



Spinal Wellness Center
of Ithaca
Pierre Gremaud, DC



114 1/2 W. Buffalo Street • Ithaca, New York 14850 • (607) 277-2570 • www.SpinalWellnessIthaca.com

Email: _____ Date: _____

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Home Phone: _____ Business Phone: _____

Date of Birth: _____ Age: _____ Male Female Marital Status: _____ No. of Children: _____

Social Security Number: _____ Insurance: _____

How did you hear about our Office and Chiropractic? _____

Please answer the following questions about your personal history:

Have you ever had your spine or nervous system examined professionally? _____

If Yes, when, and by whom? _____

Have you received chiropractic spinal adjustments by a Doctor of Chiropractic? _____

If Yes, when was your last visit? _____ For how long were you receiving chiropractic adjustments? _____

How often did you go? _____ If you stopped, why did you stop going? _____

Do you know what type of adjustments the chiropractor performed, or what technique(s) or methods he or she used? _____

Were you pleased with his or her service? _____

Does your immediate family receive chiropractic adjustments? _____

Have you had, or do you receive the following vehicles towards growth and development?

If Yes, please list when and any comments you wish to share:

Chiropractic: _____

Bodywork / massage: _____

Osteopathy / cranial work: _____

Meditation: _____ Yoga: _____

Movement or exercise: _____

Psychotherapy: _____

Rebirthing / breathwork: _____

Prayer: _____

Other: _____

Do you currently have any health concerns? Please describe. _____

What do you hope to receive from care in this office? _____

The practice of chiropractic is based upon the location and adjustment of vertebral subluxations. These spinal subluxations are caused by any stress your body can not properly perceive, adapt to or recover from. These stresses may be **PHYSICAL, CHEMICAL, or EMOTIONAL** in nature.

PHYSICAL HISTORY:

BIRTH STRESS: *If you have information about your birth history:*

Was your mother outwardly ill prior to her pregnancy with you? Yes No
 Did your mother have a difficult pregnancy with you? Yes No
 Did your mother have any falls, accidents or physical injuries during pregnancy? Yes No
 Was your delivery traumatic? Yes No
 Was your delivery: drug induced forceps or suction
 "C" section cord around the neck
 breech prolonged
 Other _____

Was there any other physical or mechanical stress to mother or you as labor progressed, delivery progressed, or as a newborn? Yes No

GENERAL PHYSICAL TRAUMA: *Give dates when at all possible.*

Next to the potential cause of vertebral subluxations is provided a space for a check mark. Please write in appropriate space either "P" for past or "C" for current under the correct level of trauma: Mild, Moderate, or Extreme.

	Mild		Moderate		Extreme			Mild		Moderate		Extreme	
	P	C	P	C	P	C		P	C	P	C	P	C
Falls from crib, carriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sports impacts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls down or up steps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Physical Fight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Falls on ice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Armed services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

Were you ever knocked unconscious? Yes No

Comments: _____

Have you ever used crutches, a walker, or cane? Yes No

Comments: _____

Have you ever broken any bones? Yes No

Comments: _____

Have you ever had any impacts, falls or jolts that you feel specifically may have injured your spine? Yes No

Comments: _____

Have you had extensive dental work performed? Yes No

Orthodontal work? Yes No

During the day I: sit stand walk do desk work
 drive do mechanical work heavy lifting phone work

I exercise: daily weekly monthly

SPORTS or LEISURE:

Were you, or are you active in any particular sport(s)? Yes No

Which one(s)? _____

Have you been hurt in any of these activities? Yes No

Comments: _____

Do you read for prolonged periods? Yes No

Do you play a musical instrument? Yes No

Do you have a particular position for watching television? Yes No

Comments: _____

I wear: glasses Bifocals contact lenses

AUTOMOBILE ACCIDENTS:

Have you, (even as a passenger, even if you do not think you were hurt), been involved in a vehicular collision / near collision?
Please list approximate dates and severity (Mild, Moderate or Extreme)?

Automobile: _____

Bus, bicycle, motorcycle, train, airplane, moped, or other vehicles: _____

MEDICAL TREATMENT: *Please give dates.*

Have you ever been hospitalized? Yes No

If Yes, what was actually done to you? _____

Have you had surgery? _____

Do you still have all your body parts? _____

Have you had:

a spinal tap <input type="checkbox"/>	spinal injections <input type="checkbox"/>	physiotherapy <input type="checkbox"/>
neck collar <input type="checkbox"/>	spinal brace <input type="checkbox"/>	traction <input type="checkbox"/>
heel lift <input type="checkbox"/>	X-ray treatments <input type="checkbox"/>	corrective shoes or bars on shoes <input type="checkbox"/>
extensive diagnostic X-rays <input type="checkbox"/>	Acupuncture <input type="checkbox"/>	Chemotherapy <input type="checkbox"/>
transfusion <input type="checkbox"/>	bone in a cast or immobilized <input type="checkbox"/>	

