

⊙ New Patient  
**Stress History**



**All stress can cause or contribute to vertebral subluxations (spinal nerve stress). 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 <input type="radio"/> hospital <input type="radio"/> birthing center <input type="radio"/> home			
Was your mother's pregnancy or delivery difficult/with complications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Was your birth <input type="radio"/> induced <input type="radio"/> C-section <input type="radio"/> forceps			
<input type="radio"/> vacuum extraction <input type="radio"/> breech			
Did your mother smoke/drink/take medication during pregnancy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you incubated or isolated after birth?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, to any of these questions, please explain _____			
_____			
Were you tossed, yanked, shaken and/or hurt as a child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, please explain _____			
_____			
Were you vaccinated?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have any vaccine reactions?	<input type="radio"/>		
If yes, please explain _____			
_____			
Were you breast-fed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If yes, for how long? _____ years    _____ months			
Do (or did) you have allergies?	<input type="radio"/>	<input type="radio"/>	
Do (or did) you have asthma?	<input type="radio"/>	<input type="radio"/>	
Do (or did) you have skin conditions?	<input type="radio"/>	<input type="radio"/>	
Was your childhood a happy one?	<input type="radio"/>	<input type="radio"/>	
Was it abusive?	<input type="radio"/>	<input type="radio"/>	
If yes to any of these questions, please describe _____			
_____			
Have you had extensive dental work, orthodontia or jaw problems?	<input type="radio"/>	<input type="radio"/>	
Do you have astigmatism or other visual problems?	<input type="radio"/>	<input type="radio"/>	
Do you get enough sleep?	<input type="radio"/>	<input type="radio"/>	
Do you wake up refreshed?	<input type="radio"/>	<input type="radio"/>	
How old is your mattress? _____			

# 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	1	2	3	4	5	6	7	8	9	10
Health problems	1	2	3	4	5	6	7	8	9	10
Other _____	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
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**Your emotional health**

1	2	3	4	5	6	7	8	9	10
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**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 stress level?**

1	2	3	4	5	6	7	8	9	10
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**NO YES Please explain or enter amount**

Is your stress constant?  NO  YES \_\_\_\_\_

Do you think any aspects of your lifestyle contribute to your health problems?  NO  YES \_\_\_\_\_

Describe your diet and eating habits.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you keep regular hours?  NO  YES \_\_\_\_\_

Do you sit at a computer or desk?  NO  YES \_\_\_\_\_

Are you presently (or have you been) active in any sport or exercise?  NO  YES \_\_\_\_\_

Which one(s)? \_\_\_\_\_

Have you ever been hurt exercising or playing?  NO  YES \_\_\_\_\_

Age at the time and injury \_\_\_\_\_

Do any family members have similar problems to yours?  NO  YES \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Notes \_\_\_\_\_

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