

## ***Winters Wellness Center – Chiropractic Redefined***

|                                                 |                     |        |                 |         |                 |
|-------------------------------------------------|---------------------|--------|-----------------|---------|-----------------|
| Name:Last                                       |                     | First  |                 | M.I.    |                 |
| Address                                         | (city, state & zip) |        |                 |         |                 |
| Date of birth                                   | Age:                |        | Social Security |         |                 |
| Sex(mark one)                                   | Male                | Female | Marital Status  | M       | S      W      D |
| Home Phone #                                    |                     |        | Cell Phone #    |         |                 |
| Emerg. Contact                                  |                     |        | Phone #         |         |                 |
| Employer                                        |                     |        |                 |         |                 |
| Employer address                                | (city, state & zip) |        |                 |         |                 |
| Employer #                                      |                     |        | Referred by:    |         |                 |
| E-mail                                          |                     |        | Height:         | Weight: |                 |
| May we e-mail you office newsletters?(mark one) |                     |        |                 |         |                 |
| Yes                      No                     |                     |        |                 |         |                 |

Pursuant to HIPAA regulation, for any of our patients over the age of 18, we are unable to give any information, whether medical or financial, to any family member. This includes information about your spouse or your child, 18 years of age or older. Please read below and consider carefully who you want to have access to your medical/billing information.

I, \_\_\_\_\_, give Winters Wellness Center permission to leave phone messages regarding my medical care and/or lab results at the following numbers. My medical care/billing account may be discussed with the person(s) listed below.

We **will not** leave messages with anyone except the patient or legal guardian. We **will not** leave any information on an answering machine. We **will not** leave messages on a voice mail. **.....unless we have your written permission to do so.**

| Initials | Name | Relationship | Home Phone | Cell Phone |
|----------|------|--------------|------------|------------|
|          |      |              |            |            |
|          |      |              |            |            |
|          |      |              |            |            |

|          |  |                                                                                        |
|----------|--|----------------------------------------------------------------------------------------|
| Initials |  | My initials give permission to leave phone messages on my cellular phone voice mail    |
| Initials |  | My initials give permission to leave phone messages on my home phone answering machine |
| Initials |  | My initials give permission to leave phone messages on my office/work voice mail       |

**Patient's Responsibilities Policy**

1. If you have any updated information since your last visit (such as, change in name, address, phone number, or insurance) please notify the front desk staff when you arrive for your appointment.
2. It is your responsibility to determine, prior to your visit, if you have insurance benefits that cover chiropractic services.
3. Self-pay patients are required to make payment arrangements or pay in full on the day of your office visit.
4. If you have a previous balance on your account, you must pay this amount or make payment arrangements before your office visit.
5. If your insurance requires you to pay a co-pay or has a deductible that has not been met, you will be required to pay that amount at the date of service.
6. You agree, in order for us to serve your account, notify you of information pertaining to your account, or for the purposes of collection, that we may contact you by telephone at any number provided by you including wireless telephone numbers. Methods of contact may include the use of pre-recorded and artificial voice messages, text messaging and/or use of an automated dialing service.
7. Any appointments that are not cancelled before 24 hours of appointment time, will be billed to patient account at 50% of the service fee.

**Notice of Privacy Practices**

I have read, understand, and agree to the Notice of Privacy Practices for protected health information that was provided to me by Winters Wellness Center.

**MEDICARE/INSURANCE uniform of assignment, release of information and financial disclosure**

**ASSIGNMENT OF BENEFITS:** I hereby assign or transfer payment benefits made to me and my behalf to Winters Wellness Center for any services furnished to me by this facility. I further agree that I am responsible for payment or charges incurred by me that are not covered by my insurance or for which my insurance has paid me.

**RELEASE OF INFORMATION:** I hereby authorize Winters Wellness Center to release information acquired during the course of my examination or treatment to my primary care doctor or to an appropriate insurance carrier. If Medicare patients, I further authorize release, of the Center of Medicare Services and its agents, any information needed to determine benefits payable for related charges.

