

# My Life Story

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Ph \_\_\_\_\_ Work Ph \_\_\_\_\_ Cell \_\_\_\_\_  
Email \_\_\_\_\_ Birthday! \_\_\_\_\_ Age \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Marital/Relationship Status \_\_\_\_\_ Spouse/Partner Name \_\_\_\_\_  
Names & Ages of all Children \_\_\_\_\_  
\_\_\_\_\_

Reason for seeking our services? \_\_\_\_\_  
\_\_\_\_\_

What other action steps have you taken? \_\_\_\_\_  
\_\_\_\_\_

Who can we thank for referring you to **Brilliant Life**? \_\_\_\_\_

Have you ever been adjusted by a Chiropractor? \_\_\_\_\_ Who and Where? \_\_\_\_\_

Date of last adjustment? \_\_\_\_\_

Do you have a Primary Care Provider? \_\_\_\_\_ Who and Where? \_\_\_\_\_  
\_\_\_\_\_

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Many of the health challenges that people face originate from stressors experienced during developmental and adult years. These stressors (traumas) may be emotional, mental, physical, or chemical. Our goal is to help your body release stored/deep tensions and the more we know about you, the more we can help you with your healing process. *Please answer all of the following questions to the best of your ability.*

## **Birth history** (if known, please indicate all that apply to your own personal birth experience):

- |  |  |  |
|--|--|--|
| <input type="radio"/> mother smoked/drank/drugs while pregnant | <input type="radio"/> vacuum extraction      | <input type="radio"/> forceps delivery   |
| <input type="radio"/> C-section                                | <input type="radio"/> epidural/meds in labor | <input type="radio"/> induced labor      |
| <input type="radio"/> hospital birth                           | <input type="radio"/> home birth             | <input type="radio"/> midwife            |
| <input type="radio"/> doula                                    | <input type="radio"/> breast-fed             | <input type="radio"/> bottle-fed formula |

## **History of Physical Stress, Trauma or Challenges**

- |   |   |   |
|---|---|---|
| <input type="radio"/> repetitive lifting /bending /typing | <input type="radio"/> work injury           | <input type="radio"/> sit a lot/traffic     |
| <input type="radio"/> car accidents                       | <input type="radio"/> surgeries             | <input type="radio"/> hospitalizations      |
| <input type="radio"/> serious falls                       | <input type="radio"/> active in sports      | <input type="radio"/> sit on wallet         |
| <input type="radio"/> no exercise                         | <input type="radio"/> alcohol or drug abuse | <input type="radio"/> not enough/poor sleep |
| <input type="radio"/> physical abuse                      | <input type="radio"/> broken bones          | <input type="radio"/> other injuries _____  |

## **History of Chemical Stress, Trauma or Challenges**

- |   |   |   |
|---|---|---|
| <input type="radio"/> smoker past/present   | <input type="radio"/> poisoning             | <input type="radio"/> vaccinated                          |
| <input type="radio"/> alcohol use           | <input type="radio"/> work with chemicals   | <input type="radio"/> caffeine/sugar/artificial sweetener |
| <input type="radio"/> drug use              | <input type="radio"/> over the counter meds | <input type="radio"/> prescription medications            |
| <input type="radio"/> drug/alcohol overdose | <input type="radio"/> antibiotics           | <input type="radio"/> poor diet                           |
| <input type="radio"/> other _____           |   |   |

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## **History of Mental/Emotional Stress, Trauma or Challenges**

- |   |   |  |
|---|---|--|
| <input type="radio"/> recurrent physical/mental illness | <input type="radio"/> hold in feelings      | <input type="radio"/> quick tempered             |
| <input type="radio"/> made fun of/teased                | <input type="radio"/> loss of loved one     | <input type="radio"/> high family stress         |
| <input type="radio"/> body image issues                 | <input type="radio"/> not valued            | <input type="radio"/> high personal stress       |
| <input type="radio"/> mental/emotional/sexual abuse     | <input type="radio"/> alcohol or drug abuse | <input type="radio"/> high job stress            |
| <input type="radio"/> physical abuse                    | <input type="radio"/> money stress          | <input type="radio"/> difficult divorce/break-up |
| <input type="radio"/> other _____                       |   |  |

