Today's Date____________________

PERSONAL DATA

Name ____

Age __________ Date of Birth ____________________

Parent's names (if minor)____________________________________

Address ___________________________________ City __________________ State ______ Zip ___________

Home phone (____) __________________Cell Phone(____) _______________________________

E-mail ____@____

Occupation ___________________________Employer ____

Marital Status ☐ S ☐ M ☐ D ☐ W ☐ L/W Partner Name____

Names and Ages of Children____

Whom may we thank for referring you to our office?

____

REASON FOR SEEKING CARE

What concerns do you feel we can address for you?

____

____

Are these concerns affecting your quality of life? (Please circle all that apply)

Work:	Y	N	Driving:	Y	N	Sleep:	Y	N
School:	Y	N	Walking:	Y	N	Sitting:	Y	N
Exercise/sports:	Y	N	Eating:	Y	N			

HEALTH CARE PRACTITIONER HISTORY

Have you ever received Chiropractic care? ☐ Y ☐ N Name of D.C. ___________________________________

How long under care? ☐ ______days ☐ ______weeks ☐ ______months ☐ ______ years

Date of last visit: ____________________Why did you stop care?____

Have you consulted or do you regularly consult any of the following providers? (check all that apply)

☐ Medical Physician ☐ Naturopath ☐ Acupuncturist ☐ Homeopath

☐ Massage Therapist ☐ Psychotherapist ☐ Energy Healer ☐ Dentist

Reason:____

FOR WOMEN

Are you pregnant? Y / N Date of last menstrual period: ____

If pregnant, Due Date: _____________ Name of OBGYN or Midwife______________________________________

Where will you be birthing your baby? ☐ Hospital ☐ Home ☐ Birthing Center ☐ Other_____________________

If you no longer menstruate, why? ____

The primary system in the body which coordinates health is the NERVE SYSTEM.

The vertebrae (bones of the spinal column) surround and protect the delicate NERVE SYSTEM. Injury to the SPINE and NERVE SYSTEM is a condition called VERTEBRAL SUBLUXATION. VERTEBRAL SUBLUXATION results in nerve malfunction due to vertebral/spinal misalignment.

Vertebral Subluxations can have Physical, Emotional and Chemical causes and effects.

The information below will help us to see the types of **PHYSICAL, EMOTIONAL & CHEMICAL** stresses you have been subjected to in your life, how they may relate to your present spinal, nerve and health status and whether they may have caused **Vertebral Subluxations** to occur.

PHYSICAL STRESS: BIRTH AND INFANCY

The birth process can traumatize a baby's spine and cause damage to the spine & nerve system. Please CHECK where and how you were birthed. (If you do not know, please skip to next question)

☐ Home ☐ Natural ☐ Hospital ☐ Caesarian section ☐ Forceps

☐ Breech ☐ Cord around neck ☐ Prolonged labor ☐ Drug induced labor ☐ Suction

PHYSICAL STRESS: CHILDHOOD THROUGH ADULT

The minor & often ignored repetitive physical traumas that we have endured are often too numerous to list. Please list the major traumas that you remember from your childhood up to the present.

Have you had any accidents due to any of the following? (Check all that apply)

☐ Automobile ☐ Motorcycle ☐ Bicycle ☐ Sports ☐ Playground ☐ Abuse

If yes, state type of injury and date:

____

Have you ever hurt, broken, fractured, sprained, injured or felt pain in any bones or joints (spine, head, neck, ribs, chest, upper or lower back, pelvis or hips, legs or arms)? ☐ Y ☐ N If yes, list body parts injured and dates of injuries:

____

Have you ever been hospitalized or had surgery? ☐ Y ☐ N If yes, state reason and dates:

____

Do you now or have you ever had:

- ☐ AIDS/HIV
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Backaches
- ☐ Cancer
- ☐ Concussion
- ☐ Diabetes
- ☐ Digestive Disorder
- ☐ Dizziness/Vertigo
- ☐ Emphysema
- ☐ Fractures
- ☐ Epilepsy
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Inflammatory Arthritis
- ☐ Migraine Headaches
- ☐ Other Headaches
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Neuritis
- ☐ Numbness
- ☐ Parkinson's Disease
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pinched Nerve
- ☐ Polio
- ☐ Prostrate Issues
- ☐ Rheumatoid Arthritis
- ☐ Sinus Condition
- ☐ Stroke
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers

