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Confidential Personal Information

Name: ____

Address: ____

City: _____________________________ State: ______ ZIP ______________

Phone (h): (________) __________________ Cell: (________) ______________

Phone (w): (________) __________________ Fax: (________) ______________

Email: ____

Occupation: _________________________

Date of Birth: _____ / _____ / __________ Age: ______________

Circle one: Married Single Divorced Widowed

Spouse/Domestic Partner: ____

____

____

Children, names & ages (oldest to youngest): ____________________________

____

____

Comments: ____

____

____

____

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PATIENT HEALTH HISTORY

Name: ____ Date: ________________________________

Personal Health History

__ Heart disease	__ High Blood Pressure	__ Digestive Problems	__ Gall Bladder	__ Immune System
__ Urinary Bladder	__ Kidney Problems	__ Liver Problems	__ Food Cravings	__ Nervous System
__ Sexual System	__ Stomach Problems	__ Lung Problems	__ Eating Disorder	__ Cancer (if yes, what type?)
__ Muscular System	__ Diabetes	__ Depression	__ Anxiety	Type: ____________
__ Skeletal System	__ Sprains	__ Strains	__ Disc Problems	Other: ___________
__ Neck Pain	__ Mid Back Pain	__ Low Back Pain	__ Sciatica	Other: ___________

Family Health History

__ Heart disease	__ High Blood Pressure	__ Digestive Problems	__ Gall Bladder	__ Immune System
__ Urinary Bladder	__ Kidney Problems	__ Liver Problems	__ Food Cravings	__ Nervous System
__ Sexual System	__ Stomach Problems	__ Lung Problems	__ Eating Disorder	__ Cancer (if yes, what type?)
__ Muscular System	__ Diabetes	__ Depression	__ Anxiety	Type: ____________
__ Skeletal System	__ Sprains	__ Strains	__ Disc Problems	Other: ___________
__ Neck Pain	__ Mid Back Pain	__ Low Back Pain	__ Sciatica	Other: ___________

Please circle if you have ever sprained any ligaments or strained any muscles or tendons in the following areas:

Head	Neck	Shoulder	Elbow	Wrist/Hand	Finger	Toes
Mid-Back	Low-Back	Hip	Knee	Ankle/Foot	Other _____________	

What treatments did you receive and what were the results? ____

____

____

Was your birth traumatic (Forceps, Torticollis), etc.?		Yes	No
For women who have given birth, did any of your children have a traumatic birth?	N/A	Yes	No
Have you had any (serious) slips and falls in your childhood?		Yes	No
How you ever had any car accidents in your life?		Yes	No
Did you ever have an <u>injury</u> that required hospitalization?		Yes	No
Were you ever hospitalized for <u>any other reason</u>?................		Yes	No

If yes, please explain:____

Did you lose consciousness from any injury?	Yes	No
Did you ever lose consciousness for any other reason?................	Yes	No

If yes, please explain:____

Did you ever have any X-rays, MRI's or CT Scans?	Yes	No

If Yes, for what? ____

At what location? ____

Have you every fractured a bone?................	Yes	No

If Yes, what bone(s)?____

Have you ever dislocated a joint?................	Yes	No

If Yes, what joint and what was the treatment? ____

____

Exercise: ____ Minutes Type ____________ Any Difficulties _____________________________________

How much do you: smoke ______ Packs/day alcohol consumption: _______ drinks/week

coffee ______ cups/day soda ______ oz/day

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HEALTH Questionnaire

Name: ____ Date: __________________________________

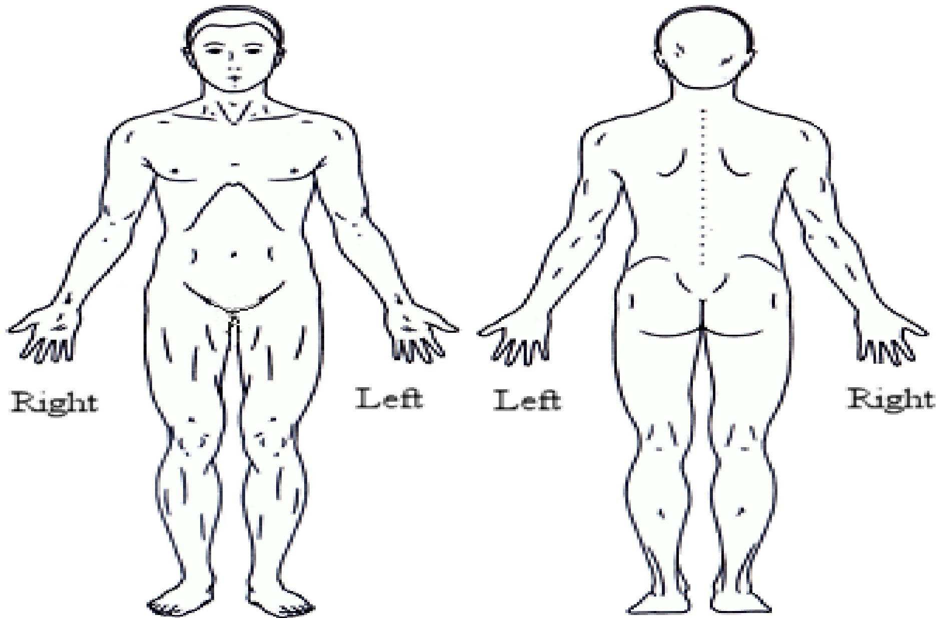
Ht._______" Wt. _______ lbs.

S: Patient reports the main reason they are here is: ____

____

Location of Problem/Pain/Dysfunction: ____

FRONT BACK



How did it happen? ____

Frequency of Problem: Constant Frequent Intermittent Every now & then Seldom

When did it happen? ____

What makes it better? ____

What makes it worse? ____

Is the pain: Sharp Dull Burning Throbbing Aching Stabbing No Feeling Other ____________

Does the pain travel? _____________________________

On a scale of 0 to 10, if 0 is pain/problem Free and 10 is Unbearable, what number would you assign the pain/problem when it is *at its worst*?

0 – No concern 1 – Slight 2 – Mild 3 – Uncomfortable 4 – Disturbing 5 – Highly Uncomfortable
6 – Distressing 7 – Increasingly Distressing 8 – Intense 9 – Extremely Intense 10 – Unbearable

Any time of day where pain is worse? ________________

Additional Symptoms / other than pain: ____

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Thank you for choosing our office for taking care of your health. We provide a variety of healthcare services. These include: Initial Consultations, Extensive Consultations, Chiropractic Adjustments, Therapeutic Muscle Stretching, Applied Kinesiology, Stress Reduction through Neuro Emotional Technique, Food Cravings and Stress Eating. We also use nutrition and homeopathy as a support for better health.

The fee for services is $75 per 20 minutes and pro-rated thereafter. Nutritional Supplements are extra and Homeopathic remedies are $25 each. For best results, focused discussion and follow-through on all recommendation is important.

For NET, I understand Dr. Strasburger's attempt to coordinate my body and nervous system are NOT the practice of psychology or psychiatry. While many patients have received wonderful results, we do not guarantee results. Insurance coverage does not apply as is true of most elective procedures.

If there are any questions, please feel free to contact our office. Thank you.