chiropractic

Bringing Out The Best In You!

New Patient Stress History

Patient _____ Date _____

All stress can cause or contribute to subluxations. To better understand your health and well-being it is important that we review your stress history.

If you are unsure or feel uncomfortable about answering any question or if you would like to discuss things personally with the doctor please let us know. If you answer Yes to any of the questions below, please provide an explanation on the line(s) provided.

Physical, Emotional & Chemical Stress

Please check ✓ the appropriate circles	**NO**	**YES**	**DON'T KNOW**
Location of your birth ❍ hospital ❍ birthing center ❍ home			
Was your mother's pregnancy or delivery difficult/with complications?	❍	❍	❍
Was your birth ❍ induced ❍ C-section ❍ forceps ❍ breech ❍ vacuum extraction			
Did your mother smoke/drink/take medication during pregnancy?	❍	❍	❍
Were you incubated or isolated after birth?	❍	❍	❍
If yes to any of these questions, please explain _____			
Were you tossed, yanked, shaken and/or hurt as a child?	❍	❍	❍
If yes, please explain _____			
Were you vaccinated?	❍	❍	❍
Did you have any vaccine reactions?	❍	❍	❍
If yes, please explain _____			
Were you breast-fed?	❍	❍	❍
If yes, for how long? _____ years _____ months			❍
Do (or did) you have allergies?	❍	❍	❍
Do (or did) you have asthma?	❍	❍	❍
Do (or did) you have skin conditions?	❍	❍	❍
Was your childhood a happy one?	❍	❍	❍
Was it abusive?	❍	❍	❍
If yes to any of these questions, please describe _____			
Have you had extensive dental work, orthodontia or jaw problems?	❍	❍	❍
Do you have astigmatism or other visual problems?	❍	❍	❍
Do you wake up refreshed?	❍	❍	❍
How old is your mattress? _____ years			❍

This form continues on the reverse side.

Lifestyle Stresses

On a scale of 1-10 (1 least, 10 most), please rate:

Your stress from:										
Work/School	1	2	3	4	5	6	7	8	9	10
Family relationships	1	2	3	4	5	6	7	8	9	10
Loss of loved one(s)	1	2	3	4	5	6	7	8	9	10
Health problems	1	2	3	4	5	6	7	8	9	10
Other(s) _____	1	2	3	4	5	6	7	8	9	10
_____	1	2	3	4	5	6	7	8	9	10
Your physical health	1	2	3	4	5	6	7	8	9	10
Your emotional health	1	2	3	4	5	6	7	8	9	10
Your satisfaction with:										
Work	1	2	3	4	5	6	7	8	9	10
Family relationships	1	2	3	4	5	6	7	8	9	10
Achievements	1	2	3	4	5	6	7	8	9	10
Other _____	1	2	3	4	5	6	7	8	9	10
Your current overall stress level	1	2	3	4	5	6	7	8	9	10

	NO	**YES**	**Please explain or enter amount**
Is your stress constant?	❍	❍	_____
Do you think any aspects of your lifestyle contribute to your health problems?	❍	❍	_____
Describe your diet and eating habits.			
Do you keep regular hours?	❍	❍	_____
Are you presently (or have you been) active in any sport or exercise?	❍	❍	_____
Which one(s)?			_____
Have you ever been hurt exercising or playing?	❍	❍	_____
If yes, age at the time and injury			_____
Do any family members have similar problems to yours?	❍	❍	_____

Is there anything additional you'd like us to know?