Network Wellness Healing Center
www.spinalfreedom.com
Email: DrZev@Network-Wellness-Chiropractic.com

Manhattan East side: 420 East 81th St. Suite 1
Manhattan Midtown: 57 West 57 St, Suite 1204
Armonk, NY: 430 Bedford Road, Unit RT22, Suite 203

Name:_____ Phone: _____ Date: _____
DOB:_____Age:____Ht. _____ Wt. _____ ◉M ○F Marital Status: ☐S ☐M ☐D ☐W
Address: _____City:_____ State: ___ Zip: _____ Email: _____
Spouse/Partner: _____ Children's Names & Ages: _____
Occupation: _____ Stress Level: Mild ○ Moderate ○ Extreme ○
What do you hope to receive from this office?_____
_____
Do you currently have any health concerns? ☐Y N☐ Please describe: _____
_____
_____
Please list all of your present health goals?_____
_____
_____

_____

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)
☐On ice _____ ☐Out of tree _____ ☐Bars at school _____ ☐Steps Skating☐_____
☐Skiing _____ ☐Snowboarding _____ ☐Crib/carriage _____ ☐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 contacts
☐ Drive	☐ read prolonged periods		☐ Mechanical work	☐ Heavy lifting	☐ Wear bifocals

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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 _____
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: _____
Medications: _____
For women: Are you pregnant? ◯ Y ◯ N Date of last monthly period: _____
How do you grade your physical health? ◯ Excellent ◯ Good ◯ Fair ◉ Poor ◯ 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 _____
☐ School _____
☐ recreational _____
☐ Family _____
☐ Parents' divorce _____
☐ Personal relationship _____
☐ Divorce/separation _____
☐ Work related _____
☐ Financial _____
☐ Commuting _____
☐ Change of vocation _____
☐ Change of life style _____
☐ Loss of loved one _____
☐ Stress of being sick _____
☐ Abuse _____
☐ Moving _____

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? _____