**Nutritional History** (please check the items that apply to your typical diet)

- junk food (\_\_\_ x's per week)
- microwave food (\_\_\_ x's per week)
- gluten-free
- vegan
- other special diet \_\_\_\_\_
- excess sugar
- artificial sweetener
- dairy-free
- omnivore
- skip meals
- no breakfast
- vegetarian
- raw food
- water (# of glasses per day \_\_\_\_)
- soda
- caffeine
- alcohol
- energy drinks
- tea/coffee
- juice

Do you relate any of the experiences checked above to your current state of health?  Yes  No  
If yes, which ones? \_\_\_\_\_

**Has your body communicated any of the following to you?** (While they may seem unrelated to the purpose of the appointment, they can affect the overall assessment, care plan, and/or the possibility of being accepted for care.)

- Headaches
- High Blood Pressure
- Low back pain
- Neck Pain
- Ringing in Ears
- Rashes/Eczema
- Sinus problems
- Mood Swings
- Allergies
- Chest pain
- Dizziness
- Cancer
- Fatigue
- Asthma
- Loss of sleep
- Heartburn
- HIV
- Vertigo
- Anxiety
- Sweats/Chills
- PMS
- Fever
- Arthritis
- Anemia
- Shortness of Breath
- Loss of smell or taste
- Stomach Problems
- Heart Conditions
- Weight Changes
- Urinary Changes
- Digestions Problems
- Other \_\_\_\_\_
- Tension across top of shoulders
- Tension between shoulder blades
- Numbness in Arms/Legs
- Depression/Nervousness
- Constipation/Diarrhea/Gas
- Cold Hands/Feet
- Diabetes

**For women:**

- past pregnancy
- birth control pills/patch/ring
- currently pregnant
- painful periods
- breast-feeding
- irregular cycles

**Have you had or do you use any of the following for your growth, healing and development?**

- Massage/Bodywork
- Emotional Therapy/Psychotherapy
- Physiotherapy/Occupational Therapy
- Music/Dance/Sound/Light/Aromatherapy
- Yoga/Pilates/Dance/Tai Chi
- Homeopathy/Herbalist
- Naturopathic Medicine
- Ayurvedic Medicine
- Acupuncture
- Cranial-Sacral
- Nutritional Cleansing
- Nutritional Counseling
- Breathwork/Re-birthing
- Feldenkrais
- Other \_\_\_\_\_

Are you currently taking any medications (prescribed or over the counter)? Please list here.

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## Clarifying Your Intentions

What do you hope to receive from our care? (i.e. full, abundant health and well-being, pain relief, reconnection of my spiritual/physical body, etc.)

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What is your level of commitment to yourself, your life and well-being? **Low** 1 2 3 4 5 6 7 8 9 10 **High**

# Life Inventory

Please rate these different areas of your life expression on a scale of 1-10.  
1 = extremely dissatisfied. 10 = completely fulfilled.

Energy level \_\_\_\_\_

Clarity of thought \_\_\_\_\_

Physical Flexibility and Ease \_\_\_\_\_

Mental Flexibility \_\_\_\_\_

Emotional balance \_\_\_\_\_

Level of pain \_\_\_\_\_

Sleep quality \_\_\_\_\_

Connection to spirit/source \_\_\_\_\_

Feelings of abundance \_\_\_\_\_

Level of joy in life \_\_\_\_\_

Relationships \_\_\_\_\_

Sense of Peace \_\_\_\_\_

Ability to adapt to change \_\_\_\_\_

Overall health and wellbeing \_\_\_\_\_

**Privacy Statement:** The information you provide on this form is confidential. We will provide you and designated family members with this information by request only and will not use it for any purpose other than to aid us in providing you with the highest standard of wellness care that we are capable of giving. We appreciate your time and commitment to your ongoing health and well-being.

