

# WELCOME

*Thank you for choosing our practice for your health needs. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

Date \_\_\_\_\_

## PATIENT INFORMATION

Name \_\_\_\_\_ Sex:  Female  Male Birth date \_\_\_\_\_ Age \_\_\_\_\_  
                    First                      MI                      Last

Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-Mail: \_\_\_\_\_

Do you prefer to receive call at:       Home       Work       Either

Would you like to receive announcements and newsletters by E-mail?    Y      N

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_

Marital Status:  Single       Married       Divorced       Widowed       Other

Spouse's Name \_\_\_\_\_ Spouse's Occupation \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Work Phone \_\_\_\_\_

Children's Names and Ages \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

Have you ever received chiropractic care?      Y      N

Why did you previously seek care? \_\_\_\_\_

Were you satisfied with your care and happy with the results?    Y      N

Please elaborate on the positive and negative aspects of your previous chiropractic experience: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## ABOUT YOUR HEALTH

The human body is designed to be healthy. Throughout life, events occur which can interfere with our inborn healing potential. This case history will help us identify layers of damage, that can prevent optimal health

### PRENATAL:

	Yes	No	Comments
While pregnant, did your mother:			
smoke or drink alcohol?	_____	_____	_____
eat a proper diet?	_____	_____	_____
take medications?	_____	_____	_____
exercise through pregnancy?	_____	_____	_____
have physical trauma/difficulty?	_____	_____	_____
have emotional trauma/difficulty?	_____	_____	_____
have any ultrasounds?	_____	_____	_____
have any other invasive procedures?	_____	_____	_____

### BIRTH PROCESS:

Was the delivery long?	_____	_____	_____
Was the delivery difficult?	_____	_____	_____
Forceps/Vacuum Extraction?	_____	_____	_____
Caesarean?	_____	_____	_____
Breach/Cephalic?	_____	_____	_____
Home birth?	_____	_____	_____
Hospital birth?	_____	_____	_____
Mother given drugs?	_____	_____	_____
Was labor induced?	_____	_____	_____

### GROWTH & DEVELOPMENT:

Were you breast fed?	_____	_____	_____
Childhood illnesses?	_____	_____	_____
Recurrent ear/throat infections?	_____	_____	_____
Accidents?	_____	_____	_____
Surgeries?	_____	_____	_____
Medications?	_____	_____	_____
Child abuse?	_____	_____	_____
Were you immunized?	_____	_____	_____
Broken bones?	_____	_____	_____
Any other traumas?	_____	_____	_____

### HEALTH HISTORY

Did / do you smoke?	_____	_____	_____
Did / do you drink alcohol?	_____	_____	_____
Do you eat healthy foods?	_____	_____	_____
Do you exercise regularly?	_____	_____	_____
Dental problems?	_____	_____	_____

Eye problems? \_\_\_\_\_  
 Hearing problems? \_\_\_\_\_  
 Any surgeries? \_\_\_\_\_  
 STD's or infectious diseases? \_\_\_\_\_  
 Drugs? (prescription or non) \_\_\_\_\_  
 Any automobile accidents? \_\_\_\_\_  
 Other accidents or trauma? \_\_\_\_\_  
 Hobby or sports injuries? \_\_\_\_\_  
 Occupational stress? \_\_\_\_\_  
 Physical stress? \_\_\_\_\_  
 Mental / emotional stress? \_\_\_\_\_

**WOMEN ONLY:**

Are you presently pregnant? \_\_\_\_\_  
 Any unsuccessful pregnancies? \_\_\_\_\_  
 Any menstrual problems? \_\_\_\_\_  
 Are you using birth control pills? \_\_\_\_\_  
 Are you undergoing hormone therapy? \_\_\_\_\_

**SLEEPING HABITS:**

How many hours of sleep do you get per night? \_\_\_\_\_  
 Do you sleep through the night? Y N  
 Do you wake feeling rested? Y N  
 Do you wake easily? Y N  
 Do you grind your teeth ? Y N  
 Do you wear a bite plate? Y N  
 Do you dream? Y N If yes,  Peaceful  Disturbing  
 What position do you sleep in?  Side  Stomach  Back  
 How supportive is you mattress? \_\_\_\_\_  
 Do you use a cervical pillow? Y N

