

**PRACTICE MEMBER INFORMATION**

Practice Member Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Sex: M F Email: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_  
Emergency contact: \_\_\_\_\_ Their phone number: \_\_\_\_\_ ext. \_\_\_\_\_  
Employer/school: \_\_\_\_\_ Occupation/student \_\_\_\_\_  
Employer/school address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Marital status: Child Single Married Widowed Divorced Spouse's name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Children's names & ages: \_\_\_\_\_

*All charges are due when services are rendered!*

Preferred Method of Payment: Cash Check Credit Card Insurance  
Who besides yourself, may also be responsible for your bill: Spouse Workers Comp Auto Ins Medicare  
Their name: \_\_\_\_\_ Their Birth date: \_\_\_\_\_  
Their Social Security #: \_\_\_\_\_ Policy # &/or Group #: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ *Give your insurance card to the front desk to copy*  
Practice Member or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Who may we "Thank" for referring you to our office?** \_\_\_\_\_

Previous Chiropractor/s: \_\_\_\_\_ City: \_\_\_\_\_ Last Visit: \_\_\_\_\_

Reason/s for leaving: \_\_\_\_\_

Primary MD \_\_\_\_\_ City: \_\_\_\_\_ Last visit: \_\_\_\_\_

Medical Specialists you are seeing or have seen and WHY: \_\_\_\_\_

**Is the reason you are here due to:** Motor vehicle accident Job injury other? \_\_\_\_\_

To who have you reported this injury to: Auto Insurance Employer Workers Comp other? \_\_\_\_\_

Attorney name if applicable: \_\_\_\_\_

Have you had chiropractic care for this injury?  No  Yes If yes please explain whom, where, when and the care provided: \_\_\_\_\_

Did you require post-accident hospitalization?  No  Yes If yes please explain whom, where, when and the care provided: \_\_\_\_\_

You deserve to be healthy. Life is a miracle and so are you. When you were created, you were given all the blue-prints, intelligence, tools, and systems to live an active healthy life. Unfortunately, your health can be interfered with through accidents and challenges that cause a disruption to your health expression. Through your examination and through your lifetime involvement in chiropractic care, we will work to remove these interferences to your natural health expression so that you can live the quality of life you deserve.

Check all that Apply	Yes	No	Comments	Chiropractor's Comments	88	89	96
<b>1. Was Your Birth Traumatic?</b>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Long Delivery?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Difficult Delivery?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Forceps?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Caesarian?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Breach/cephalic?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Home birth?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Mother given drugs during delivery	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Induced Labor?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
<b>2. Growth and Development - Did you ever once...</b>							
Learn to care for your spine?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Fall out of bed?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Bang your head?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Breastfeed?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Childhood sickness?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have any Accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have Surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Take Drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Fall while learning to walk?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Bullied by your siblings?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Child abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Spanking?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Pulled ear/chin	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Chair pulled out when sitting?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Fall down the stairs?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Pulled by your arm?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Experience other traumas?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
<b>3. Current Health Habits – Did/do you...</b>							
Smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Do you eat healthy foods?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Supplement with an Omega-3?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Supplement with probiotics?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Supplement with a liquid vitamin?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Use others supplements?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Eat at least 2 fruit servings per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Eat at least 3 vegetable' servings per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Drink ½ your body weight in ounces per day?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have you been in accidents?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have Teeth Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have Eye Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E

...continued on the next page...

Name: \_\_\_\_\_ Date: \_\_\_\_\_

...continued... Check all that Apply	Yes	No	Comments	Chiropractor's Comments	88	89	96
Have Hearing Problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Exercise regularly?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have physical stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have hobbies/sports injuries?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Sleeping posture – side–stomach–back	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Do you perform aerobic exercise (i.e. walk, jog, elliptical, etc...) for 20 minutes or more 4 or more day a week?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Do you stretch daily?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Do you lift weights or perform some type of resistance exercise 2 or more times a week for each body part?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have mental stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have sleeping problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have occupational stress?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Do you attend church?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E
Have positive self talk?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	P	C	E

