Our Mission

At Life Refined Chiropractic (LRC), we have one mission: to see you living your life as close to your 100% as possible. Whether it's eliminating or reducing pain, stiffness or headaches, improving focus at school or work, increasing physical performance & mobility, or experiencing more energy at the end of the day with those you love, we want to help you achieve your 100% as quickly as possible.

This is a CONFIDENTIAL questionnaire to help us determine the best treatment plan for you.
Please write clearly, if you have questions, please ask our clinic staff. Thank you.

Personal Information

Full Name _____ Date _____

Home Address _____

City _____ State _____ Zip _____

Home/Cell Phone _____ Email _____

Occupation _____ Person Responsible for your Account _____

Emergency Contact Name _____ Phone _____

Sex ☐ M ☐ F ☐ Other _____ Gender _____

Height _____ Weight _____

Birth Date _____ Age _____

Marital Status ◯ Married ◯ Single ◯ Divorced ◯ Widowed ◯ Partnered Number of Children _____

Previous Acupuncture? ◯ Yes ◯ No If yes, when? _____ With whom? _____

Physician History

Have you seen a physician in the last year? ◯ Yes ◯ No If yes, approx. date of recent visit _____

Please indicate any significant illness you or blood relative (grandparents, parent or sibling) have had:

Illness	You	Relative	When?	Illness	You	Relative	When?
Cancer	☐	☐	_____	Diabetes	☐	☐	_____
Hepatitis	☐	☐	_____	Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____	Seizures	☐	☐	_____
Rheumatic Fever	☐	☐	_____	Emotional Disorder	☐	☐	_____
Covid-19	☐	☐	_____	Tuberculosis	☐	☐	_____

Please check the box if any of the statements are true:

I have known skin allergies: ◯ Yes ◯ No

I am taking Coumadin/Warfarin/Plavix: ◯ Yes ◯ No

I have a pacemaker: ◯ Yes ◯ No

I am taking lithium (Eskalith, Lithobid, Lithonate, Lithotabs): ◯ Yes ◯ No

List of Medications
(Please list any prescription or OTC medication or supplements and herbs you are currently taking)

RX/Supplement/Herb	Dosage	Reason for taking the item	How long?	Prescribed by	Date last of last check-up?

Patient Last Name, First Name _____

What are the main health problems for which you are seeking treatment?

What other forms of treatment have you sought?

List any other health problems you now have.

List any allergies, food sensitivities and food cravings that you have.

List any accidents, surgeries, hospitalizations (include date).

Lab Results (please include copies, if applicable).

How do you FEEL about following areas of your life?
Please check the appropriate boxes and indicate any problems you may be experiencing.

	Great	Good	Fair	Poor	Bad	Your comments
Signifcant other	○	○	○	○	○	
Family	○	○	○	○	○	
Diet	○	○	○	○	○	
Sex	○	○	○	○	○	
Self	○	○	○	○	○	
Work	○	○	○	○	○	
Exercise	○	○	○	○	○	
Spirituality	○	○	○	○	○	

LIFE REFINED ACUPUNCTURE

For Women

Age of 1st period (menarche)_____ Are you Pregnant? ◯ Yes ◯ No # of Pregnancies _____
Age of last period (menopause) _____ # of live births _____ # of Abortions _____ # of Miscarriages_____
Number of days between period_____ Date of last Gynecological exam _____ Pap Smear_____
Number of days of flow _____ Mammogram _____ Bone Density Scan _____
Color of flow _____ Results _____
Clots? ◯ Yes ◯ No Color of the Clot _____
Average number of pads you use per day 1st day_____ 2nd day _____ 3rd day _____ 4th day _____ +days _____
Have you been diagnosed with: ☐ Fibrocystic Breast ☐ Endometriosis ☐ Ovarian cysts ☐ PID ☐ Other _____
Location of Pain: ☐ lower abdomen ☐ lower back ☐ thighs ☐ other _____
Nature of Pain (please indicate before, during or after menses)

Cramping _____ Stabbing/sharp _____
Burning _____ Aching _____
Dull _____ Bloating _____
Consistent _____ Intermittent _____
Bearing down sensation _____

Other symptoms related to menses

☐Discharges ☐Vaginal Dryness ☐Headaches
☐Nausea ☐Constipation ☐Diarrhea
☐Swollen Breasts ☐Mood Swings ☐Insatiable Appetite
☐Poor Appetite ☐Hot Flashes ☐Night Sweats
☐Increased Libido ☐Decreased Libido ☐Insomnia

For Men

Date of last prostate check up _____ PSA results_____ Manual Prostate Exam Results _____
Lab results _____
Frequency of urination: Daytime_____ Nighttime _____ Color of Urine ☐clear ☐murky Odor: _____
Symptoms related to Prostate:

☐Prostate Problems ☐Delayed Stream ☐Premature Ejaculation ☐Incontinence ☐Retention of Urine
☐Rectal Dysfunction ☐Increased Libido ☐Decreased Libido ☐Dribbling ☐Impotence
☐Back Pain ☐Groin Pain ☐Testicular Pain ☐Other _____

Symptom Survey (for everyone)

The following is a list of symptoms that you may or may not ever experience. Please indicate as follows:
No mark () = never experience Minus mark (-) = sometimes experience Plus sign (+) = frequently experience

_____ lack of appetite
_____ excessive appetite
_____ loose stool or diarrhea
_____ digestive problems, indigestion
_____ vomiting
_____ belching, burping
_____ heartburn/reflux
_____ feeling the retention of food in the stomach
_____ tendency to become obsessive in work, relationships

_____ nightmares
_____ insomnia, difficult sleeping
_____ heart palpitations
_____ cold hands and feet
_____ mentally restless
_____ laughing for no reason
_____ angina pains

_____ abdominal pain
_____ chest pain
_____ sciatic pain
_____ headaches
_____ pain or coldness in the genital region

_____ cough
_____ shortness of breath
_____ decreased sense of smell
_____ nasal discharge
_____ skin problems
_____ feeling of claustrophobia
_____ bronchitis
_____ Colitis of diverticulitis
_____ constipation
_____ hemorrhoids
_____ recent use of antibiotic
_____ eye problems
_____ gall stones

_____ difficulty digesting oily food
_____ jaundice (yellowish eyes or skin)
_____ light colored stool
_____ soft or brittle nails
_____ easily angered or agitated
_____ difficulty in making decisions
_____ spasms or twitching of muscles

_____ low back pain
_____ knee problems
_____ hearing impairment
_____ ear ringing
_____ kidney stones
_____ decreased sex drive
_____ hair loss
_____ urinary problems

_____ fatigue
_____ edema
_____ blood in stool
_____ black tarry stool
_____ easily bruised
_____ difficult to stop bleeding
_____ asthma
_____ tendency to catch a cold easily
_____ intolerance to weather change
_____ allergies
_____ hay fever
_____ dizziness
_____ tendency to faint easily
_____ high cholesterol
_____ sudden weight loss