Gentle Touch CHIROPRACTIC & Wellness Center
Wellness from the Inside Out

FOUNDATION FOR WELLNESS PROFESSIONALS™
A National Non-profit Foundation

Chiropractic Acupuncture Nutrition

BODY-STRESS SURVEY

Name: _____ Date of Birth: _____
Address: _____ City: _____ State: ____ Zip: _____
Cell Phone: _____ Home Phone: _____
E-mail address: _____Are you on Medicare? _____
Occupation: _____ #Hrs. per week currently working: _____
Spouse Occupation: _____#Hrs. per week currently working: _____
Have you ever been in a fender bender? _____ Date of your most recent fender bender:_____
Other accidents? Please explain:_____

I. Circle the number of any of the following symptoms you have experienced in the past 4 months:

1. Neck Pain
2. Low Back Pain
3. Dizziness
4. Headaches
5. Tired or Fatigued
6. Wrist/Hand Pain
7. Elbow Pain
8. Shoulder Pain
9. Hip Pain
10. Knee Pain
11. Ankle/Foot Pain
12. Ringing in ears
13. Allergies
14. Digestive Trouble
15. Weight Trouble
16. Tension Across the top shoulders
17. Tingling/Numbness in Arms or Hands
18. Tingling/Numbness in Legs or Feet
19. Pain between Shoulder Blades
20. Nervousness
21. Difficulty Sleeping

Which one of the above symptoms is worse? _____ How long have you had it? _____
When it is at its worst, how does it feel? _____
What medications are you taking for it? _____

II. Circle how this causes you to act:

1. Moody 2. Irritable 3. Interrupts Sleep 4 Restricted on daily activities 5. Other_____

III. Circle how this bothers you at work: .

1. Decision Making
2. Exhausted at End of Day
3. Decreased Productivity
4. Poor Attitude
5. Unable to Work Long Hours
6. Other_____

IV. Circle how this hinders your life:

1. Lose patience with spouse or kids.
2. Hinders ability to exercise or participate in sports.
3. Restricted household duties.
4. Interferes with ability to participate in other desired activities.
5. Other_____

You could be suffering from **Excessive Stress, Structural Misalignment or Pinched Nerves.** Chiropractic Doctors treat the body gently, naturally and without drugs to remove stress and the imbalances that CAUSE health problems.

WOULD YOU LIKE TO GET RID OF THE PROBLEM? Yes_____ No_____
If your answer is YES, there are several alternatives available to you. We will discuss these options during your consultation.

A. HEALTH INFORMATION:

Describe your **major** health concern? _____
When did this health concern begin to bother you? __ ._____
Anything make the complaint feel **better** (i.e. Ice, heat, rest)? _____
Anything make the complaint feel **worse** (i.e. Driving, standing, sitting)? _____
Regarding the **pain**, check all that apply:

_____ Constant Pain	_____ Very Severe	_____ Dull, Ache	_____ Throbbing
_____ Frequent Pain	_____ Severe	_____ Stabbing, Sharp, Shooting	_____ Crawling
_____ Intermittent Pain	_____ Moderate	_____ Excruciating	_____ Stinging
_____ Occasional Pain	_____ Mild	_____ Pins and Needles	_____ Numbness

Other health conditions which concern you? _____
_____

B. MEDICAL HISTORY:

List **ALL** medications, over the counter drugs, and vitamins you currently take:

1._____	2._____	3._____
4._____	5._____	6._____
7._____	8._____	9._____
10._____	11._____	12._____

Have you ever been hospitalized or had surgery of any kind? _____

Have any organs been removed from your body i.e. Appendix, Tonsils, Adenoids, Gallbladder?
_____

Do you suffer from any of the symptoms listed below **frequently** (check all that apply)?

_____Headaches	_____Upset Stomach	_____Difficulty Breathing
_____Neck Pain/Stiffness	_____Diarrhea	_____Asthma
_____Low Back Pain	_____Constipation	_____Excessive and Dry Cough
_____Chest/Heart Trouble	_____Excessive Thirst	_____Excessive Cough with Mucus Production
_____Cold Hands/Feet	_____Hemorrhoids	_____Painful Urination
_____Depression	_____Nervousness	_____Excessive Urination
_____Fatigue	_____Stress/Tension	_____Loss of Balance/Dizziness
_____Difficulty Swallowing	_____Sleeplessness	_____Ringing in the Ears
_____Heart Burn	_____Easy Bruising	_____Loss of Memory, Smell or Taste (circle)

Who is your primary health care provider (i.e. Medical Doctor)? _____
_____

Do you or anyone in your immediate family suffer from any of these diseases (check all that apply)?
_____Diabetes _____Heart Disease, High Blood Pressure_____ Cancer _____Any other major disease

C. ADDITIONAL INFORMATION:

Describe in detail how your condition affects your day to day living? For example: Do you avoid certain work/recreational activities? Is it affecting your ability to sleep?

_____
_____
_____

Is your condition due to a _____Automobile Accident _____Job Injury _____Other?

If so please describe **in detail** what happened during the accident/ traumatic event:

_____
_____
_____

Describe **in detail** your specific health goal(s):

_____
_____
_____

How did you hear about us? _____Massage Event _____Health Talk _____Patient Referral
_____Gift Certificate _____Health Fair _____Dinner Event
Other (please specify) _____

D. SERVICES OFFERED AND POLICIES:

At Gentle Touch Chiropractic and Wellness Center we offer the following methods to restore vitality:

1. Gentile Chiropractic Adjustments
2. Medical Acupuncture
3. Nutrition Therapy
4. Hydrotherapy Massage

There are three things you need to know about our office before you agree to the consultation:

1. We don't prescribe drugs or dispense medication.
2. We don't perform surgery.
3. We don't accept every patient who comes to us for help.

By signing this form, I agree to a consultation. I have read and understood the above listed services offered and policies outlined.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name **Date**

_____

Parent, Guardian or Patient's legal representative

_____

Signature