**4. Current Health Condition**

Present Complaint (be brief) Reason For Your Visit Today 1 \_\_\_\_\_

Pain or Problem started on 77 \_\_\_\_\_

Pains are: 84  Sharp  Dull  Constant  On & Off  Radiating

On a scale of 1 to 10 (being the worst) where would you rate your pain right now? 14 \_\_\_\_\_/10 & at its 15 worst\_/10 & at its least\_/10

What activities aggravate your condition/pain? 81 \_\_\_\_\_

When is the condition at its worst during your day? 73 \_\_\_\_\_

Is this condition interfering with: 80  Work  Sleep  Routine  Other? \_\_\_\_\_

Is this condition? 35 i  improving n  not changing w  getting worse Have you ever experienced this before  NO 78  Yes

Other Doctors seen for this condition 44 \_\_\_\_\_

\_\_\_\_\_

Any home remedies? 45 \_\_\_\_\_

\_\_\_\_\_

51 List prescription medications/drugs \_\_\_\_\_ ...for what? \_\_\_\_\_ ...since? \_\_\_\_\_ ...side effects? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

52 List OTC (over-the-counter) medications/drugs \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

68 What surgeries have you had (including organs replaced or removed)?...when? \_\_\_\_\_ ...side effects? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have a family history of: Heart Disease Arthritis Cancer Diabetes Other

61 Father's Side      \_\_\_\_\_

65 Mother's Side      \_\_\_\_\_

I attest to the above being true to the best of my understanding. Signature \_\_\_\_\_

Upon the completion of your first visit, you will be scheduled for a Chiropractic Report of Findings on your next visit. Here Dr. Glas will discuss his findings, recommendations and the different types of Care Plans that are available to you. Chiropractic Care Plans are designed to help get you feeling better quickly and to help you and your family be as healthy as possible. Please review the explanations of the Chiropractic Care Plans prior to your Chiropractic Report of Findings appointment so you can choose the level of participation that supports you in reaching all of your health goals.



# Glas Chiropractic

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## QUIZ...ARE YOU READY TO BEGIN?

Name \_\_\_\_\_ Date \_\_\_\_\_

1. What prompted you to come here now (as opposed to a month, or a year ago), seeking chiropractic care? (Hint: Your friend who referred you, or the ad that you saw, is not the answer. I want to know why you decided to take action now.) \_\_\_\_\_

2. Have you given up on other options (drugs, surgery, etc.)? Why or why not? \_\_\_\_\_

3. What KIND OF DOCTOR are you looking for? Uncovering your previous experience with "doctors" is important so we can best help meet your health needs and goals. What I mean by this is what role would you like me to play in your recovery?

- A wizard, magician, or Houdini?       Do you want someone to bug you to do what's best?       A listener?  
 Do you prefer a coach, someone to give you information about how to prevent this sort of thing in the future?  
 Do you prefer the authoritarian type, someone to tell you what to do?       Other? \_\_\_\_\_

4. Why did you choose me, as opposed to another chiropractor? \_\_\_\_\_

5. Do you have any particular fears, questions or concerns about Chiropractic?       No       Yes      If "yes," please explain: \_\_\_\_\_

6. What are your reasons for coming here? (You may check as many as you like):

- General Health/Wellness       Improve immune function       Improve athletic performance  
 Pain relief       Decrease or eliminate drugs       Decrease or eliminate disease

7. Is there anyone else (spouse/partner, etc.) part of your decision to begin chiropractic care, here and now?

- No       Yes      If "yes," who are you bringing to your Report of Findings? \_\_\_\_\_

8. Are you ready to do something different, to take action, to improve your current level of health, and the quality of your life?

- No       Yes      If "yes," when?       Now       Later

9. How do you think that your health, and your life, might change for the better, from coming here for chiropractic care? \_\_\_\_\_

10. Five years from now, with chiropractic care, how do you see your health? \_\_\_\_\_

*Thank you for completing this quiz.*

***A LIFETIME OF WELLNESS!***