The Soloman Center

Danielle Stetzel D.C.

First Name: Mid.Init: Last Name:

_____ _____

Address:

_____

City: State: Zip Code:

_____ _____ _____

Cell Phone: Business Phone:

_____ _____

EMAIL: Marital Status:

_____ ☐Married ☐Single ☐Widowed ☐Divorced

Date of Birth: (Month/Day/Year) Name of Spouse/Partner:

_____ _____

Occupation: Do you have children? Number of children:

_____ ☐Yes ☐No _____

Names & D.O.B. of Children:

_____

How were you referred to Soloman Chiropractic & what its your primary reason for visiting?

_____

Part I: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Do you have any current health or spinal concerns? If so, please describe:

_____

_____

2. When did this situation or concern begin?

_____

3. Have you done anything about this concern or gotten any advice or treatment for it?

☐Yes ☐No

If yes, what were you told and what was done?

_____

4. Did it seem to work? ☐Yes ☐No

5. How aware of this are you during the day? 0 1 2 3 At night? 0 1 2 3

6. Is there any activity that makes you more aware of it?

_____

7. Do you think this is the sole cause? ☐Yes ☐No

If no, what else is involved?_____

8. Which best describes your current feeling about yourself or your situation? (Please circle all that applies):

a) I feel helpless, like little or nothing works.
b) This is terrible, really bad, I'm scared, and hope you can fix it for me.
c) I feel stuck, and can't help myself right now.
d) I deserve more than what I have been experiencing, and would like assistance in achieving that.
e) Anything else?

9. What is your level of commitment to yourself, your life, and your journey to Optimal Living?

High ☐ Medium☐ Low☐

What would you like to receive from this care?

_____

Part II: Health/Trauma/Medical/Chiropractic and Healing History:

1. Have you injured your spine (neck, head, back, hips)? ☐ Yes ☐ No
   a. Date of **most significant** injury: _____
   b. What happened? _____
   c. Date of **most recent** injury:_____
   d. What happened? _____
2. Please list any drugs(prescription, non-prescription, or recreational) you have taken within the past 60 days:

   _____
3. In the past, have you taken other medications for a period of more than 3 months? ☐ Yes ☐ No
   a. What did you take?_____
   b. What was the reason for taking this medication?_____
4. Have you had any spinal X-rays, CAT scans or MRI imaging of your spine (neck, head, back, hips)?

   ☐ Yes ☐ No

   A. When? _____
   B. What were you told about them? _____
5. Have you had any surgeries? ☐ Yes ☐ No

   Please explain: _____
6. Have you broken any bones, or significantly sprained part of your body? ☐ Yes ☐ No

   Please explain: _____
7. Have you had a work **and/or** auto collision related injury? ☐ Yes ☐ No

   When/what happened?_____
8. Do you have any history of:
   a. Cardiovascular disease_____
   b. Bowl/bladder dysfunction_____
   c. Reproductive dysfuction_____
      i. Women- Regular menstrual cycle_____
   d. Substance abuse(self or family)_____
   e. Physical or emotional abuse_____
10. Do you consult with a physician or any other health care provider for other than routine evaluations?

    ☐ Yes ☐ No

    a. What is the reason for the visit(s)?_____
    b. When was your last visit?_____
    c. What has been done or suggested?_____
11. Please describe your sleep habits:

    Do you sleep: ☐ Heavily ☐ Moderately ☐ Lightly
12. Please check the boxes that apply to sleep difficulties:

    ☐ Falling asleep ☐ Staying asleep

    ☐ Sleeping with sound/noise around me

    ☐ I need white noise to sleep

    ☐ Sleeping with others in the room ☐ Sleeping with the lights on

    ☐ I have no difficulty sleeping

Emotional stressors: (Please circle)

Relationships? Work? Children/family? Finances? Quick tempered? Hold in feelings? Perfectionist? Procrastinator? Illness or loss of a loved one? Depression? Suicidal thoughts? Anxiety? Fears? PTSD? Abuse?

Chemical stressors: (Please circle)

Have you been exposed to large amounts of: Industrial pollutants? Cigarettes? Second hand smoke? Junk food? Caffeine? Artificial sweeteners? Drugs of any kind? Vaccines? Cosmetics and hair dyes? Cleaning solutions? Pesticides? Herbicides? Other_____

For Women:

Are you pregnant? Y/N Currently nursing? Y/N On birth control? Y/N Excessive menstrual flow: Y/N

Irregular cycles: Y/N Extreme cramping: Y/N

Are you going through menopause: Y/N If so, any symptoms _____

Stress History:

Rate your stress levels in the last year. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Rate your stress levels over your lifetime. (low) 1 2 3 4 5 6 7 8 9 10 (high)

Is there anything else you feel is relevant for the doctor to know about you?

_____

_____

Why Chiropractic? People go to Chiropractor for a variety of reasons. Some go for symptomatic relief of pain or discomfort(Relief Care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved.(Corrective Care). Your Doctor will weigh your needs and desires when recommending your treatment program. Please circle the type of care that best meets your needs.

Relief Care

Relief Care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time but is more lasting.

I authorize Soloman Chiropractic Center to render necessary services to me and understand that I am responsible for all charges incurred.

Patient Signature: _____ Date:_____

Parent or Legal Guardian Authorizing Care:

THANK YOU FOR ALLOWING US TO SERVE YOU!