



1347 Kapiolani Blvd. 3<sup>rd</sup> Floor  
Honolulu, HI 96826  
(808) 943-2872

## DIRECTIONS TO OUR OFFICE

1347 Kapiolani Blvd. 3<sup>rd</sup> Floor

### FROM EWA:

Take **H-1 East**

Exit **Kinau Street** and go straight

Turn Right on **Pensacola St.**

Turn Left on **Kapiolani Blvd.** Get in far right lane

After crossing over **Piikoi Street**, our building is located 100 yards from the corner of Piikoi and Kapiolani on the right.

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### FROM DIAMOND HEAD: (This is a round-about way but much safer!)

Take **H-1 West**

Exit **Kapiolani Blvd.** and continue heading straight down towards Town

Turn left on **Atkinson Drive**

Take immediate right on **Kona St.** and go straight through to Piikoi St.

Turn right on **Piikoi St.**

Turn right on **Kapiolani Blvd.**

Our building is located 100 yards from the corner of Piikoi and Kapiolani on the right

\*\*\*\*We are located on the 3<sup>rd</sup> Floor. Go up the **first ramp** closest to our building to park.

Parking stalls designated "CUSTOMER" on the ground are free. Stalls marked "PAY" require you to put money in the box marked "Pay Here."

After parking your car, enter through the doors that say **Lifetime Family Wellness Centers** in the building that is on the Kapiolani side of the lot.

\*\*\*\*If you are on foot, there are stairs and an elevator located in the lobby at the street entrance of the building.

**On the 3<sup>rd</sup> Floor, turn the corner and enter our office from the outside.**

# CONFIDENTIAL PATIENT INFORMATION

(Please Print Clearly)

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

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

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Work Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Age \_\_\_\_ Sex: M F Marital Status: S M W D Spouse's Name: \_\_\_\_\_

Children: Names & Ages \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Have you ever been to a chiropractor before? \_\_\_\_\_. If yes, who & when?

\_\_\_\_\_

Was it a **corrective** or **symptomatic** chiropractor? (Circle one)

What health challenges do you have? List your complaints in order of severity:

1. \_\_\_\_\_ For how long? \_\_\_\_\_

2. \_\_\_\_\_ For how long? \_\_\_\_\_

3. \_\_\_\_\_ For how long? \_\_\_\_\_

List other doctors you've consulted for these conditions:

1. \_\_\_\_\_ Address: \_\_\_\_\_

2. \_\_\_\_\_ Address: \_\_\_\_\_

List the medication(s) you are currently taking:

1. \_\_\_\_\_ 4. \_\_\_\_\_

2. \_\_\_\_\_ 5. \_\_\_\_\_

3. \_\_\_\_\_ 6. \_\_\_\_\_

Cause of complaints/symptoms (Please circle) : 1) Work related injury 2) Auto accident 3) Other

What activities do you enjoy?

\_\_\_\_\_

**Goal:** If you could accomplish one important thing or mission for your life, what would that be?

\_\_\_\_\_

Females: Are you pregnant? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_

**Please notify the doctor if you are pregnant or possibly pregnant.**

## PATIENT HEALTH HISTORY

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Patient Name: \_\_\_\_\_

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

The vast majority of our patients have been involved in dozens of **IMPACTS** that could cause **VERTEBRAL SUBLUXATION (spinal misalignments)**, the doctor wants to discover 5 of yours.

1. When was your MOST recent **Auto/Motorcycle Accident**? Date: \_\_\_\_\_  
Speed? \_\_\_\_\_mph (please circle) Front Back Side Other \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No
  
  2. When was the one just before that? Date: \_\_\_\_\_  
Speed? \_\_\_\_\_mph (please circle) Front Back Side Other \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No
- 

Most people have a SLIP, STRAIN, TWIST, or FALL playing **sports**, at **home** or at **work**, whether it was reported or not.

1. When was your MOST recent **injury**? Date: \_\_\_\_\_  
Briefly describe the injury \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No
  
  2. When was the one before that? Date: \_\_\_\_\_  
Briefly describe the injury \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No
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Please list any **other important traumas**  
(i.e. childhood traumas, illnesses, fractures, sprains, surgeries):

1. Date: \_\_\_\_\_ Briefly describe the trauma \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No
  
2. Date: \_\_\_\_\_ Briefly describe the trauma \_\_\_\_\_  
Any treatment received? Yes  No  \_\_\_\_\_ Chiropractic care? Yes  No

**Vertebral subluxation affects your nervous system which affects your health.**

1. Vertebral subluxation can put pressure on nerves for a long period of time.

**How long have you had:**

- Neck pain/stiffness \_\_\_\_\_
- Headaches \_\_\_\_\_
- Shoulder pain \_\_\_\_\_
- Arm/Hand pain \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_
- Allergies/Asthma \_\_\_\_\_
- Upper/Mid back \_\_\_\_\_
- Rib problems \_\_\_\_\_
- Low back pain \_\_\_\_\_
- Hip/Groin pain \_\_\_\_\_
- Leg pain \_\_\_\_\_
- Dizziness \_\_\_\_\_
- Other \_\_\_\_\_
- \_\_\_\_\_

2. Vertebral subluxation can cause irritation to different nerve fibers, is your condition:  
**(please circle any that apply)**

Sharp      Dull      Throbbing      Burning      Aching      Stabbing pain

3. Please describe the above conditions as Constant or Occasional.  
How often do you have above conditions? \_\_\_\_\_

4. Vertebral subluxation can cause weakening to the entire spine. Is your condition worse:  
**(please circle)**

In the AM                      In the PM                      Anytime                      After activity

5. Sleeping improperly can create spinal misalignments or enhance pre-existing conditions.  
Do you **sleep**: (please circle)  
On your back                      On your stomach                      On your side: R L

6. The very first vertebral subluxation can occur during the birthing process.  
Any complications? Y N Briefly describe: \_\_\_\_\_



**Patient's Signature:** \_\_\_\_\_