Last Name:________________________________ **First Name:**_________________________ **Date:**______________

Address:______________________________________**City:**___________________________ **Zip Code:**___________

Home Phone:___________________ **Work Phone:**___________________ **Cell Phone:**_________________________

Email:____ **Date of Birth:**___________________

Occupation:_____________________ **Social Security #**__________________________ **Marital Status:** ____________

Who referred you to our office or how did you discover the professional services we offer? _____________________

____

What health/life situation/concern(s) would you like attention to right now? __________________________________

____

____

When did you first notice this situation or concern?____

____

Please describe the quality of any sensations / symptoms related to this health situation/concern and their locations.

____

What time of day are you aware for this?____

____

What makes it worse? ____

____

What brings relief? ____

____

If pain, does it radiate? Y / N To where?____

____

What is your belief, guess or knowledge of how this happened? ____

____

What else may be involved? ____

____

What actions have you taken prior to this visit to address your concern? ____________________________________

____

Did it seem to work? ____

Are you doing anything differently because of this situation/concern? Yes / No Explain: __________________________

____

How do you feel about these changes?____

____

Is there any activity during which you totally forget about this concern? Yes / No Explain: ____________________

____

Which best describes your current attitude about yourself and your health situation/concern:

__ Sometimes I feel helpless, like little or nothing ever works.

__ This is a problem, I don't like it and I hope you can fix it for me.

__ I'm STUCK and can't figure out why.

__ I deserve more than what I have been experiencing, and I'm ready to take my healing to the next level.

Please circle all activities affected by your concern and please rate your distress about it.

(1) Slight distress (2) Moderate distress (3) Significant distress

Work	**1**	**2**	**3**
Social Life	**1**	**2**	**3**
Exercise/work	**1**	**2**	**3**
Recreation/play	**1**	**2**	**3**
Walking	**1**	**2**	**3**
Eating/digestion	**1**	**2**	**3**
Rest/Sleep	**1**	**2**	**3**
Sitting	**1**	**2**	**3**
Love/Sex life	**1**	**2**	**3**

Are you on any medications? Yes / No If so, do you feel the medication is adding to your quality of life? Yes / No

List medications & reason ____

Please list herbs, nutritional supplements or natural remedies you take regularly: ______________________________

____

Please describe what your diet consists of: ____

____

Do you drink alcohol? Yes No How often? ____

Sleep well? Yes No Comments: ____

Awaken rested? Yes No Comments: ____

Spend time outdoors? Yes No Comments: ____

Please list any aspect in your life that very much pleases you, brings joy, or helps you to feel better about yourself? ____

____

Are there any particular factors or elements about your life experiences, family, work, recreation, past injuries, dietary program, exercises, outlook, etc. that you feel impair your opportunity for full glowing health? ______________________

____

____

Are there any particular factors or elements about your life experiences, family work, recreation, past injuries, dietary program, exercises, outlook, etc. that you feel give you an edge or add to your health? ___________________________

____

____

As your spine and nervous system achieve new states of balance, flexibility & upgraded strategies for living optimally, how would you envision your life now…and in the future? ____

____

____

Your answers to the following questions will help us better assist you to participate in a program of care specifically focused on your spine, your nervous system, and your health and wellness.

When we communicate with you about your spine, nervous system, health and wellness please rate your preference in order (1,2,3).

_____ Mostly speak with me about the clinical findings. Tell me about the changes I am making.

_____ Mostly show me in written form the clinical findings. Let me see the changes that I am making.

_____ Mostly let me get a sense of the clinical work. Help me to feel the difference in my body.

Of only these qualities which would best describe you? (check only one) ___ Assertive ___ Compliant ___ Withdrawn

Of only these three choices which would be your GREATEST motivator? (check only one) ___ Fear ___ Anger ___ Image

Is there anything else which may help us to better understand you, your history, or your professional needs, that have not been addressed on this survey? Please explain: ____

____

____

Thank you for choosing our Network Spinal office. We are looking forward to helping you to become successful in your ability to develop new strategies for a healthy spine, nervous system, and life. We are excited for the opportunity to assisting you as you embark on this leg of your journey towards greater health and wellness.

Signature____ Date (MM/DD/YYYY) ________________

Abbruzzese Wellness ~ Where Wellness Is the Way

Name:____ Date:____________________

Answer each of the following below by checking the box(s) that best represents you at this time in your life.

PHYSICAL STATE	Never	Rarely	Occasionally	Regularly	Constantly
Presence of physical pain (neck/backache, soreness)					
Feeling of tension or stiffness or lack of flexibility in your spine					
Fatigue or low energy					
Colds and flu					
Headaches (of any kind)					
Nausea or constipation					
(Females Only) Menstrual discomfort					
Allergies or skin rashes					
Dizziness or light-headedness					
Accidents or near accidents or falling/tripping					

MENTAL/EMOTIONAL STATE	Never	Rarely	Occasionally	Regularly	Constantly
If pain is present, how distressed are you about it?					
Presence of negative/critical feelings about yourself?					
Experience of moodiness, temper, or outbursts					
Experience of depression or lack of interest					
Being overly worries about small things					
Difficulty thinking or concentrating or indecisiveness					
Experience of vague fears or anxiety					
Being fidgety or restless; difficulty sitting/being still					
Difficulty falling or staying asleep					
Experience of recurring thoughts or dreams					

STRESS LEVEL	None	Slight	Moderate	Pronounced	Extensive
Family					
Significant Relationship					
Health					
Finances					
Sexual Connection					
Work/Career/School					
General well-being					
Emotional well-being					
Coping with daily challenges					

LIFE ENJOYMENT	Not at all	Slight	Moderate	Considerable	Extensive
Openness to guidance from your inner voice/feelings					
Experience of relaxation, ease or well-being					
Positive feelings about yourself					
Feeling open and connected when relating to others					
Interest in maintaining a healthy lifestyle					
Confidence in your ability to deal with adversity					
Satisfaction with amount and quality of recreation in your life					
Feeling joy or happiness					

OVERALL QUALITY OF LIFE	Unhappy	Mixed	Mostly Satisfied	Pleased	Delighted
Personal Life					
Relationship with significant other and/or primary relationships					
Co-workers					
The job you actually do					
The way you handle problems in your life					
Your physical appearance/how you look to yourself					
Your ability to adjust to change your life					

SKIP THIS SECTION IF TODAY IS YOUR FIRST VISIT IN THIS OFFICE

ANSWER THESE QUESTIONS IN COMPARISON TO WHEN YOU FIRST CAME TO THE OFFICE FOR CARE.

OVERALL AWARNESS	Better	Same	Worse	More creative responses	Aware of more choices
My overall physical well-being is…					
My overall mental state is…					
My overall emotional state is…					
My overall ability handling stress is…					
My overall life enjoyment is…					
Overall my quality of life is…					