EMOTIONAL STRESS: CHILDHOOD THROUGH ADULT

It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have ever or are experiencing any of the emotional stresses below:

- ☐ Childhood Trauma
- ☐ Work or School
- ☐ Lifestyle Change
- ☐ Loss of loved one
- ☐ Divorce/Separation
- ☐ Parents Divorce
- ☐ Abuse
- ☐ Financial ☐ Illness
- ☐ Other:____

CHEMICAL STRESS: CHILDHOOD THROUGH ADULT

Chemical stress can occur when a substance, that is toxic to the body, is breathed, injected, taken by mouth, or placed on the skin (e.g.: food allergies, drug reactions, exposure to chemicals in the air, etc.) The following will reveal exposures you may have had.

Were you vaccinated? ☐ Y ☐ N   If yes, did you have a reaction? ☐ Y ☐ N ☐Unsure

Have you been exposed to any of the following on a regular basis (either in the past or presently)?

☐ Toxic chemicals ☐ Second hand smoke ☐ Drug therapy

☐ Radiation ☐ Chemotherapy ☐ Other

If yes, please list:____

Do you have allergies or sensitivities to any foods? ☐ Y ☐ N If yes, please list:___________________________

____

Do you presently consume any of the following?

☐ Coffee/caffeine ☐ Alcohol ☐ Tobacco ☐ Over the counter drugs ✈ Prescribed drugs

Please list all medications (prescribed and over the counter):____

____

____

Note: It is imperative that you list all medications as they may have an influence on your care.

QUALITY OF LIFE (presently)

How do you grade your physical health? ☐ Good ☐ Fair ☐ Poor

How do you grade your emotional/mental health? ☐ Good ☐ Fair ☐ Poor

How do you rate your overall "quality of life"? ☐ Good ☐ Fair ☐ Poor

Do you exercise regularly? If yes, how often?

____

Do you take supplements? If yes, please list:

____

Do you follow a special dietary regime?

____

YOUR EXPECTATIONS FROM CARE

I would like to experience the following benefits from Chiropractic Care: (Check all that apply)

❒ Relief of a symptom or problem

❒ Relief and Prevention of a symptom or problem

❒ Healthier spine and nerve system

❒ Optimal health on all levels

❒ Other:____

Your Concerns

When did your symptoms appear?____

What treatment have you received for your condition?

☐ Medication ☐ Physical Therapy ☐ Chiropractic ☐ Surgery
☐ Massage ☐ Acupuncture ☐None

Other doctors you have seen for this condition:____

Rate the severity of your pain on a scale from 1 (least) to 10 (most) _______________________________________

Type of pain:

☐ Sharp ☐ Burning ☐ Dull ☐ Numbness
☐ Throbbing ☐ Tingling ☐ Aching ☐ Stiffness
☐ Shooting ☐ Other _____________ ________________