**\*\*Notice to all patients:** There must be a medical necessity to bill any insurance company. Maintenance therapy is not covered. "Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy." (CMS Publication 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 240.1.3A)

**I HAVE READ AND UNDERSTAND ALL OF THE ABOVE**

|                   |  |              |
|-------------------|--|--------------|
| <b>Signature:</b> |  | <b>Date:</b> |
|-------------------|--|--------------|

Please List your top 5 concerns or reasons for visiting the office today.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

Even if visiting for non-musculo skeletal concerns, please mark any of the following symptoms, mark the side involved, if any, and rate the severity from 1= extremely mild to 10= unbearable/severe

| symptom              | rating | area |        | rating |
|----------------------|--------|------|--------|--------|
|                      |        | L    | R both |        |
| headaches            | _____  |      |        | _____  |
| neck pain            | _____  |      |        | _____  |
| mid-back pain        | _____  |      |        | _____  |
| low back pain        | _____  |      |        | _____  |
| tailbone/pelvic pain | _____  |      |        | _____  |
| shoulder pain        | _____  |      |        | _____  |
| elbow pain           | _____  |      |        | _____  |
| wrist pain           |        |      |        | _____  |
| hand pain            |        |      |        | _____  |
| hip pain             |        |      |        | _____  |
| knee pain            |        |      |        | _____  |
| ankle pain           |        |      |        | _____  |
| foot pain            |        |      |        | _____  |

Please give a 1 to 10 rating to all activities which are affected.

List and rate any in addition to those listed below 1= mildly affected 10= severely affected

|               |       |                 |       |                        |       |                     |       |
|---------------|-------|-----------------|-------|------------------------|-------|---------------------|-------|
| Dressing      | _____ | Lifting         | _____ | walking                | _____ | going up/down steps | _____ |
| Bending       | _____ | Pushing/Pulling | _____ | exercise               | _____ | sleeping            | _____ |
| Driving       | _____ | arms overhead   | _____ | gardening              | _____ | -----               |       |
| Computer Work | _____ | standing        | _____ | getting out of vehicle | _____ | -----               |       |

Our office looks for hidden factors which can keep you from healing. Hidden, as in, not readily visible but also HIND as an acronym for the model we use in working with patients.

