



Name: _____ Date: _____
Date of Birth: _____ Age: _____ Ht. _____ Wt. _____ M F Marital Status: S M D W
Name of Spouse/Partner: _____ Children's Names & Ages: _____
Occupation: _____ Stress Level: MILD MODERATE EXTREME
What do you hope to receive from this office? _____

Do you currently have any health concerns? **Y N** Please describe: _____

Please list all of your present health goals? _____

Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N**
Have you had your spine or nervous system examined professionally? **Y N** By whom? _____
What type of care given: _____ Were you pleased with this service? **Y N**

Stresses that affect the spine and nervous system may be PHYSICAL, CHEMICAL or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous system assist us in serving you. With each of the following potential spinal stress situations, please check all that apply.

HISTORY OF PHYSICAL STRESSES

Birth Stress: Were there any problems associated with your mother's pregnancy with you? *(check all that apply)*

- Falls/injury Illness Difficult

Comments: _____

Was your birth: *(check all that apply)* Traumatic "C" section Breech Forceps or suction
 Cord around neck Prolonged Drug induced Home Hospital Birthing center Other location

Comments: _____

General Physical Trauma: Falls: *(check all that apply & age)* Crib/carriage _____ Steps _____

- On ice _____ Out of tree _____ Bars at school _____ Skating _____
 Skiing _____ Snowboarding _____ Other falls _____

Comments: _____

- Knocked unconscious _____ Used crutches/cane _____ Broken bones (which ones?) _____
 Involved in combat _____ Physical fight _____ Physical abuse _____
 Involved in sports _____ Extensive dental/orthodontia _____ Other _____

Accidents, near-accidents, driver or passenger: *(check all that apply & age)*

- Automobile _____
 Motorcycle _____ Bus _____ Train _____ Bicycle _____ Plane _____ Other _____

Comments: _____

Daily Activities: *(Check all that apply)*

- | | | | | | |
|---------------------------------|---|-----------------------------------|--|--|--|
| <input type="checkbox"/> Sit | <input type="checkbox"/> Stand | <input type="checkbox"/> Walk | <input type="checkbox"/> Do desk work | <input type="checkbox"/> Phone work | <input type="checkbox"/> Wear contacts |
| <input type="checkbox"/> Sports | <input type="checkbox"/> Exercise | <input type="checkbox"/> Watch TV | <input type="checkbox"/> Computer Work | <input type="checkbox"/> Play musical instrument | <input type="checkbox"/> Wear glasses |
| <input type="checkbox"/> Drive | <input type="checkbox"/> Read prolonged periods | | <input type="checkbox"/> Mechanical work | <input type="checkbox"/> Heavy lifting | <input type="checkbox"/> Wear bifocals |



Medical Intervention (Check all that apply & age)

- Hospitalization *why?* _____
 - Surgery *why?* _____
 - Chemotherapy _____ Radiation _____ Casts/collars _____ Spinal/neck brace _____
 - Corrective shoes, bars, lifts _____ Physical Therapy _____ Spinal tap/injections _____
 - X-rays _____ Transfusion _____ Organ Removal _____
- Have you or a family member suffered a serious illness? _____

Do you have a family doctor? **Y N** Who? _____
 Date of last medical consultation & result: _____
 For women: Are you pregnant? **Y N** Date of last monthly period: _____
 How do you grade your physical health? Excellent Good Fair Poor Getting Better Getting Worse

HISTORY OF CHEMICAL STRESSES

Birth Stress: During your mother's pregnancy did she: (Check all that apply)

- Use prescription drugs Use nonprescription drugs Smoke Consume alcohol
- At birth was your mother: (Check all that apply)
- Conscious Semi-conscious Unconscious Given spinal anesthesia Given chemicals to induce or alter labor?

General Chemical Stress: Do you or have you taken:

- Prescription drugs Over-the-counter drugs Antibiotics Other drugs Tobacco
- Do you or have you worked with or been exposed to:
- Chemicals Fumes Dust Powders Smoke
- Do you consume:
- Alcohol Coffee/caffeine Processed food Animal food Artificial sweeteners Refined sugar Tap water Sodas
- Describe diet/comments: _____

HISTORY OF EMOTIONAL STRESSES

Were you incubated or isolated after birth? **Y N** Were you: Bottlefed Nursed Both

General emotional trauma (Check all that apply and note severity: Mild, Moderate, Extreme)

- | | | |
|--|--|---|
| <input type="checkbox"/> Childhood _____ | <input type="checkbox"/> Divorce/separation _____ | <input type="checkbox"/> Loss of loved one _____ |
| <input type="checkbox"/> School _____ | <input type="checkbox"/> Work related _____ | <input type="checkbox"/> Stress of being sick _____ |
| <input type="checkbox"/> Recreational _____ | <input type="checkbox"/> Financial _____ | <input type="checkbox"/> Abuse _____ |
| <input type="checkbox"/> Family _____ | <input type="checkbox"/> Commuting _____ | <input type="checkbox"/> Moving _____ |
| <input type="checkbox"/> Parents' divorce _____ | <input type="checkbox"/> Change of vocation _____ | |
| <input type="checkbox"/> Personal relationship _____ | <input type="checkbox"/> Change of lifestyle _____ | |

Comments: _____

Have you pursued other avenues towards growth, healing or personal development? _____

How do you grade your emotional mental health? Excellent Good Fair Poor Getting Better Getting Worse
 How do you grade your overall quality of life? Excellent Good Fair Poor Getting Better Getting Worse
 Is there anything else you may wish to share which may help us to better understand you and why you have chosen to come to this office? _____