Today's Date_____

Spinal Resonance Chiropractic

Would you like to receive our E-Newsletter via your email? It is filled with great information on natural healing, health maintenance, health politics and more! You will also recieve the office hours schedule and any specials we may have. It is sent once per month.
Email address to send the E-Newsletter to:

_____

Welcome to our Chiropractic Office!

General Information

Name_____Address_____

City_____State_____Zip_____Home Phone_____Birthdate_____

Business Phone_____Marital Status_____No. of Children_____Occupation_____

Who were you referred by or how did you hear of our services?

_____

Insurance Information

Many insurance companies offer Chiropractic coverage. We accept assignment of benefits on your policy's "out of network" plan which is subject to a deductible. Before we can accept insurance assignment, your company must be called and verified for coverage by our office.

Company_____Phone_____Social Security #_____

Policy or Group #_____Name of the Insured person_____

Relationship to you_____

History

I have___have not___seen a Chiropractor in the past. The doctor's name is_____

My last Chiropractic visit was _____and I received care for a period of_____. I have received approximately___months___years___ of Chiropractic care in my lifetime.

The types of Chiropractic adjustments I have received are

_____

The reason I stopped care with my previous Chiropractor is

_____

I have participated in the following healing modalities: Network Chiropractic_____

Bodywork_____Massage_____Cranial Work_____

Osteopathy_____Meditation_____Psychotherapy_____

Exercise_____Yoga_____Rebirthing/breath work_____

Prayer_____Other_____

_____

History Continued

Our practice of Spinal Resonance Chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress your body can not properly adapt to or recover from, and may be physcial, chemical or emotional in nature.

What I hope to obtain from care with Dr. William Trebing and Spinal Resonance Chiropractic

_____

_____

For each of the following, please indicate the level of experience with each using 1 for mild, 2 for moderate, and 3 for severe

Facts I know about my birth, such as; My mother was ill while pregnant____my mother had a difficult delivery____my delivery was induced____I was a "C" section____I was breech____forceps or suction was used to remove me____my mother experienced physical trauma prior to my birth____my mother experienced chemical dependancy or trauma prior to my birth____my mother experienced emotional trauma while pregnant_____

I have experienced the following physical trauma: Falls on stairs____Falls on Ice____Sports Impacts____

Physical fights____been knocked unconscious____had broken bones____other_____

_____

I am involved in the following sporting activities_____

I have been injured in these activities as follows_____

_____

Postural Aspects

please check which ever apply to your lifestyle

Sleeping on stomach____restless sleep____Insomnia____prolonged periods of driving____extended sitting at work____desk job with extended computer work____use head to hold phone receiver____prolonged periods of standing____much heavy lifting____physical labor____more than 1 hour of TV at a time____

Auto Accidents

Have you ever been involved in a vehicular collision or near collision? Even if you were a passanger and do not think you were hurt, please list approximate dates and severity using Mild, Moderate, or Severe.

Car accidents_____

_____

Bus, bike, motorcycle, train, plane, or other accidents_____

_____

Medical Treatments

I Have been hospitalized for_____

_____

I have had the following operative surgery_____

_____

I have experienced the following; Spinal tap____C-Section____Spinal injections____Phyical Therapy____ bone casting/Spinal braces____Traction____Heel lifts____X-Rays____Radiation____Chemotherapy____ Transfusions____more than 12 lifetime prescriptions of antibiotics____Electircal shock therapy____ vaccinations____Hormone therapy____Prosac____Valium____Ritalin____

*Other medications I am now taking*_____

*Reasons for taking this medication*_____

*Medications I have previously taken*_____

General Chemical Stress

*Mother consumed alcohol during pregnancy with me____Mother smoked during pregnancy____Mother took prescription or other drugs during pregnancy____Mothers labor was chemically induced____Other chemical stress my mother was subject to during pregnancy*_____

I work with the following chemical stress daily (fumes, sprays, dusts, powders, smoke, etc.) _____

_____

*My diet can be classified as: Vegan____Vegetarian____Mostly Vegetarian, Fish only____No Beef____ No Dairy____No wheat____No Salt____No Sugar____No fats____No fired food____Organic only____ Food allergies I know of*_____

Please indicate D for daily or W for weekly consumption. Simply leave blank if you do not use a category; Alcohol____Coffee____Tea____Tobacco____Other smoking products____Soda____ Diet foods____Sugar____Eggs____Raw fruits and vegetables____Whole grains(oats, millet, rice etc.)____ Milk and cheese products____Fried foods____Beef____Chicken____Fish____White flour products (white bread, pastry, etc.)____Nuts____Dried fruits____Chocolate____Chips____Candy____Condiments____

General Emotional Stress

I have experienced ; Hospital birth____Home birth____Incubation or isolation after birth____Breast feeding____Bottle Feeding____Extreme Childhood stress____Moderate Childhood stress____Sexual abuse from family member____Sexual abuse from other source____Rape____Extreme daily family stress____Moderate daily family stress____Extreme stress with my children____Moderate stress with my children____Ongoing stress with my personal relationships____Stress of loneliness____Sexual performance stress____Ongoing stress of personal illness____Ongoing stress of care taking of others illness____Occupation related emotional stress____Untimely loss of a loved one____Extreme verbal abuse____Moderate verbal abuse____Personal outbursts of uncontrolled emotional releases____Prolonged depression____Mood swings____

I feel my overall physical health is excellent____good____fair____poor____getting better____getting worse____

I feel my overall emotional health is excellent____good____fair____poor____Getting better____getting worse____

*I consider myself ill because*_____

_____

*I consider myself well because*_____

_____

*I note here anything else that has not been discussed which may help you understand me better*_____

_____

_____

_____

I understand that all fees are due and payable by me at the time of service; unless in the event of accepted insurance assignment, where fees would only be due if my insurance company did not pay the doctor. I understand that co-insurance and deductible fees will be charged to me in the case of insurance assignment.

*Printed Name*_____*Signature*_____

There are no substitutes for quality Chiropractic Adjustments

Spinal
Resonance
Chiropractic