H = hormones I = Immune D = Detoxification N = Neurological

## H- HORMONES

| Insulin Resistance                                                                                                                                                                                                                                                              |                                                         |                          |                                 | VS                       |                              |                              |                                                                                                                                                                                                        | Hypoglycemia                                                  |                          |                          |                          |                          |                          |                          |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------|--------------------------|---------------------------------|--------------------------|------------------------------|------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Tired after eating <input type="checkbox"/>                                                                                                                                                                                                                                     |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        | Energy better after eating <input type="checkbox"/>           |                          |                          |                          |                          |                          |                          |
| Not hungry in AM <input type="checkbox"/>                                                                                                                                                                                                                                       |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        | Hungry in AM <input type="checkbox"/>                         |                          |                          |                          |                          |                          |                          |
| Craves sugar/ carbs AFTER meals <input type="checkbox"/>                                                                                                                                                                                                                        |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        | Craves sugar BEFORE meals <input type="checkbox"/>            |                          |                          |                          |                          |                          |                          |
| Difficulty falling asleep <input type="checkbox"/>                                                                                                                                                                                                                              |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        | Difficulty staying asleep <input type="checkbox"/>            |                          |                          |                          |                          |                          |                          |
| Large buttocks(Women) Large belly(Men) <input type="checkbox"/>                                                                                                                                                                                                                 |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        | Crashes and/or craves sweets in P.M. <input type="checkbox"/> |                          |                          |                          |                          |                          |                          |
| <b>Please Mark Symptoms You Are Experiencing and Rate the Overall Category</b><br><b>0=Never/None 1=Sometimes/Mild 2=Often/Mild 3=Always/Severe</b>                                                                                                                             |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| <b>Women</b>                                                                                                                                                                                                                                                                    |                                                         |                          |                                 |                          |                              | <b>Men</b>                   |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| Androgen Excess                                                                                                                                                                                                                                                                 | Loss of Scalp Hair, Increased Body or Facial Hair, Acne | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/>     | Androgen Excess              | Increased Sex Drive, Body or Facial Hair, Aggressive Behavior, Acne                                                                                                                                    | <input type="checkbox"/>                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
| Androgen Deficiency                                                                                                                                                                                                                                                             | Vaginal Dryness, Decreased Sex Drive/Libido             | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/>     | Androgen Deficiency          | Decreased Libido, Erections or Muscle Size, Increased Belly Fat, Apathy                                                                                                                                | <input type="checkbox"/>                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
| Estrogen Excess                                                                                                                                                                                                                                                                 | Tender or Fibrocystic Breasts                           | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/>     | Estrogen Excess              | Weight Gain (Breasts or Hips), Prostate Problems                                                                                                                                                       | <input type="checkbox"/>                                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                          |                          |                          |
| Estrogen Deficiency                                                                                                                                                                                                                                                             | Hot Flashes, Night Sweats, Vaginal Dryness              | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/>     |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                 |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| <b>Rate the Following Symptoms: 0=Never/None 1=Sometimes/Mild 2=Often/Moderate 3=Always/Severe</b>                                                                                                                                                                              |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
|                                                                                                                                                                                                                                                                                 | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |                              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> |                          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Trouble Falling Asleep                                                                                                                                                                                                                                                          | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | Morning Fatigue              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Can't Gain weight        | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Trouble Staying Asleep                                                                                                                                                                                                                                                          | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | Afternoon Fatigue            | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Intolerance to Heat      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Depression                                                                                                                                                                                                                                                                      | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | Evening Fatigue              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Night Sweats             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Anxiety                                                                                                                                                                                                                                                                         | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |                              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Internal Trembling       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Migraines                                                                                                                                                                                                                                                                       | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> |                              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Heart Palpitations       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                 |                                                         |                          |                                 |                          | Pulse Fast at Rest           | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Slow Pulse Below 65      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                 |                                                         |                          |                                 |                          | Eyelids and Face Twitch      | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      | <input type="checkbox"/> | Sleep During the Day     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
|                                                                                                                                                                                                                                                                                 | I do not suspect I have this                            | I suspect I have this    | I have been diagnosed with this |                          |                              | I do not suspect I have this | I suspect I have this                                                                                                                                                                                  | I have been diagnosed with this                               |                          |                          |                          |                          |                          |                          |
| Addison's Disease                                                                                                                                                                                                                                                               | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          | Hyperthyroidism(Overactive)  | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      |                          |                          |                          |                          |                          |                          |
| Adrenal Fatigue                                                                                                                                                                                                                                                                 | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          | Hypothyroidism(Underactive ) | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      |                          |                          |                          |                          |                          |                          |
| Chronic Fatigue                                                                                                                                                                                                                                                                 | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          | Kidney Disease               | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      |                          |                          |                          |                          |                          |                          |
| Cushing's Disease                                                                                                                                                                                                                                                               | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          | Type 2 Diabetes              | <input type="checkbox"/>     | <input type="checkbox"/>                                                                                                                                                                               | <input type="checkbox"/>                                      |                          |                          |                          |                          |                          |                          |
| High Blood Pressure                                                                                                                                                                                                                                                             | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| Polycystic Ovarian Syndrome                                                                                                                                                                                                                                                     | <input type="checkbox"/>                                | <input type="checkbox"/> | <input type="checkbox"/>        |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| <b>Which Best Describes You?</b>                                                                                                                                                                                                                                                |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| <b>Underweight <input type="checkbox"/> At Ideal weight <input type="checkbox"/> 5-20lbs Overweight <input type="checkbox"/> &gt;20lbs Overweight <input type="checkbox"/> Are you struggling to lose weight?: Yes <input type="checkbox"/> No <input type="checkbox"/></b>     |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| <b>Women</b>                                                                                                                                                                                                                                                                    |                                                         |                          |                                 |                          |                              |                              | <b>Women &amp; Men</b>                                                                                                                                                                                 |                                                               |                          |                          |                          |                          |                          |                          |
| Menstrual Cycles    None <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/><br>Ovaries Removed    None <input type="checkbox"/> One <input type="checkbox"/> Two <input type="checkbox"/><br>First day of last Menses (MM/DD/YY)_____ |                                                         |                          |                                 |                          |                              |                              | List any progesterone, estrogens, DHEA, testosterone, pregnenolone, melatonin, or cortisol you are taking and the route of administration ex: patch, transdermal cream etc.<br>_____<br>_____<br>_____ |                                                               |                          |                          |                          |                          |                          |                          |
| Pregnant                YES <input type="checkbox"/> NO <input type="checkbox"/>                                                                                                                                                                                                |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |
| Taking Birth Control    YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, what kind?_____                                                                                                                                                                        |                                                         |                          |                                 |                          |                              |                              |                                                                                                                                                                                                        |                                                               |                          |                          |                          |                          |                          |                          |

