North Rockland Chiropractic

Today's Date: ___/___/___

Name_____
What you preferred to be called: _____
Mailing (Street) Address: _____
City: _____ State: _____ Zip Code: _____
Email address: _____
Home Ph. # _____ Mobile Ph#_____
Marital Status: S M D W
Birth Date: ___/___/___ Age: _____ Spouse's Name: _____
Names and Ages of Children: Social Security #:_____
_____
How did you learn about our office?
_____
Previous Chiropractic Care? Yes ___ No ___ Approx. Last Visit Date: _____
Hobbies: _____
Employer/Business: _____ Occupation: _____
Recent work related injury? Yes ___ No ___ Recent Auto Accident? Yes____No____

Please check reasons for pursuing chiropractic care:
___ I'm continuing ongoing care from another chiropractor.
___ I'm Interested in wellness and natural health care.
___ I'm concerned about my health and I'm looking for answers.
___ I have a specific condition that concerns me.
Explain condition or symptom:
_____
___ I want to improve my immune function.
___ I have no idea why I'm here. Please take the time to explain to me what you do.

Please check any of the following body signals/conditions you have experienced within the past year:
Dizziness or Fainting___ Headache___ Poor Posture___ Arthritis___ Asthma __
Short Leg/Orthotics___ Ear Infection___ Intestinal Problems___ Frequent Colds___
Sinus Problems___ High Blood Pressure___ Bladder Problems___ Lyme Disease___
Scoliosis___ PMS___ Menopausal Symptoms___ Infertility___ Thyroid disease___
Cancer___ Diabetes___ Alcoholism___ Stroke___ Multiple Sclerosis___ Ulcers___
Other_____
List Prescription or Over-the-Counter Medications Now Taken:
_____
Known Allergies:
_____

The Stress Test

The following areas of stress can cause mis-aligned vertebra (subluxation).
Which of these stresses do you recognize? Please circle:
C (Child), T (Teenager), A (Adult)

Physical/Emotional/Chemical Stress:				Comments:
Birth Trauma	C			
Slips/Falls	C	T	A	
Car Accidents	C	T	A	
Sports Injuries	C	T	A	
Physical Abuse	C	T	A	
Poor Posture	C	T	A	
Work Injuries		T	A	
Sitting on a Wallet		T	A	
Sleeping on Stomach		T	A	
Extensive Computer Work		T	A	
Carrying Heavy Purse/Bookbag/Child		T	A	
Repetitive Lifting/Bending		T	A	
Driving for Many Hours		T	A	
Continuous Hours Sitting/Standing		T	A	
Family/Relationship Stress	C	T	A	
Career Stress			A	
Concealed Feelings	C	T	A	
Quick Tempered	C	T	A	
Smoker/Second Hand Smoke	C	T	A	Amount: _____
Poor Diet/Excessive Sugar	C	T	A	
Caffeine	C	T	A	Amount: _____
Artificial Sweeteners	C	T	A	
Prescription Drugs	C	T	A	
Over-The Counter Drugs (ex. Tylenol, Motrin)	C	T	A	

Which do you feel are your primary stresses?_____

It is important that our patients and we have the same health objectives concerning chiropractic care. Regardless of what a disease or condition is called we do not offer to treat it. Our only practice objective is to eliminate a major interference to the expression of the body's internal wisdom. Our only method is specific adjusting to correct vertebral subluxation. We believe that the greatest Doctor is the one already inside of each of our patients and we only help to maximize that inherent healing power, without using drugs or surgery. Your signature verifies that the information given in this form is complete and correct and that you accept, if eligible, chiropractic care on this basis.

Signature _____ Date: ___/___/___