



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

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Ht. \_\_\_\_\_ Wt. \_\_\_\_\_ S.S # \_\_\_\_\_

M  F Marital Status: S M D W Name of Spouse: \_\_\_\_\_

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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: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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)*

Sit  Stand  Walk  Do desk work  Phone work  Wear contacts

Sports  Exercise  Watch TV  Computer Work  Play musical instrument  Wear glasses

Drive  Read prolonged periods  Mechanical work  Heavy lifting  Wear bifocals

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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  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)

- Childhood \_\_\_\_\_  Divorce/separation \_\_\_\_\_  Loss of loved one \_\_\_\_\_
- School \_\_\_\_\_  Work related \_\_\_\_\_  Stress of being sick \_\_\_\_\_
- Recreational \_\_\_\_\_  Financial \_\_\_\_\_  Abuse \_\_\_\_\_
- Family \_\_\_\_\_  Commuting \_\_\_\_\_  Moving \_\_\_\_\_
- Parents' divorce \_\_\_\_\_  Change of vocation \_\_\_\_\_
- Personal relationship \_\_\_\_\_  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?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_