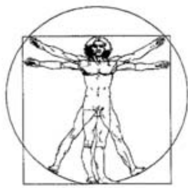


Lorenzen Chiropractic Clinic

Experience the Difference

701 N. Central Expressway, Building 3, Suite 100 Richardson, Tx 75080
Ph. 7-972-231-7580 Fax. 972-231-7580

The World Health Organization defines health as a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmary.

Consultation at the Doctor's Expense

Date:______________ Whom may we thank for referring you? ___________________

Name: _________________________________ Sex: M/F Birthday:_________________

Address:_________________________________ SS# _____________________________

_________________________________ Ph: ______________________________

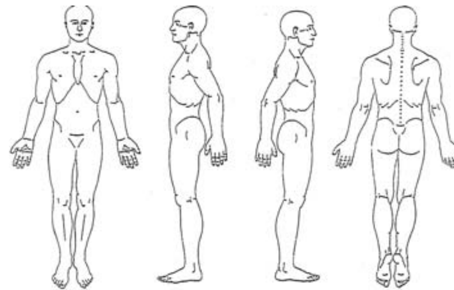
Occupation:__________________ E-mail:___________________ Newsletter: Y / N

What brings you to our office?

1. ___________________________________

2. ___________________________________

3. ___________________________________



How long have you been aware of these problems?______________________________

Have you sought any professional help?_______________ Has it helped?___________

Have these complaints affected your: ☐ Work, ☐ Recreation, ☐ Family, ☐ Mood, YET?

If so how? ____

Have you ever?	When was your last?	How often do you?
Joined a health club	Physical exam	Exercise
Bought bottled water	Medical appt	Drink alcohol
Used a water filter	Chiropractic appt	Drink water
Meditated	X-rays	Smoke
Bought organic foods	Dental	Take supplements
Used homeopathic	Optometrist	Sit at a desk
Used Acupuncture	Male >30 Prostate	Work on a computer
Received a massage	Female Gynecologist	Work on the phone
	Menstrual Period	Drive for work

1. Have you ever been to a chiropractor before?____

   What was your experience?____

   ____

2. Explore symptoms

   When did you first notice the symptoms?____

   Gradual or Sudden onset?____

   Is the condition getting Better / Worse / Not changing?____________________________________

   What makes condition better/worse?____

   Constant or comes and goes? Frequency __________, duration _________

   Pain Level Current _____ / 10   At its worst_____/10   Worse am/pm?__________

   Type of sensation: Sharp, dull, aching, burning, numbness, tingling, throbbing shooting, cramping, stiffness, swelling, Other: ____

   Does pain awaken you from sleep Y/N, Does pain change with position Y/N?

3. Change in bowel/bladder, digestion, respiration, vision, hearing, sexual function?__________________

   ____

4. Any medications, Rx, OTC, herbal, or vitamin supplements?___________________________________

5. History, and dates, of trauma, injuries, accidents, slips, falls, fractures, blackouts?__________________

   ____

6. History, and dates, of surgeries, hospitalizations, illnesses, infections?___________________________

   ____

7. Family history of spinal cord, arthritis, arteriosclerosis, cancer, stroke, seizures, Heart disease, high blood pressure, Diabetes, Oral contraceptives [How long _______], Blood Pressure medication or Blood thinning medication (coumadin, heparin, aspirin), Allergies:__________________________

   ____

8. Schedule/Budget

   Is there anything preventing you from doing what it takes to get well?

   (Time / Money / Family) ____

9. Evaluation Decision

   Would you like to explore what chiropractic can do for you? In this office that would involve a comprehensive physical exam and possibly x-rays to gather the information necessary to properly evaluate if you can be helped through chiropractic care.

   Exam fee ($150) X-rays ($100) Appointment: _________________ I look forward to seeing you soon, and getting you on the road to better health. Thank you for coming in.

Signature:_______________________________________ Date:____________________

Dr. Signature:___________________________________ Date:____________________