**DIETARY HABITS:**

How would you describe your diet?  Excellent  Good  Poor  
 Do you eat regularly? Y N  
 Number of meals per day? \_\_\_\_\_  
 Special diet? Y N \_\_\_\_\_  
 Are you taking vitamins? Y N \_\_\_\_\_  
 Dietary supplements? Y N \_\_\_\_\_  
 Herbal supplements? Y N \_\_\_\_\_  
 Have you ever done a cleansing or detoxification program? Y N

**Have you ever been tested for (please check all that apply):**

\_\_\_\_\_ Food Allergies (immediate or delayed) \_\_\_\_\_ Adrenal Stress Syndrome  
 \_\_\_\_\_ Systemic Candida Albicans \_\_\_\_\_ Thyroid Function  
 \_\_\_\_\_ Gluten Sensitivity \_\_\_\_\_ Female Hormonal Panel (28 day)  
 \_\_\_\_\_ Parasites \_\_\_\_\_ Menopausal Hormone Panel  
 \_\_\_\_\_ Leaky Gut Syndrome \_\_\_\_\_ Other: \_\_\_\_\_

**EXERCISE HABITS:**

Do you exercise regularly?                    Y        N  
How many times per week? \_\_\_\_\_  
What type of exercise do you do? \_\_\_\_\_  
Why do you exercise? \_\_\_\_\_

**MENTAL ATTITUDE:**

How would you describe your attitude         Positive     Negative     Other  
Would you describe yourself as:     Optimist     Pessimist  
Describe your predominant emotion:     Happy     Sad     Depressed     Other  
Are you currently experiencing any type of mental or emotional stress?    Y        N  
Explain: \_\_\_\_\_  
How much personal time do you have? \_\_\_\_\_  
Do you make time to play?    Y        N  
How do you unwind? \_\_\_\_\_  
What do you like to do for fun? \_\_\_\_\_  
Parents: do you take time away from the children?    Y        N

**PRESENT STATE OF HEALTH**

Present Complaint(s) \_\_\_\_\_  
\_\_\_\_\_  
Is this complaint the result of an accident? \_\_\_\_\_  
Problem started on \_\_\_\_\_  
Symptoms are:     Sharp     Dull     Constant     Intermittent  
What makes it worse? \_\_\_\_\_  
What makes it better? \_\_\_\_\_  
Is this condition worse at certain times of the day? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_  
Does this condition interfere with work? \_\_\_\_\_ Sleep? \_\_\_\_\_ Recreation? \_\_\_\_\_  
Other doctors seen for this condition? \_\_\_\_\_  
Any home remedies? \_\_\_\_\_  
What other previous methods have you tested?  
 Exercise     Physical Therapy     Prescription Drugs     Massage     Nothing  
Were any of these previous methods effective? \_\_\_\_\_

**Other Symptoms:**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Headaches              | <input type="checkbox"/> Pins & Needles in Legs   | <input type="checkbox"/> Fainting            |
| <input type="checkbox"/> Neck Pain              | <input type="checkbox"/> Pins & Needles in Arms   | <input type="checkbox"/> Loss of Smell       |
| <input type="checkbox"/> Upper Back Pain        | <input type="checkbox"/> Numbness in Toes         | <input type="checkbox"/> Loss of Taste       |
| <input type="checkbox"/> Low Back Pain          | <input type="checkbox"/> Numbness in Fingers      | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Shoulder / Arm Pain    | <input type="checkbox"/> Coldness in Feet         | <input type="checkbox"/> Fatigue             |
| <input type="checkbox"/> Wrist / Hand Pain      | <input type="checkbox"/> Coldness in Hands        | <input type="checkbox"/> Loss of Memory      |
| <input type="checkbox"/> Leg / Knee / Foot Pain | <input type="checkbox"/> Chest Pain               | <input type="checkbox"/> Loss of Balance     |
| <input type="checkbox"/> Tension                | <input type="checkbox"/> Face Flushed             | <input type="checkbox"/> Cold Sweats         |
| <input type="checkbox"/> Irritability           | <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Ringing Ears        |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Sensitive to Light       | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Upset Stomach          | <input type="checkbox"/> Difficulty Concentrating | <input type="checkbox"/> Diarrhea            |
| <input type="checkbox"/> Sleeping problems      | <input type="checkbox"/> Buzzing in Ears          | <input type="checkbox"/> Constipation        |

Please use this section to provide any additional health related information not covered on the previous pages:

