THE NERVE HEALTH INSTITUTE
DR. CHRIS CORMIER, D.C.

108 Republic Ave. Suite B Lafayette LA 70508
phone (337) 456-6555 | email drc@nervehealthinstitute.com
www.nervehealthinstitute.com

New Patient Registration

Full Name:_____ Business/Employer:_____
Address:_____ Business Address:_____
City:_____State:____Zip:_____ Business City:_____State:___Zip_____
Home Phone# _____ Business Phone#_____
Marital Status(circle one): **Single Married Divorced Separated Widowed**
Birthdate:_____ Age:_____ Sex (circle one): **MALE FEMALE**
Social Security Number:_____ E-Mail Address:_____
Occupation:_____ Height:_____Weight_____
How Were You Referred To this Office?_____

A) We take pride in helping people to reach their optimum health and wellness. With that being said, we need an honest assessment of where you believe your **current level of health**.

- Please place an "**X**" on the scale below to mark your **current** level of health and wellness.
- Next, place a star "**W**" on the diagram indicating where **you would like to be** regarding your health and wellness.

Very challenged	Challenged	Transition	Good	Excellent
0-50	50-75	75-100	100-125	125+

1) Chief Complaints (please circle all that apply):

Headaches Neck Pain Lower Back Pain Middle Back Pain
Dizziness Weakness Shoulder Pain(RorL) Arm/Hand Pain(RorL)
Hip Pain(RorL) Leg/Foot Pain(RorL) Other_____

a) Please check (☐) the following symptoms you have had, whether **CURRENT** or **PAST** or **both**:

	Past	Current		Past	Current
Headaches	☐	☐	**Nausea**	☐	☐
Loss of smell	☐	☐	**Neck stiff/pain**	☐	☐
Loss of taste	☐	☐	**Loss of balance**	☐	☐
Ulcers	☐	☐	**Tension**	☐	☐
Fatigue	☐	☐	**Dizziness**	☐	☐
Cold Hands	☐	☐	**Irritability**	☐	☐
Diarrhea	☐	☐	**Constipation**	☐	☐
Cold Sweats	☐	☐	**Hot flashes**	☐	☐
Fainting	☐	☐	**Urinary problems**	☐	☐
Back pain	☐	☐	**Asthma**	☐	☐
Nervousness	☐	☐	**Arm tingling**	☐	☐
Stomach upset	☐	☐	**Buzz/ring in ears**	☐	☐
Depression	☐	☐	**Numbness in fingers**	☐	☐
Cold feet	☐	☐	**Numbness in toes**	☐	☐
Fever	☐	☐	**Sleeping problems**	☐	☐
Menstrual Pain	☐	☐	**Lights bother eyes**	☐	☐
Heartburn	☐	☐	**Menstrual irregularity**	☐	☐
Tingling in legs	☐	☐	**Allergies**	☐	☐
Sinus problems	☐	☐	**High blood pressure**	☐	☐

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Breast problems	☐	☐	**Itching**	☐	☐
Bed Wetting	☐	☐	**Addiction**	☐	☐
Swollen Glands	☐	☐	**Skin Rashes**	☐	☐

OTHER_____

_____

2) Is your pain/discomfort constant? ___**Yes** ____**No**

3) Is the pain/discomfort on and off (intermittent)? ___**Yes** ____**No**

4) How would you describe your pain/discomfort?(please circle all that apply):
Sharp/Stabbing **Dull** **Achy** **Cramping** **Soreness**
Other_____

5) 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 10

6) What makes your pain/discomfort worse?(please circle all that apply)

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**_____

7) Do you have any(please circle): **NUMBNESS** **TINGLING** **PAIN**
**If so, does this numbness tingling, or pain radiate/shoot into your (please circle):
Left arm/hand **Right arm/hand**
Left leg/foot **Right leg/foot**

8) What relieves or eases your pain/discomfort?(please circle all that apply)

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**_____	

9) Have you lost any time at work due to this pain/discomfort?___**Yes** ____**No**
If yes, how many days have you taken off of work?_____

10) When did this pain/discomfort begin approximately?(please circle)

Within the past 72 hours	**4-7 days ago**	**1-3 weeks ago**
1-3 months ago	**4-6 months ago**	**6-9 months ago**
Other_____	**Exact date if known:**_____	

*Have you ever experienced this pain/discomfort before?__**Yes**__**No**
-- If yes, how long ago?_____

11) What were you doing when you first noticed this pain/discomfort?(please describe**)**

_____

_____

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

Blood Pressure Medication_____ **Cholesterol Medication**_____
Diabetic Medication_____ **Multi-Vitamin**_____
Supplements_____
Aspirin_____ **Advil**_____ **Tylenol**_____ **Ibuprofen**_____ **Aleve**_____
Motrin_____ **Acetometophen**_____
Other Medications_____

13) 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.

a) **GENETICS**: Does/Did your mom, dad, brothers, or sisters suffer from any of the following?

b) (Please check the condition and also check either deceased or living.

	MOM	DAD	BROTHER1	BROTHER2	SISTER1	SISTER2
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Cancer						
Living						
Deceased						

c) **PHYSICAL STRESS:**

1. Please list/circle 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_____

2. 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**_____

3. 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.

_____
_____
_____

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4. 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

5. 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

6. How many hours do you sleep each night on average? **(please CIRCLE)**
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.

d) 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: _____

5. 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.

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e) BIOCHEMICAL STRESS:

1) Do you smoke cigarettes/cigars? ___**Yes** ____**No**
*If yes, approximately how many per day?_____

2) Do you drink alcohol?___**Yes** ____**No**
*If yes, approximately how many drinks per week?_____

3) Do you consume artificial sugars like chewing gum, diet drinks, crystal lite, Splenda, Equal, Sweet-n-low? ____**Yes** ____**No**
*If yes, approximately how many per day?_____

4) How many VEGETABLES do you eat each day? (please CIRCLE)
0 1 2 3 4 5 6 7 8+

5) How many FRUITS do you eat each day? (please CIRCLE)
0 1 2 3 4 5 6 7 8+

6) How many SODAS/SOFT DRINKS do you drink each day? (please CIRCLE)
0 1 2 3 4 5 6 7 8+

7) **Are you interested in learning what foods/drinks you should be eating/drinking based on your body's DNA**?
☐ Yes ☐ No

YOUR GOALS

At our office we pride ourselves in helping you to achieve phenomenal results with your health and wellness. In order for us to truly help you to be as healthy as possibly, it is important that we understand your goals for your overall health and wellbeing.
Please list your goals for your health and wellness in the spaces provided.

Physical Goals	Nutritional/Biochemical Goals	Psychological Goals

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20) In case of an emergency, who should we contact?

Name: _____
Home Phone #:_____
Work Phone #:_____
Relation: _____

21) **FEMALES ONLY**:

a) Are you having your monthly period right now?___**Yes** ____**No**

*If no, when was the last day (include month and year) of your last menstrual period?_____

b) Are you pregnant?___**Yes** ____**No**

****If yes, how far along are you (weeks or months)?_____

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: _____

THANK YOU FOR FILLING OUT THIS FORM.
IT IS YOUR FIRST STEP TO CREATING WELLNESS!
Present this to our staff and in a moment we will be starting our journey together!