Name:_____ Date: _____ ___

Date of Birth: _____ Age:_____ Ht. _____ Wt. _____ S.S #_____

❑ M ❑ F Marital Status: S M D W Name of Spouse: _____

Children's Names & Ages: _____

Occupation: _____ Stress Level: MILD MODERATE EXTREME

What do you hope to receive from this office? _____

Network
WELLNESS CENTER
33 Montecito Drive
Corte Madera, CA 94925
415-927-3909
www.networkwellness.com

Do you currently have any health concerns? **Y N** Please describe:_____

Is the reason you are consulting our office the result of an injury at work or an auto accident? **Y N**

Have you had your spine or nervous system examined professionally? **Y N** By whom? _____

What type of care given:_____Were you pleased with this service? **Y N**

Stresses that affect the spine and nervous system may be PHYSICAL, CHEMICAL or EMOTIONAL in nature. Understanding the stresses that have acted upon your spine and nervous system assist us in serving you. With each of the following potential spinal stress situations, please check all that apply.

HISTORY OF PHYSICAL STRESSES

Birth Stress: Were there any problems associated with your mother's pregnancy with you? *(check all that apply)*

❑ Falls/injury ❑ Illness ❑ Difficult

Comments:_____

Was your birth: *(check all that apply)* ❑ Traumatic ❑ "C" section ❑ Breech ❑ Forceps or suction ❑ Cord around neck

❑ Prolonged ❑ Drug induced ❑ Home ❑ Hospital ❑ Birthing center ❑ Other location

Comments:_____

General Physical Trauma: Falls: *(check all that apply & age)* ❑ Crib/carriage _____ ❑ Steps _____

❑ On ice _____ ❑ Out of tree _____ ❑ Bars at school _____ ❑ Skating _____

❑ Skiing _____ ❑ Snowboarding _____ ❑ Other falls_____

Comments: _____

❑ Knocked unconscious _____ ❑ Used crutches/cane _____ ❑ Broken bones (which ones?) _____

❑ Involved in combat _____ ❑ Physical fight _____ ❑ Physical abuse _____

❑ Involved in sports _____ ❑ Extensive dental/orthodontia _____ ❑ Other _____

Accidents, near-accidents, driver or passenger: *(check all that apply & age)*

❑ Automobile _____

❑ Motorcycle _____ ❑ Bus _____ ❑ Train _____ ❑ Bicycle _____ ❑ Plane _____ ❑ Other _____

Comments:_____

Daily Activities: *(Check all that apply)*

❑ Sit	❑ Stand	❑ Walk	❑ Do desk work	❑ Phone work	❑ Wear contacts
❑ Sports	❑ Exercise	❑ Watch TV	❑ Computer Work	❑ Play musical instrument	❑ Wear glasses
❑ Drive	❑ Read prolonged periods		❑ Mechanical work	❑ Heavy lifting	❑ Wear bifocals

Comments: _____

Medical Intervention *(Check all that apply & age)*
❑ Hospitalization *why?* _____
❑ Surgery *why?* _____
❑ Chemotherapy _____ ❑ Radiation _____ ❑ Casts/collars _____ ❑ Spinal/neck brace _____
❑ Corrective shoes, bars, lifts _____ ❑ Physical Therapy _____ ❑ Spinal tap/injections _____
❑ X-rays _____ ❑ Transfusion _____ ❑ Organ Removal _____

Comments: _____

Have you or a family member suffered a serious illness? _____
Do you have a family doctor? **Y N** Who? _____
Date of last medical consultation & result: _____
For women: Are you pregnant? **Y N** Date of last monthly period: _____
How do you grade your physical health? ❑ Excellent ❑ Good ❑ Fair ❑ Getting Better ❑ Getting Worse

HISTORY OF CHEMICAL STRESSES

Birth Stress: During your mother's pregnancy did she: *(Check all that apply)*
❑ Use prescription drugs ❑ Use nonprescription drugs ❑ Smoke ❑ Consume alcohol
At birth was your mother: *(Check all that apply)*
❑ Conscious ❑ Semi-conscious ❑ Unconscious ❑ Given spinal anesthesia ❑ Given chemicals to induce or alter labor?

General Chemical Stress: Do you or have you taken:
❑ Prescription drugs ❑ Over-the-counter drugs ❑ Antibiotics ❑ Other drugs ❑ Tobacco
Do you or have you worked with or been exposed to:
❑ Chemicals ❑ Fumes ❑ Dust ❑ Powders ❑ Smoke
Do you consume:
❑ Alcohol ❑ Coffee/caffeine ❑ Processed food ❑ Animal food ❑ Artificial sweeteners ❑ Refined sugar ❑ Tap water ❑ Sodas
Describe diet/comments: _____

HISTORY OF EMOTIONAL STRESSES

Were you incubated or isolated after birth? Y N Were you: ❑ Bottlefed ❑ Nursed ❑ Both

General emotional trauma *(Check all that apply and note severity: Mild, Moderate, Extreme)*

❑ Childhood _____	❑ Divorce/separation _____	❑ Loss of loved one _____
❑ School _____	❑ Work related _____	❑ Stress of being sick _____
❑ Recreational _____	❑ Financial _____	❑ Abuse _____
❑ Family _____	❑ Commuting _____	❑ Moving _____
❑ Parents' divorce _____	❑ Change of vocation _____	
❑ Personal relationship _____	❑ Change of lifestyle _____	

Comments: _____

Have you pursued other avenues towards growth, healing or personal development? _____

How do you grade your emotional mental health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting Better ❑ Getting Worse
How do you grade your overall quality of life? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Getting Better ❑ Getting Worse
Is there anything else you may wish to share which may help us to better understand you and why you have chosen to come to this office?