

Name _____ Called Name _____ Date _____
 Address _____ City _____ State _____ Zip _____
 Date of Birth _____ (Age _____) Social Security # _____
 Home Phone (_____) _____ Work Phone (_____) _____ Cell Phone (_____) _____
 Where do you prefer to be contacted: Home Work Cell Email Address _____
 Occupation _____ Employer _____
 Marital Status S M D W Spouses Name _____ Date of Birth _____
 Spouses Occupation _____ Number of Children and Ages _____
 Referred by _____ Have you ever received Chiropractic Care? Yes No

Health Goals

What are your goals in coming to our office? (check all that apply)

- Address my present concern only
- Address my present concern and prevent its return
- Work towards a healthier body by keeping my nerve system healthy
- Live an overall healthier lifestyle

Symptoms and Ill Health (Present State of Ill Health)

Present Complaint (be brief)
 Major _____
 Pain or Problem started on _____
 Pains are: Sharp Dull Constant Intermittent
 What activities aggravate your condition/pain? _____
 What activities lessen your condition/pain? _____
 Is condition worse during certain times of the day? _____
 Is this condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____
 Is condition getting progressively worse? _____
 Other Doctors seen for this condition _____
 Any home remedies? _____

Other symptoms:

<input type="checkbox"/> Headaches/ Migraines	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Frequent Colds/flu	<input type="checkbox"/> Reflux
<input type="checkbox"/> Neck Pain/Stiffness	<input type="checkbox"/> Sleeping difficulty	<input type="checkbox"/> Loss of Smell/ Taste	<input type="checkbox"/> Pins & Needles in legs
<input type="checkbox"/> Upper/mid back pain	<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Asthma/brochitis	<input type="checkbox"/> Pins & Needles in Arms
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Loss of Concentration	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Numbness in Fingers
<input type="checkbox"/> Shoulder/Arm/Elbow pain (L / R / Both)	<input type="checkbox"/> Run Down/ Fainting	<input type="checkbox"/> Chest Pains	<input type="checkbox"/> Numbness in Toes
<input type="checkbox"/> Hand/Wrist pain (L / R / Both)	<input type="checkbox"/> Sinus pain/allergies	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Feet Cold
<input type="checkbox"/> Hip/Leg/Knee pain (L / R / Both)	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Depression	<input type="checkbox"/> Hands Cold
<input type="checkbox"/> Ankle/Foot pain (L / R / Both)	<input type="checkbox"/> Ears Ring/ Buzz	<input type="checkbox"/> Digestive trouble	<input type="checkbox"/> Fatigue
<input type="checkbox"/> TMJ	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Constipation/ Diarrhea	<input type="checkbox"/> Emotional Stress

What medications are you taking? _____
 How Long? _____ Have you had surgery? _____
 what side effects have you experienced from the drugs and surgery? _____
 Is there a family history of:

	Heart Disease	Arthritis	Cancer	Diabetes	Other _____
Father's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother's Side	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

About Your Health

The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, your Chiropractor will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Loss of Wellness

Let's begin at birth when you first damaged your nerve system, lost your wellness and began your journey to ill health.

Yes	No		Comments
1. <u>Birth Process</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Was your birth traumatic?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery long?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was the delivery difficult?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Forceps?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Caesarean (C-section)?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Breach/Cephalic?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Home birth?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hospital birth?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mother given drugs during delivery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Was labor induced?	_____
2. <u>Growth & Development</u>			
<input type="checkbox"/>	<input type="checkbox"/>	Were you taught how to care for your spine?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall out of bed?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you breast fed?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Childhood sicknesses?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Accidents in childhood?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Surgery?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall while learning to walk?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you picked on by siblings?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Child abuse?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Spanking (how?)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Pulled ear/chin	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chair pulled out when you sat down?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you fall down stairs?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Were you yanked by your arm?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did you have other traumas? What? When?	_____
Yes	No	3. <u>Current Health Habits</u>	(page 2 of 2)
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you smoke?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you drink any alcohol?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diet (Do you eat healthy foods?)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you been in accidents as an adult?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Have you had surgery and organs removed/replaced?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Drugs? (prescription or non-prescription)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Teeth problems?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Eye problems?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hearing problems?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Exercise regularly? (please specify type & amt)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Interrupted Sleep Patterns?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping posture <input type="checkbox"/> side <input type="checkbox"/> stomach <input type="checkbox"/> back	_____
<input type="checkbox"/>	<input type="checkbox"/>	Did/do you have occupational stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Physical stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Mental stress?	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hobbies/Sports injuries?	_____

About Your Care

New England Spinal Care provides three types of care. The ultimate goal is for everyone to have lifetime wellness for themselves and their entire family. To get there, the first phase is **Initial Intensive Care** which corrects the most recent layer of Spinal and Neurological stress (Vertebral Subluxation Complex). This care usually reduces or eliminates the concern/symptoms. Then **Reconstructive Care** begins which aims to address the years of stress/damage that have been accumulating when there were a few symptoms. And finally, Chiropractic offers a genuine approach to wellness. The aim of **Wellness Care** is to assist the body in its efforts to reach greater possibilities in health.