**Authorization for Care**

I hereby authorize the Chiropractor(s) to work with me through the use of adjustments to my spine, as he or she deems appropriate. In this office we do not treat symptoms and diseases. We offer true healing and greater life expression through chiropractic. The Chiropractor(s) will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

The medical insurance industry pays for the treatment of symptoms and disease rather than the maintenance of our well-being. As chiropractic is not a treatment nor cure of disease, we require your "investment" to be paid directly to us at time of service. However, we will provide you with a form to submit your claims to your insurance company if you desire. Your insurance policy is between you and your insurance company, not between your insurance company and us.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment of all bills incurred at this office. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I, \_\_\_\_\_, have completed this form to the best of my ability and have read the privacy statement and agree to the terms set forth by this office

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent, Guardian or Spouse Authorizing Care

\_\_\_\_\_  
Date

*Our mission is to serve every human being with respect, compassion, gratitude, and love. We will strive to provide the exceptional chiropractic experience through the chiropractic adjustment and the teaching of our body's magnificent innate potential. We aim for excellence, mastery, and constant growth while enjoying the perfection of the process itself.*

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**Chiropractor's Notes:**  
(please leave blank)

# Understanding Our Service

**When a person seeks chiropractic care, it is essential for both the Individual and the Chiropractor to be working towards the same objective.**

In this office, chiropractic adjustments are delivered to free up Life Force, allowing every individual whether a newborn, an athlete, or a grandparent to express more health. **Health** is defined as the state of optimal physical, mental and social well being, not merely the absence of disease or infirmity. **Adjustments** are specific applications of forces delivered to facilitate the body's correction of subluxations. **Subluxations** are patterns of tension stored in the body causing an alteration of nerve function and interference to the transmission of mental impulses (Life Force); the essential impulses that allow the expression of health, vitality, and personal expression.

Specific chiropractic adjustments deepen everyone's potential to heal biologically and at the core. In some, physical, emotional, mental, or spiritual challenges may clear up quickly, in others, the process is slower, and in some, it appears partial or not at all. Yet everyone will benefit from a properly functioning nerve system and greater life expression. Healing is a non-linear path, which means that one might experience ups and downs during a course of chiropractic care. This might include the experience of emotions, soreness, fatigue, and sensation awareness as subluxations are released and the body finds a new alignment. It also might mean greater energy, rest, ease, creativity, and connectivity.

**Chiropractic is not a substitute, an alternative or a preventative form of medicine.**

Chiropractic specializes in the expression of life, wellness, healing and well being, whereas medicine specializes in the diagnosis and treatment of symptoms, sickness, and disease. It is not Dr. Paul Martin's nor Dr. Laelle Martin's goal or intention to diagnose, treat, or attempt to cure any physical, mental, or emotional ailments. The only diagnosis made in this office is that of subluxations. However, if during the course of chiropractic care non-chiropractic or unusual findings are encountered, these will be brought to your attention. If you desire advice, diagnosis, or treatment for those findings, the chiropractor will recommend that you seek the services of another health care provider.

I, \_\_\_\_\_ the undersigned, have completely read and understood the above statements and choose to be served by Dr. Paul Martin and/or Dr. Laelle Martin with this understanding for myself. All questions regarding the doctors' objective pertaining to my care in this office have been answered to my complete satisfaction. Therefore, I accept chiropractic care on this basis.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of parent or Guardian (for anyone under the age of 18)  
\_\_\_\_\_ Date \_\_\_\_\_



## NOTICE OF PRIVACY PRACTICES

### Appointment Calls, Open Room Adjusting & Health Care Information

Brilliant Life Chiropractic, including Dr. Paul Martin, Dr. Laelle Martin, and members of the practice staff, may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and you are not home, a message will be left on your answering machine or with a family member. By signing this form, you are giving us authorization to contact you with these reminders and information.

You can restrict individuals or organizations to which your health care information is released or you may revoke your authorization to us at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

Information that we use or disclose based on the authorization you are giving us may be subject to re-disclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

We offer spinal adjustments in an open room style with other patients in the same room. Occasionally comments about your symptoms, improvement or lack thereof may be discussed at your office visits.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives or other health related information at any time. (#164.524)

This notice is effective at time of signing and will expire seven years after the date in which you last received services from us.

*I authorize you to use or disclose my health information in the manner described above. I also understand that I may receive a copy of this form when needed.*

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_