**I = Immune (70% of the Immune system in our gut)**

Was your birth: vaginal \_\_\_\_\_ c-section \_\_\_\_\_

Were you: breastfeed \_\_\_\_\_ Bottle Fed \_\_\_\_\_

How long? \_\_\_\_\_

Number of antibiotics taken in 1<sup>st</sup> year of life (if known) \_\_\_\_\_

Number of antibiotics taken as an adult(make best estimate) \_\_\_\_\_

Describe any re-occurring infections you have had trouble getting over.

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Have you had any tick bites or ever been diagnosed with Lyme, Rocky Mtn Spotted Fever, etc? No \_\_\_\_\_ Yes \_\_\_\_\_

If Yes, please describe \_\_\_\_\_

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Have you ever reacted to any vaccines? \_\_\_\_\_

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Have you travelled to any foreign countries? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, have you had any illnesses while there or shortly after returning? \_\_\_\_\_

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Have you ever lived or worked in a building with visible or suspected mold? No \_\_\_\_\_ Yes \_\_\_\_\_

Do you have frequent or re-occurring fevers? \_\_\_\_\_

Check the box for any of the following symptoms that occur more than occasionally and

rate the severity from 1= extremely mild to 10= unbearable/severe on the line after the symptom...

- |                                                                                                                 |                                                                    |                                                                                    |
|-----------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------|------------------------------------------------------------------------------------|
| <input type="checkbox"/> Indigestion _____                                                                      | <input type="checkbox"/> Bloating following meals _____            | <input type="checkbox"/> Stomach pain relieved by taking antacids _____            |
| <input type="checkbox"/> Burping _____                                                                          | <input type="checkbox"/> Stomach cramping _____                    | <input type="checkbox"/> Pain tenderness or soreness under left rib cage _____     |
| <input type="checkbox"/> Belching _____                                                                         | <input type="checkbox"/> Food feels like it just sits _____        | <input type="checkbox"/> Indigestion or fullness 2-4 hrs after eating a meal _____ |
| <input type="checkbox"/> Pain or nausea when eating _____                                                       | <input type="checkbox"/> Feel hungry 1-2 hrs after a meal _____    | <input type="checkbox"/> Stool is small, hard and dry _____                        |
| <input type="checkbox"/> Undigested food in stool _____                                                         | <input type="checkbox"/> Embarrassing stool odor _____             | <input type="checkbox"/> Passing mucous in stool _____                             |
| <input type="checkbox"/> Diarrhea _____                                                                         | <input type="checkbox"/> Bowel movement shortly after eating _____ | <input type="checkbox"/> Rectal pain, itching or cramping _____                    |
| <input type="checkbox"/> Discomfort, pain or cramps in lower abdominal area _____                               |                                                                    |                                                                                    |
| <input type="checkbox"/> Spicy, fried foods, coffee, citrus, alcohol or peppers cause stomach to ache _____     |                                                                    |                                                                                    |
| <input type="checkbox"/> Lower abdominal discomfort relieved after bowel movement or passage of gas _____       |                                                                    |                                                                                    |
| <input type="checkbox"/> Discomfort, pain or cramps in lower abdominal area _____                               |                                                                    |                                                                                    |
| <input type="checkbox"/> Eating raw fruits and vegetables causes abdominal pains, bloating, cramps or gas _____ |                                                                    |                                                                                    |
| <input type="checkbox"/> No urge to have a bowel movement _____                                                 |                                                                    |                                                                                    |
| <input type="checkbox"/> Almost continual urge to have a bowel movement _____                                   |                                                                    |                                                                                    |