CHEMICAL HISTORY:

BIRTH STRESS:

Was your mother regularly taking any drug prior to or during her pregnancy with you? Alcohol Smoking

Was her labor chemically induced or altered? Yes No

During your delivery, was your mother: conscious semiconscious unconscious

Any other chemical stress that your mother may have been subject to: _____

GENERAL CHEMICAL TRAUMA:

Are you now taking any drug (prescription or over-the-counter) regularly? Please list: _____

Are these drugs being prescribed by a physician? _____ Last visit: _____

Were you previously taking any medication regularly? _____

Do you work with any chemical, fume, dust, powder, smoke for prolonged periods? _____

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

- O - *Do not consume this*
- M - *Consume this monthly*
- FM - *Consume a few times per month (less than weekly)*
- FD - *Consume this a few times per day*
- W - *Consume this weekly*
- FW - *Consume this a few times per week*
- D - *Consume this daily*

Alcohol _____	Eggs _____	Beef _____
Coffee _____	Cooked, canned vegetables _____	Poultry _____
Tobacco _____	Raw Vegetables _____	Fish _____
Artificial Sweeteners _____	Fruit _____	Seafood _____
Soda _____	Whole Grains _____	Weight Control Diet _____
Diet Food _____	Dairy (milk products) _____	Fasting _____
Refined Sugar _____	Fried Foods _____	Organic Foods _____

The type of diet I usually follow is classified as: _____

EMOTIONAL HISTORY:

BIRTH STRESS:

My birth was: at home in a Birthing Center in a hospital

Were you incubated or isolated after birth: _____

Were you: bottle fed formula bottle fed mother's milk nursed nursed and bottle fed

GENERAL EMOTIONAL TRAUMA:

With each of the following spinal stress situations, please check either "P" for Past or "C" for current.

	Mild		Moderate		Extreme			Mild		Moderate		Extreme	
	P	C	P	C	P	C		P	C	P	C	P	C
Childhood stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Work related stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
School stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stress of commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Play or recreational	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in lifestyle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Change in vocation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress of being sick	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How do you grade your physical health? Excellent Good Fair Poor
 Getting Better Getting Worse

How do you grade your emotional-mental health? Excellent Good Fair Poor
 Getting Better Getting Worse

If you consider yourself ill, why do you feel you are ill? _____

If you consider yourself well, why do you feel you are well?

Is there anything else which may help to better understand you which has not been discussed? _____

Symptom Chart

Name: _____ Date: _____

What is your current weight: _____ lbs. Height: _____ Feet _____ Inches.

ABOUT YOU:

Please describe your present condition as you understand it:

Signature: _____ Date: _____

SHOW US WHERE IT HURTS:

Please mark area(s) of injury or discomfort as shown in the example below. Mark all areas with appropriate symbols and indicate the degree of pain using a scale from 1 (discomfort) to 10 (extreme pain)

Description →
Symbol →

Numbness
NNNN

Pins & Needles
PPPP

Burning
BBBB

Aching
AAAA

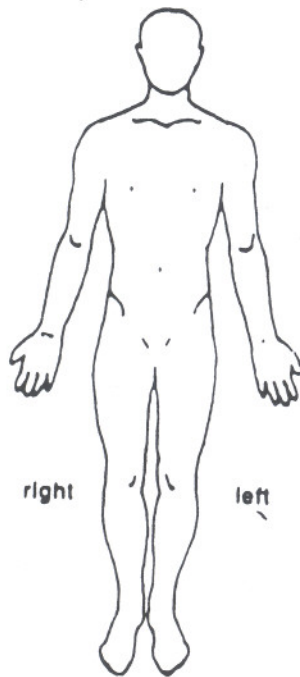
Stabbing
SSSS



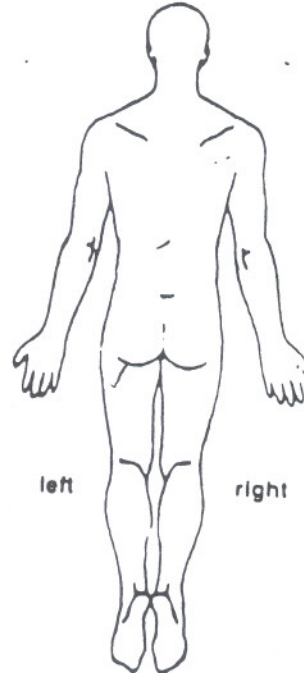
Example



Right



Front



Back



Left

Please tell us when and how often these symptoms happen:

How long has this been going on? _____

Describe how your movements or activities are presently affected:
