Restore balance ~ Create wellness

NORI CONNELL, R.N., D.C. (914) 466-0024
Holistic Chiropractic www.andersonholistichealth.com/holisticchiropractic

Name: _____

Address: _____

Occupation: _____

Cell Phone: _____ eMail: _____

Emergency Contact Name / Cell / Relationship: _____

Date of Birth: _____ Age: _____ ☐ Male ☐ Female

Marital Status: _____ No. of children? _____

Were you referred to me? ☐ Yes ☐ No If so, by whom? _____

Please answer the following questions about your personal history

Have you ever had your spine or nervous system examined professionally? _____
If yes, when, and by whom? _____
Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? _____
If yes, when was your last visit? _____
For how long were you receiving chiropractic adjustments? _____
How often did you go? _____
If you stopped, why did you stop going?

What type of adjustments did the chiropractor perform, or what techniques or methods did he or she use?

_____

Were you pleased with his or her service? _____
Does your immediate family receive the following vehicles towards growth and development:
If yes, please list when and any comments you wish to share
Network Chiropractic: _____
Bodywork/Massage: _____
Osteopathy/Cranial Work: _____
Meditation: _____
Psychotherapy: _____
Movement or Exercise: _____
Yoga: _____
Rebirthing/Breath work: _____
Prayer: _____
Other: _____
What do you hope to receive from Network Chiropractic?

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be PHYSICAL, CHEMICAL, or EMOTIONAL in nature.

PHYSICAL STRESS BIRTH HISTORY: If you have information about your birth history:

1. Was your mother outwardly ill prior to her pregnancy with you? □Yes □No
2. Did your mother have a difficult pregnancy with you? □Yes □No
3. Did your mother have any falls, accidents or physical injuries during pregnancy? □Yes □No
4. Was your delivery traumatic? □Yes □No
5. Was your delivery:

   □ drug induced □ forceps or suction
   □ "c" section □ cord around the neck
   □ breech □ prolonged

6. Was there any other physical or mechanical stress to mother or you as labor progressed, or delivery progressed, or as a newborn? □Yes □No

GENERAL PHYSICAL TRAUMA:

7. Next to the potential cause of vertebral subluxations is provided a space for a check mark. Please write in appropriate space either 'P' for Past or 'C' for current under the correct level of trauma: Mild, Moderate, or Extreme.

	Mild		**Moderate**		**Extreme**			**Mild**		**Moderate**		**Extreme**	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, carriage	□	□	□	□	□	□	Sports Impacts	□	□	□	□	□	□
Falls down or up steps	□	□	□	□	□	□	Physical Fight	□	□	□	□	□	□
Falls on ice	□	□	□	□	□	□	Armed Services	□	□	□	□	□	□

Comments: _____

8. Were you ever knocked unconscious? □Yes □No
   Comments:
   _____
9. Have you ever used crutches, a walker, or cane? □Yes □No
   Comments:
   _____
10. Have you ever broken any bones? □Yes □No
    Comments:
    _____
11. Have you ever had any impacts, falls, or jolts that you feel specifically may have injured your spine? □Yes □No
    Comments:
    _____
12. Have you had extensive dental work performed? □Yes □No
    Orthodontial work? □Yes □No
13. During the day I: □sit □stand □walk □do desk work □phone work □drive □do mechanical work □heavy lifting
14. I exercise: □ daily □ weekly □ monthly

SPORTS or LEISURE:

15. Were you, or are you active in any particular sport(s)? □Yes □ No
    Which one(s)?

    _____

16. Have you been hurt in any of these activities? □Yes □ No
17. Do you read for prolonged periods? □Yes □No
18. Do you play a musical instrument? □Yes □No
19. Do you have a particular position for watching television? □Yes □No
    Comments:

    _____

20. I wear: □ glasses □ Bifocal □ contact lenses

AUTOMOBILE ACCIDENTS:

21. Have you, (even as a passenger, even if you do not think you were hurt) been involved in a vehicular collision/near collision? Please list approximate dates and severity (Mild, Moderate or Extreme)?

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

_____

MEDICAL TREATMENT:

22. Have you ever been hospitalized? □Yes □No
    If yes, what was actually done to you?

_____

Have you had surgery? □Yes □No
Do you still have all your body parts? □Yes □No
Have you had: □a spinal tap □spinal injections □physiotherapy □neck collar □spinal brace □traction □heel lift □X-ray treatments □corrective shoes or bars on shoes □transfusion □extensive diagnostic X-rays □acupuncture □chemotherapy □bone in a cast or immobilized

CHEMICAL STRESS:

BIRTH HISTORY

23. Was your mother regularly taking any drug prior to or during her pregnancy with you?
    □Alcohol □Smoking
24. Was her labor chemically induced or altered? □Yes □No
25. Was your mother: □conscious □semi-conscious □unconscious during your delivery
26. Any other chemical stress that your mother may have been subject to:

_____

GENERAL CHEMICAL TRAUMA

27. Are you now taking any drug (prescription or over-the-counter) regularly? Please list:

    _____

    Are these drugs being prescribed by a physician? □Yes □No Last visit: _____

28. Were you previously taking any medication regularly? □Yes □No

29. Do you work with any chemical, fume, dust, powder, or smoke for prolonged periods?
    □Yes □No

30. Please mark any dietary selection that is appropriate for you, and grade according to the following scale:

0 -	Do not consume this Consume this weekly	FD -	Consume this a few times per day
M -	Consume this monthly	W -	Consume this weekly
FM -	Consume a few times per month (less than weekly)	FW -	Consume this a few times per week
		D -	Consume this daily

_ Alcohol	_ Eggs	_ Beef
_ Coffee	_ Cooked canned vegetables	_ Poultry
_ Artificial Sweeteners	_ Fruit	_ Seafood
_ Soda	_ Whole grains	_ Weight Control Diet
_ Diet Food	_ Dairy (milk products)	_ Fasting
_ Refined Sugar	_ Fried Food	_ Organic Food

The type of diet I usually follow is classified as: _____

EMOTIONAL STRESS:

31. My birth was: □ at home □ in a Birthing Center □in a hospital
32. Were you incubated or isolated after birth? □Yes □No
33. Were you: □ bottle fed formula □ bottle fed mother's milk □ nursed □ nursed and bottle fed

GENERAL PHYSICAL TRAUMA:

With each of the following spinal stress situations, please check ether "P" for Past or "C" for Current.

	Mild	**Moderate**	**Extreme**		**Mild**	**Moderate**	**Extreme**
	P C	P C	P C		P C	P C	P C
Childhood stress	□ □	□ □	□ □	Work related stress	□ □	□ □	□ □
School stress	□ □	□ □	□ □	Stress or commuting	□ □	□ □	□ □
Play or recreational	□ □	□ □	□ □	Loss of loved one	□ □	□ □	□ □
Family stress	□ □	□ □	□ □	Change in lifestyle	□ □	□ □	□ □
Pers. relationships	□ □	□ □	□ □	Change in vocation	□ □	□ □	□ □
Stress of being sick	□ □	□ □	□ □	Abuse	□ □	□ □	□ □

How do you grade your physical health? □ Excellent □ Good □ Fair Poor □ Getting Better □ Getting Worse

How do you grade your emotional health?□ Excellent □ Good □ Fair Poor □ Getting Better □ Getting Worse

If you consider yourself ill, why do you feel you are ill?

If you consider yourself well, why do you feel you are well?

Is there anything else which may help to better understand you which has not been discussed?