Name: _____ Date: _____

Address: _____ Referral: _____

City: _____ Prov. _____ PC _____ Email: _____

Home phone: _____ Bus. Phone: _____ Cell: _____

Date of Birth: _____ Age: _____ Ht. _____ Wt. _____ **M** **F**

Marital Status: **S M D W** Name of Spouse: _____

Children's Names & Ages: _____

Occupation: _____ Stress Level: **MILD** **MODERATE** **EXTREME**

What do you hope to receive from this office? _____

_____

_____

Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N**
(For present health concerns, see exam form)

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**

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: _____

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 Physical Trauma: Falls: *(check all that apply & age)* ☐ Crib/carriage _____ ☐ Steps _____
☐ On ice _____ ☐ Out of tree _____ ☐ Bars at school _____ ☐ Skating _____
☐ Skiing _____ ☐ Snowboarding _____ ☐ Other falls _____
☐ 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: _____

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

IMPACT OF YOUR SYMPTOMS

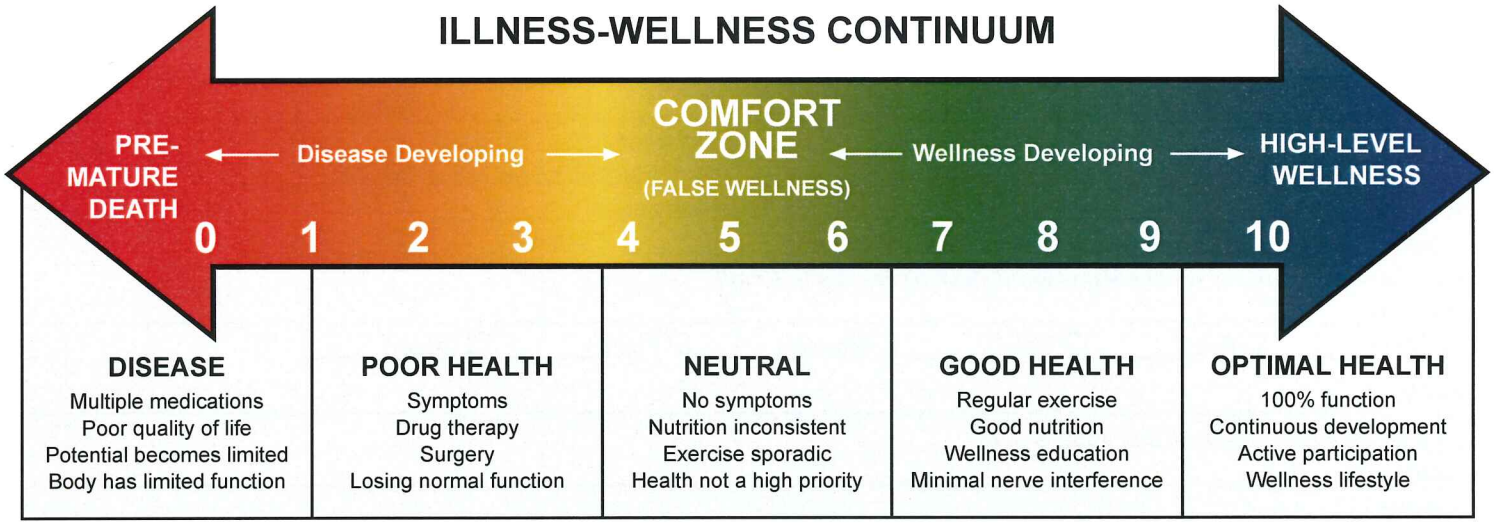
How is this symptom / condition interfering with your life? (check where appropriate)

	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	☐	☐	☐	☐	Energy	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	Attitude	☐	☐	☐	☐
Recreation	☐	☐	☐	☐	Patience	☐	☐	☐	☐
Relationships	☐	☐	☐	☐	Productivity	☐	☐	☐	☐
Sleep	☐	☐	☐	☐	Creativity	☐	☐	☐	☐
Self-Care	☐	☐	☐	☐	Other _____	☐	☐	☐	☐

How committed are you to correcting this issue? 0 1 2 3 4 5 6 7 8 9 10

NOT COMMITTED — VERY COMMITTED

PATIENT WELLNESS ASSESSMENT



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____