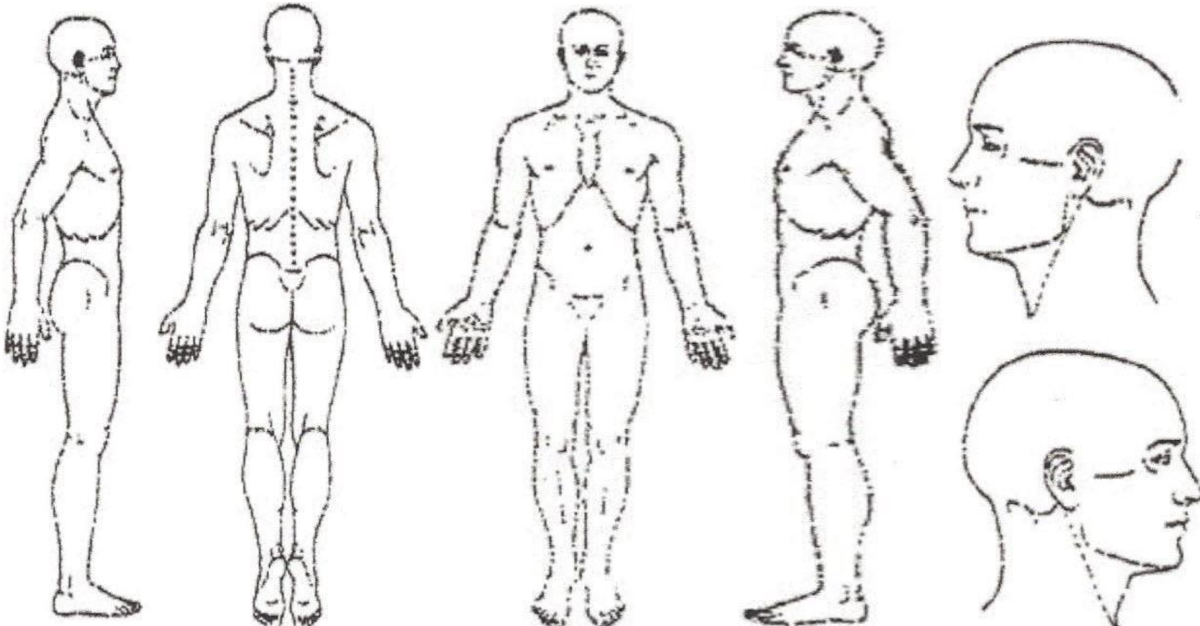
Does it interfere with:

❒ Work (0-25%) (25-50%) (50-75%) (75-100%)
❒ Sleep (0-25%) (25-50%) (50-75%) (75-100%)
❒ Daily routine (0-25%) (25-50%) (50-75%) (75-100%)
❒ Recreation (0-25%) (25-50%) (50-75%) (75-100%)

List activities or movements that are painful to perform: ____

How often do you have this pain: (circle one)Constantly Frequently Occasionally Intermittently

Please indicate on the diagram where you are experiencing your symptoms.



Payment in full is expected at the time of service.

Please Read, Mark the Boxes and Sign

- ☐ I acknowledge that Natural Living Chiropractic & Acupuncture has informed me that Dr.Jacquelyn Schorling and Dr. Amanda Butterbaugh are not in network with any insurance companies. Therefore, they cannot guarantee that claims for any services rendered to me by Natural Living Chiropractic & Acupuncture will be covered under self-made claims.

- ☐ I have been informed that a copy of Natural Living Chiropractic & Acupuncture's *"Notice of Privacy Practices for Protected Health Information (HIPAA)"* brochure is available for my review in the practice.

- ☐ I consent to receive communication from Natural Living Chriopractic & Acupuncture via email, postal mail, text and telephone messaging in connection with my care. If I should withdraw my consent, I will notify the office in writing.

- ☐ I certify that I am not now and will not be under the influence of alcohol, marijuana, or illegal substances during my office visits.

- ☐ I acknowledge that I understand the following cancellation policy:

  We understand there are times when a patient must miss an appointment. However, when you do not call to cancel, you prevent another person from utilizing that time. All cancellations require 24 hour notice. **Failure to give sufficient notice and no call/no show will result in a charge of full price of the scheduled missed service**.

The information I have provided on this case history form is true and accurate to the best of my knowledge.

I give Dr. Jacquelyn Schorling and Dr. Amanda Butterbaugh permission to render care to me today.

Name: (Printed) ____Date: ______________

Signature:____

Signature of Parent (for minor):_________________________________ Date: ______________

Thank you for choosing Natural Living Chiropractic & Acupuncture.
We look forward to helping you and your family.

Spinal Segmental Analysis

	Pain	Asymmetry	ROM Abnormal	Tension	Trigger Point	Edema	Subluxation	Listings
C0								
1								
2								
3								
4								
5								
6								
7								
T1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
L1								
L2								
L3								
L4								
L5								
S								
LI								
RI								

ROM Exam

Flexion

/60	Pain / No pain

Extension

/25	Pain / No pain

LLF

/25	Pain / No pain

RLF

/25	Pain / No pain

LR

/30	Pain / No pain

RR

/30	Pain / No pain