THE NERVE HEALTH INSTITUTE
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***Acct. #*_____**

Full Name:_____ Birthdate:_____ Age:_____

Address:_____ City:_____ State:____ Zip_____

Phone# _____ Height:_____Weight_____

E-Mail:_____ SS Number:_____

Sex (circle one): MALE FEMALE Occupation:_____

Marital Status(circle one): Single Married Divorced Separated Widowed

Business/Employer:_____ Business Phone#_____

Business Address:_____ City:_____

State:_____ Zip:_____

How Were You Referred To this Office?_____

PLEASE LIST YOUR *TOP 4* COMPLAINTS

1. **Area of Complaint:_____**
   What percentage of your day would you say you feel this discomfort?_____%
   How would you describe your pain/discomfort?(please circle all that apply):
   Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
   Other_____
   What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)
   0 1 2 3 4 5 6 7 8 9 1 0

   Does anything make the pain better?
   Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around
   Resting Sitting Leaning forward Leaning to the side Laying on back Standing
   Hot Bath/Shower Other_____

   Does anything make the pain worse?
   Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting
   Moving Arms or Legs Bathing Dressing Other_____

2. **Area of Complaint:**_____

What percentage of your day would you say you feel this discomfort?_____%

How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
Other_____

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?

Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other_____

Does anything make the pain worse?

Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other_____

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3. **Area of Complaint:**_____

What percentage of your day would you say you feel this discomfort?_____%

How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
Other_____

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?

Advil(Ibuprofen) Tylenol(Acetometophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other_____

Does anything make the pain worse?

Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other_____

4. **Area of Complaint:**_____

What percentage of your day would you say you feel this discomfort?_____%

How would you describe your pain/discomfort?(please circle all that apply):

Sharp Stabbing Dull Achy Cramping Sore Tight Burning Tingling Numb
Other_____

What would you rate your pain at its worst on a scale from 0-10, with "10" being the worst possible pain and "0" being no pain at all? (please circle)

0 1 2 3 4 5 6 7 8 9 1 0

Does anything make the pain better?

Advil(Ibuprofen) Tylenol(Acetaminophen) Aleve Heating Pad Ice Moving around Resting Sitting Leaning forward Leaning to the side Laying on back Standing Hot Bath/Shower Other_____

Does anything make the pain worse?

Rising from a chair Sitting Standing Sneezing Coughing Straining during bowel movements Moving head Lifting Driving Bending Forward Twisting Moving Arms or Legs Bathing Dressing Other_____

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Please check circle the following symptoms you have had, whether PAST, CURRENT, or BOTH

Headaches	P C B	Stomach upset	P C B
Nausea	P C B	Buzz/ring in ears	P C B
Loss of smell	P C B	Depression	P C B
Neck stiff/pain	P C B	Numbness in fingers	P C B
Loss of taste	P C B	Cold feet	P C B
Loss of balance	P C B	Numbness in toes	P C B
Ulcers	P C B	Fever	P C B
Tension	P C B	Sleeping problems	P C B
Fatigue	P C B	Menstrual Pain	P C B
Dizziness	P C B	Lights bother eyes	P C B
Cold Hands	P C B	Heartburn	P C B
Irritability	P C B	Menstrual irregularity	P C B
Diarrhea	P C B	Tingling in legs	P C B
Constipation	P C B	Allergies	P C B
Cold Sweats	P C B	Sinus problems	P C B
Hot flashes	P C B	High blood pressure	P C B
Fainting	P C B	Breast problems	P C B
Urinary problems	P C B	Itching	P C B
Back pain	P C B	Bed Wetting	P C B
Asthma	P C B	Addiction	P C B
Nervousness	P C B	Swollen Glands	P C B
Arm tingling	P C B	Skin Rashes	P C B
		OTHER_____	

P=PAST C=Current B=BOTH

What medications/vitamins/supplements do you currently take daily? (please write dosage/day)

