

Name: _____ Date: _____
Address: _____ Referral: _____
City: _____ State: _____ Zip _____ Email: _____
Home phone: _____ Bus phone: _____ Fax: _____
Date of Birth: _____ Age: _____ Ht _____ Wt _____ SS#: _____
 M F Marital Status: S M D W Name of Spouse/Partner: _____
Children's Names & Ages: _____
Occupation: _____ Stress Level: Mild Mod 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 was given? _____ Where you pleased? 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 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 _____

Knocked unconscious _____ Used crutches/cane _____ Broken bones (which ones?) _____

Involved in combat _____ Physical fights _____ Physical Abuse _____

Involved in Sports _____ Extensive dental/orthodontial _____ Other _____

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

Automobile (how many and years) _____ Bicycle _____

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?* (include circumcision) _____

Chemotherapy Radiation Casts/collars Spinal Neck Brace _____

Corrective shoes Physical Therapy Spinal tap/injections _____

X-Rays Transfusion Organ Removal _____

Comments: _____

Have you or your family 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

Why? _____

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 labor?

General Chemical Stress: Do you or have you taken: (past / present)

- Prescription drugs Over the counter drugs Other drugs Antibiotics Tobacco/2nd Hand

Do you or have you worked with or been exposed to:

- Chemicals Paint Fumes Dust Powders Smoke

Do you consume:

- Alcohol Coffee/caffeine Processed Foods Animal products Artificial sweeteners Refined sugar Tap water Sodas

Comments: _____

HISTORY OF EMOTIONAL STRESSES

Were you incubated or isolated after birth? Y N Were you : Bottle fed Nursed Both

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

- Childhood _____ Personal relationship _____ Change of vocation _____ Moving _____

- School _____ Divorce/separation _____ Changes in lifestyle _____

- Recreational _____ Work related _____ Loss of loved one _____

- Family _____ Financial _____ Stress of being sick/pain _____

- Parents' divorce _____ Commuting _____ Abuse (emotional, sexual, physical) _____

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 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? _____

FOR OFFICE USE ONLY

- | | |
|--|---|
| <input type="checkbox"/> Acknowledge entry to L1 & confirm recommendations for care & target dates | V A K DR EX AN AM |
| <input type="checkbox"/> Confirm financial agreement ___/___ | <input type="checkbox"/> LI Talk Booked |
| <input type="checkbox"/> Method of payment: CA/CK/CC/CCP | <input type="checkbox"/> Statement of purpose signed Y or N |
| <input type="checkbox"/> A ST SB INS WC PI | <input type="checkbox"/> Pro. Fees & Hardship & Finan. Agreement Signed |

Method of Scheduling: Master/Wkly/ PV

Status: Act. Inact. Trans. React. Child Other

- | | | | |
|--|--|--|---|
| ◆ Date begin L1 \$ _____ | ◆ Date of L2 RE _____ | ◆ Date of L3 RE _____ | ◆ Date Well RE _____ |
| ◆ Level 1 Financial Plan ___/___ | ◆ Date begin L2 \$ _____ | ◆ Date begin L3 \$ _____ | ◆ Date begin Wellness \$ _____ |
| <input type="checkbox"/> Dots/Flags | ◆ Level 2 Financial Plan ___/___ | ◆ Level 3 Financial Plan ___/___ | ◆ Wellness Financial Plan ___/___ |
| <input type="checkbox"/> Treatment plan TC | <input type="checkbox"/> Dots/Flags | <input type="checkbox"/> Dots/Flags | <input type="checkbox"/> Dots/Flags |
| <input type="checkbox"/> Send TY referral | <input type="checkbox"/> Level 2 talk booked | <input type="checkbox"/> Level 3 talk booked | <input type="checkbox"/> Wellness talk booked |
| <input type="checkbox"/> Send Welcome | <input type="checkbox"/> Level 2 CD given | <input type="checkbox"/> Level 3 CD given | <input type="checkbox"/> Wellness CD given |
| <input type="checkbox"/> Name on chalk board | <input type="checkbox"/> Database MS | <input type="checkbox"/> Database MS | <input type="checkbox"/> Database MS |
| <input type="checkbox"/> Enter database MS | <input type="checkbox"/> Schedule OHP | <input type="checkbox"/> Schedule OHP | <input type="checkbox"/> Schedule OHP |
| <input type="checkbox"/> Email entered into database | <input type="checkbox"/> Pink tag DC check | <input type="checkbox"/> Pink tag DC check | <input type="checkbox"/> Pink tag DC check |
| <input type="checkbox"/> Enter schedule OHP | | | |
| <input type="checkbox"/> NP File Created | | | |
| <input type="checkbox"/> Pink tag DC check | | | |

- | | |
|-------------------------|---|
| Date of Well RE _____ ▲ | <input type="checkbox"/> Date of Last Visit _____ |
| Date of Well RE _____ ▲ | <input type="checkbox"/> Database & status on T.C. |
| Date of Well RE _____ ▲ | <input type="checkbox"/> Sent SYS letter/bill _____ |
| Date of Well RE _____ ▲ | <input type="checkbox"/> Recall Letter in TM |
| Date of Well RE _____ ▲ | <input type="checkbox"/> Conv \$ _____ |

- Reason for leaving**
- | | |
|--|--|
| <input type="checkbox"/> \$ | <input type="checkbox"/> moved |
| <input type="checkbox"/> dissatisfied | <input type="checkbox"/> commute |
| <input type="checkbox"/> noncompliance | <input type="checkbox"/> didn't start care |
| <input type="checkbox"/> completed level | <input type="checkbox"/> PAD/GOH |
| <input type="checkbox"/> shifting priorities | <input type="checkbox"/> \$ _____ deal |
| <input type="checkbox"/> dismissed | <input type="checkbox"/> \$150 deal |