## **D = Detoxification**

List medications currently taking and reason for their use.

| Medication | Reason for use | # years taken |
|------------|----------------|---------------|
|            |                |               |
|            |                |               |
|            |                |               |
|            |                |               |
|            |                |               |
|            |                |               |
|            |                |               |

List all supplements currently taking.

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## **Habits and Lifestyle**

Please note any that apply to you, now or in the past, and indicate your usage per day or week. If none apply to you, leave blank.

|                      | Per Day/Week | Age started | Age Quit |
|----------------------|--------------|-------------|----------|
| Tobacco              |              |             |          |
| Alcohol              |              |             |          |
| Coffee               |              |             |          |
| Marijuana            |              |             |          |
| Energy Drinks        |              |             |          |
| Soda                 |              |             |          |
| Artificial Sweetener |              |             |          |
| Recreational drugs   |              |             |          |

How many non tooth colored fillings do you currently have? \_\_\_\_\_ How many have you had in the past? \_\_\_\_\_

How many root canals do you have? \_\_\_\_\_ Do you have any dental implants or fixtures? \_\_\_\_\_

Is your home or work sprayed for pests? \_\_\_\_\_

Mark any product regularly used:    disinfectants    bleaches    polishes    paint

Mark any frequent exposure:    nail polish    perfume    hairspray    cosmetics    gasoline fumes    diesel fumes    exhaust

Do you have any other significant exposures? If so, please describe \_\_\_\_\_

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Any health changes noted after moving to a new home or starting a new job? \_\_\_\_\_

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**N = Neurological**

**Accidents: Auto, Work Related, Sports, Other**

| Type of Accident | Year | Complications(esp. note if concussion or head trauma) |
|------------------|------|-------------------------------------------------------|
| 1.               |      |                                                       |
| 2.               |      |                                                       |
| 3.               |      |                                                       |
| 4.               |      |                                                       |

**Any other head trauma not described above?** \_\_\_\_\_

**Do you have any problems with your TMJ or your bite?** \_\_\_\_\_ **If yes, please describe** \_\_\_\_\_

**Surgeries:**

| Surgery | Year | Reason for Surgery |
|---------|------|--------------------|
| 1.      |      |                    |
| 2.      |      |                    |
| 3.      |      |                    |
| 4.      |      |                    |
| 5.      |      |                    |

**Scars, piercings, and tattoos can cause mechanical soft tissue disturbance as well as disturb energy flow to our organs. Please describe the location of any scars, piercings, or tattoos not associated with a surgery listed above.** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Do you sleep with a clock or a cell phone in transmitting mode near the head of your bed?** No \_\_\_\_\_ Yes \_\_\_\_\_

**Do you use an electric blanket?** No \_\_\_\_\_ Yes \_\_\_\_\_

**How many hours per day are you:** In front of a computer \_\_\_\_\_ Talking on a cell phone \_\_\_\_\_

Texting or using the internet on a cell phone \_\_\_\_\_ Under florescent lighting \_\_\_\_\_ Near Wi-Fi \_\_\_\_\_

**Describe your exercise routines:** \_\_\_\_\_

\_\_\_\_\_

**Check any you have trouble with:**

\_\_\_\_\_ mood \_\_\_\_\_memory \_\_\_\_\_concentration \_\_\_\_\_making decisions

**List any past emotional traumas or stress as well any ongoing stress you feel could be affecting your health.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**\*\* If you have seen multiple doctors, please attach a sheet listing each doctor's name and the outcome of your treatment.**