Blood Pressure Medication_____ Cholesterol Medication_____

Diabetic Medication_____ Multi-Vitamin_____

Aspirin_____ Advil_____ Tylenol_____ Ibuprofen_____ Aleve_____

Motrin_____ Acetaminophen_____ Other Medications_____

Supplements_____

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*Your nerve health level is a result of your genetics combined with all the **physical, mental/emotional, and biochemical stress** you have put your body through.*

	MOM	DAD	BROTHER 1	BROTHER 2	SISTER 1	SISTER 2
DIABETES						
HIGH BLOOD PRESSURE						
CANCER						
STROKE						
LIVING						
DECEASED						

PHYSICAL STRESS:Please list all past surgeries/hospitalizations and include the approximate date(s):

Appendectomy_____ Tonsillectomy_____ Hysterectomy_____

Gall Bladder Removal_____ Back_____ Neck_____

Hernia_____ Leg_____ Hip_____

Arm_____ Heart(please specify)_____

Other_____

Have you ever had a broken/fractured bone?___Yes ____No

**If yes, please circle and write how old you were when the fracture occurred.*

Arm(R or L)_____ Leg(R or L)_____ Hand(R or L)_____ Foot(R or L)_____

Ankle(R orL)_____ Wrist(R or L)_____ Hip(R or L)_____ Neck_____

Shoulder(R or L)_____ Middle Back_____ Lower Back_____

Rib_____Tailbone_____Other_____

Any other injuries/automobile accidents/falls whereby you remember even having minimal injuries like soreness or a cut or a bruise or stitches? If so, please list them.

_____

_____

_____

How many hours per week do you exercise?

A. I exercise 3-5 times a week.
B. I walk daily.
C. I don't exercise.
D. I want to exercise

How many hours per day do you sit at work and/or in in front of the computer or on the couch?

A. Less than 2 hours/day
B. 2-4 hours/day
C. 4-6 hours/day
D. 6-8 hours/day
E. 8-10 hours/day

How many hours do you sleep each night on average?

A. I sleep 7-9 hours/night
B. I wake up well rested
C. I wake up tired.
D. I toss and turn.
E. I stay up late.

What is your overall Mind Set?(circle more than one if applicable)

A. I have a positive outlook.
B. I have a negative outlook.
C. I am always in a bad mood.
D. I am always in a good mood.
E. I trap things inside.
F. I share easily.

EMOTIONAL/MENTAL STRESS:

1. In any point of your lifetime, has anyone close to you (family, friend, business) died that you were close to?

___Yes ____No *If yes, who and what relation?_____

2. Any history of physical, emotional, or sexual abuse throughout your lifetime?

___Yes ____No *If yes, please give general details?_____

3. Any bad relationships with family members, friends, or business associates?

___Yes ____No *If yes, please give general details?_____

4. On a scale of 1-10 describe your psychological/emotional stress levels: (1= none/ 10=extreme)

Occupational: _____ Personal: _____

BIOCHEMICAL STRESS:

Do you smoke cigarettes/cigars? ___Yes ____No
*If yes, approximately how many per day?_____

Do you drink alcohol?___Yes ____No
*If yes, approximately how many drinks per week?_____

Do you consume artificial sugars like gum, diet drinks, crystal lite, Splenda, Equal? ____Yes ____No
*If yes, approximately how many per day?_____

How many VEGETABLES do you eat each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

How many FRUITS do you eat each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

How many SODAS/SOFT DRINKS do you drink each day? (please CIRCLE)

0 1 2 3 4 5 6 7 8 +

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FEMALES ONLY: a) Are you having your monthly period right now?___Yes ____No
*If no, when was the last day (include month/year) of your last menstrual period?

_____

b) Are you pregnant?___Yes ____No
****If yes, how far along are you (weeks or months)?_____

In case of an emergency, who should we contact?
Name: _____
Home Phone #:_____
Work Phone #:_____
Relation: _____

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Now we just need your permission to continue through our process!

I consent to a professional and complete chiropractic examination and to any radiographic examination that the doctor deems necessary. I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Signature_____ Date: _____