PERSONAL INFORMATION

Last Name: _____ First: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Email: _____

Gender: M F Birthdate: _____ Age: _____

Please check: O Married O Single O Divorced

Who may we thank for referring you? _____

WORK INFORMATION

Employer: _____

Occupation: _____

Work Phone: _____

IN CASE OF EMERGENCY

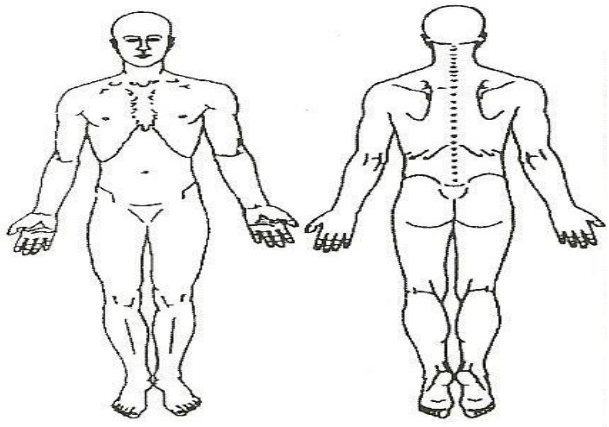
Contact Name: _____

Contact Phone: _____

Relationship: _____

HOW CAN WE HELP YOU?

Please circle on the diagram anywhere you have discomfort or other **symptoms**:



What does it feel like? (Please check all that apply)

O Numbness	O Sharp	O Shooting	O Stiffness
O Dull	O Cramping	O Stabbing	O Nagging
O Annoying	O Tingling	O Burning	O Aching
O Swelling	O Weakness	O Other _____	
O Throbbing	O Radiates to _____		

What is your MAIN area of concern?_____

On what date did this start (about)? _____

How did it happen? _____

How bad is it? How intense are your symptoms? (minimal) 0 1 2 3 4 5 6 7 8 9 10 (intense)

Is it worse in the (please circle all that apply): AMs PMs constant on/off What makes it better? _____

What makes it worse? _____ Has this happened before? Y N _____

Have you seen anyone else for this condition? Y N _____

IMPACT OF YOUR SYMPTOMS

How is this interfering with your life? (Please check all that apply)

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

PREGNANT MOMS

How many weeks pregnant are you? _____ Anticipated due date: _____ Gender of baby: **M F ?!**

Is the baby breech? **Y N** For how long: _____ weeks Is this your first baby: **Y N** Other kids' ages: _____

HEALTH & ILLNESS HISTORY

Please check the circle beside ANY conditions or systems you have or have had problems with:

O Alcoholism	O Anxiety	O Arteriosclerosis	O Arthritis	O Asthma
O Allergies	O Back pain	O Cardiovascular	O Cancer	O Circulatory
O Childhood illness	O Depression	O Diabetes	O Digestive	O Elbow/wrist/hand
O Hormone/Endocrine	O Foot/ankle	O Gout	O Headaches/migraines	O Heart disease
O Hepatitis	O Hip issues	O Immunity	O Lymphatic	O MS
O Neck pain	O Reproductive	O Ringing in ears	O Scoliosis	O Shoulder issues
O Stroke	O TMJ issues	O UTI	O Osteoporosis	

Please list any medications you are CURRENTLY taking and a brief description of their use: _____

_____

_____

STRESSORS

Your current state of stress WILL affect your health and your ability to heal. Please answer the following (for your child if it applies):

- Do you feel you eat healthy? **Y N** Do you eat vegetables regularly? **Y N** Do you eat a lot of high carb or sugary foods? **Y N** How many 8 oz. cups of water do you drink per day? **1-3 4-6 7-10 >10**
- How many hours of exercise do you get per week? **0-1 1-3 3-6 >6** Do you feel you sit too much? **Y N**
- How many hours of sleep each night? **<4 4-6 6-8 >8** If you get less than 6 hours of sleep, how well do you sleep (please check)? ___ It's hard to get to sleep ___ I get up a lot ___ I toss and turn ___ No problems
- Do you feel like you are under stress? **Y N** Do you find it hard to relax? **Y N** Do you want that change? **Y N**

HEALTH & GOALS ASSESSMENT

Please circle the number on the continuum below that applies to you right now, and then indicate (by drawing an arrow) which direction you feel you are currently headed.

So that we may better understand your expectations, please indicate the type of care you desire:

RELIEF CARE is quicker and designed to help minimize your discomfort ASAP, but won't *fully* correct the underlying cause of your problem or move your health to the right on the continuum above. Please check here if this is what you expect: _____

CORRECTIVE CARE takes longer and is designed to help minimize your discomfort ASAP, but ***will*** help correct the underlying cause of your problem ***and*** improve your overall health and well-being. Please check here if this is what you expect: _____

I'm not sure at this point, but would like to know more: _____