

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Fainting | <input type="checkbox"/> Neck pain |
| <input type="checkbox"/> Pins and needles in arms | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Back pain | <input type="checkbox"/> Nervousness/Irritability |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Stomach upset |
| <input type="checkbox"/> Numbness in fingers | <input type="checkbox"/> Numbness in toes | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Depression | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Sleeping problems | <input type="checkbox"/> Constipation | <input type="checkbox"/> Fever | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Lights bother eyes | <input type="checkbox"/> Problem urinating | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cold sweats | <input type="checkbox"/> Menstrual pain | <input type="checkbox"/> Menstrual irregularity | <input type="checkbox"/> Breathing conditions |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eczema | <input type="checkbox"/> Blood pressure ↓↑high/low | <input type="checkbox"/> Asthma |

The following three areas of stress can cause a misaligned vertebra (subluxation). Do you recognized any of these stresses? Please circle when you experienced these stresses. C (child), T (teenager), A (adult), or N (not at all).

PHYSICAL STRESS:

	C	T	A	N	DATE/DETAILS
Birth traumas (as a mother or child)					_____
Childhood illnesses					_____
Falls/jumps from a height of over 3 ft?					_____
Slips					_____
Car accidents					_____
Sports injuries/extreme sports					_____
Physical abuse					_____
Work injuries					_____
Poor posture					_____
Sitting on your wallet for years					_____
Sleeping position – stomach					_____
Extensive computer work					_____
Carrying heavy purse/book bag/child					_____
Repetitive lifting/bending					_____
Continuous hours sitting/standing					_____
Driving for many hours					_____
Vaccinations					_____
Surgery					_____
Bone fractures					_____

EMOTIONAL STRESS

	C	T	A	N	DATE/DETAILS
Relationships					_____
Career					_____
Children					_____
Money					_____
Fast-paced life					_____
Held-in feelings					_____
Quick tempered					_____
Verbal abuse					_____
Perfectionist					_____
Procrastinator					_____
Sickness or loss of a loved one					_____

CHEMICAL STRESS

	C	T	A	N	DATE/DETAILS
Environment, i.e., pollution					_____
Smoker – amount?					_____
Second-hand smoke					_____
Poor diet					_____
Alcohol					_____
Caffeine – (coffee/tea/soda) – amount?					_____
Chocolate					_____
Excessive sugar					_____
Artificial sweeteners					_____
Prescription drugs					_____
Over-the-counter drugs (Tylenol, Motrin)					_____

What do you feel is your primary stress and for how long?

On a scale of 1-10, describe your stress level (1= none, 10 = extreme) Occupational _____ Personal _____

On a scale of Poor, Good, Excellent, describe your Diet _____ Exercise _____ Sleep _____ General Health _____

Have you ever (or do you presently):	Past	Present		Past	Present
Bought bottled water?	<input type="checkbox"/>	<input type="checkbox"/>	Belonged to a health club?	<input type="checkbox"/>	<input type="checkbox"/>
Consumed vitamins or supplements?	<input type="checkbox"/>	<input type="checkbox"/>	Purchased any thing from a health food store?	<input type="checkbox"/>	<input type="checkbox"/>
			Bought the “better” quality food at the grocery store?	<input type="checkbox"/>	<input type="checkbox"/>