwatukeeLifeCenter.com

Statement of Purpose

Ahwatukee Life! Center offers a unique opportunity for you and your family to discover the benefits of Chiropractic care and learn how this will assist you in obtaining your goal of optimum health.

Confidential Personal Information

Patient Name _____ Date of Birth ____/____/____ Age ____
SS# ____/____/____ Home Ph () ____-____ Cel Ph () ____-____
Address _____
Apt# _____ City _____ State _____ Zip _____
Occupation _____ Employer _____ Wk Ph () ____-____
(If Minor) Parent/Guardian's Name _____
Spouse's Name _____ Spouse's Employer _____
In case of emergency, call _____ Relationship _____ Phone () ____-____
Email address _____ How did you hear about our office?
 Referral _____ Google YellowPages Directory Ad Other

Health History

Chief Complaint _____
Other doctors seen for this condition _____
Is this condition/injury due to work injury or an automobile accident? Work Auto No
List all medications you are currently taking _____
History of all surgeries _____
Relevant family history: Diabetes Cancer High Blood Pressure Arthritis Heart Disease
Emphysema Stroke Other _____

Females Only Are you pregnant? No Yes Maybe

Have you had chiropractic care? No Yes, when was your last adjustment?

Signature **X** _____ Date _____

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Please **circle the number** that describes your pain

1-2-3=Little 4-5-6=Medium 7-8-9-10=Severe

SKELETAL

- Neck 1 2 3 4 5 6 7 8 9 10
- Headaches 1 2 3 4 5 6 7 8 9 10
- TMJ/Jaw 1 2 3 4 5 6 7 8 9 10
- Upper Back 1 2 3 4 5 6 7 8 9 10
- Shoulders 1 2 3 4 5 6 7 8 9 10
- Arms Lt/Rt 1 2 3 4 5 6 7 8 9 10
- Mid Back 1 2 3 4 5 6 7 8 9 10
- Low Back 1 2 3 4 5 6 7 8 9 10
- Hips Lt/Rt 1 2 3 4 5 6 7 8 9 10
- Legs Lt/Rt 1 2 3 4 5 6 7 8 9 10
- 1 2 3 4 5 6 7 8 9 10

Please **check all symptoms** you have currently
OR list the **date** when you last had the symptom.

DIGESTIVE

- Irritable Bowel Syndrome _____
- Heartburn _____
- Ulcers _____
- Gas/Bloating _____
- Constipation _____
- Diarrhea _____
- Frequent Nausea/Vomiting _____
- Gallbladder Problems _____
- Liver Problems _____
- Weight Trouble _____
- Abdominal Cramps _____
- _____

URINARY

- Kidney Stones _____
- Bladder Infections _____
- Urination Problems _____
- _____

Please **check all symptoms** you have currently
OR list the **date** when you last had the symptom.

NERVOUS SYSTEM

- Concussion _____
- Fainting _____
- Dizziness _____
- Numbness _____
- Buzz/Ring in Ears _____
- Confusion/Depression _____
- Paralysis _____
- Forgetfulness _____
- _____

CIRCULATORY

- High Blood Pressure _____
- Heart Problems _____
- Chest Pain _____
- Shortness of Breath _____
- Stroke _____
- _____

RESPIRATORY

- Asthma _____
- Allergies _____
- Sinus Infection _____
- Lung Problems _____
- _____

HORMONAL

- Thyroid Problems _____
- Estrogen _____
- Insulin/Diabetes _____
- _____