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Is there a family history of:    Heart Disease    Arthritis    Cancer    Diabetes    Other \_\_\_\_\_  
Father's Side:                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_  
Mother's Side:                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_                    \_\_\_\_\_

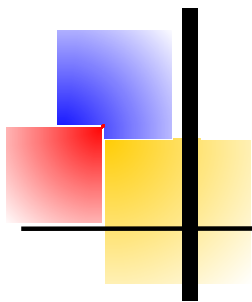
Would you like to find the cause of your problem?                    Y                    N                    Maybe

What results do you want for yourself?     Reduce Pain     Restore Health     Enhance Health

What has prevented you from finding out?     Money     Time     Other



Payment for our first day's services is due at the completion of your office visit.



# *Life Expansion Center*

*Creating Outrageous Health, Happiness and the Full Expression of Life!*

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## *A Statement of Clinical Objective*

My purpose in sharing this statement of clinical objective is to clearly define my approach to Chiropractic, healing, and those I serve in this office. I wish to clearly communicate our responsibilities in this exciting relationship.

The following concepts are central to the way in which I practice Chiropractic. I am pleased to share these ideas with you so our purpose can be in alignment from the very beginning.

- There is an intelligence within each individual which not only keeps that person alive, but also animates, coordinates, repairs, renews, empowers, and heals.
- The nervous system is a main coordinating system and distribution center for this Innate Intelligence.
- Alteration in the shape, position, tone or tension of the nervous system, at the spinal level, will block, inhibit, or redirect the expression of this intelligence.
- Spinal Subluxations are an interference to the proper functioning of the nervous system and its ability to send, receive and coordinate life force and intelligence.
- Proper coordination, repair, movement, inspiration, empowerment, healing, can not be expressed when this life power and intelligence is blocked, or redirected.
- The purpose of the professional care in this office is to assist in the reduction of spinal cord tension and associated vertebral subluxations and to develop and maintain spinal and nerve system integrity. This empowers a greater communication of this life power and coordinating intelligence. A healthier spine, nervous system and enhanced health and quality of life, is a desired outcome.
- Everyone, in spite of specific symptoms or ailments, can benefit from a more flexible, elastic, and subluxation-free spine and nervous system.
- Symptoms are not necessarily a sign of illness. They can occur to alert the individual of the need for change.
- Specific location of symptoms does not correlate to specific subluxations or areas of spinal tension needing to be adjusted. Severity of symptoms does not correlate to severity of subluxations. The reduction of symptoms is not an effective indicator of improved health.

- An individual may have symptoms and not need an adjustment on a particular visit. An individual may have no symptoms and may require extensive adjustments on a particular visit. A person's symptoms are not necessarily in direct relationship to his or her prognosis.
- I do not treat specific symptoms, conditions or ailments, other than vertebral subluxations. I do not imply that any particular adjustment or series of adjustments will have a direct effect on any symptom or condition a person may be presenting. Research studies show improved physical and emotional health and well being reported by thousands of patients receiving Network care.
- I encourage any individual having concerns about symptoms or ailments to consult with his or her physician at any time during care.
- Your Innate Intelligence is the true agent of healing, empowerment, coordination, inspiration, movement, and joy. Healing is an inside job, coordinated by the same power which develops and renews your body.
- By their very intent, various treatments may interfere with the functioning of the nervous system. This may include drugs such as pain relievers, muscle relaxers, anti-inflammatory compounds and mood altering medication. This can often prolong the time for spinal correction.
- Medication levels for a non flexible body-mind stuck in sickness are not necessarily the same as for a body becoming well.
- I will not venture into the practice of medicine by advising about the need for reduction of medication. I suggest you speak with your physician to determine the objective and goal to be obtained by receiving a particular medical treatment. Determine if this is consistent with your desire for wellness at this point in time. Your physician may guide you in changing any medication or treatments you are presently utilizing to accommodate for your changing body-mind.

Sincerely,

Dr. Lauren Cohen, DC

I \_\_\_\_\_ have read this statement of purpose, and understand its contents. I understand that the spinal adjustment offered in this office are not a replacement for any form of treatment provided by other types of practitioners. I understand that I am not being treated for any condition or symptom other than spinal tension, vertebral subluxation and the associated loss of spinal and nerve system integrity. This office offers Chiropractic as a form of health and wellness care. To promote the natural mechanisms for self healing and empowerment, as compared to specific target treatment.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_