Dr. Maura Davis & Dr. Jessica Roan
Marcelle Racine L.M.T.
105 Washington St., North Easton, MA 02356
(508) 230-2323

Name_________________________________ Today's Date ____________
Social Security # ____________________________ Date of Birth ____________
Address ____
Phone # (H) ________________________(C) ______________________
(W) ________________________ E-mail ______________________
Have you received previous chiropractic care? __________________________
Who may we thank for referring you? ______________________________
Employer / Occupation _______________________________________
Marital Status: S M D W Spouse's Name_______________Employer ____________
Children : Previous Chiropractic Care?
Name ________________Age ______ Y N Reason ______________
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Your body is designed to be healthy. Throughout life, stresses and traumatic events occur that affect your spine/nerve system and therefore your health expression. Understanding the physical, chemical and emotional stresses that have acted upon your spine and nerve system assists us in serving you.

Let's begin at birth when you may have had stress placed on your spine & nerve system.

(Birth – Age 5)

Your Mother's Pregnancy - Did your mother: **(Check all that apply)**
___Smoke ___ Drink alcohol ___Have a proper diet ___Exercise
___Experience any falls or injuries ___Experience any physical and/or mental abuse?
Comments: ____

Your Birth Process - Was your birth: **(Check all that apply)**
___Traumatic ___Long ___Forceps used ___C-section ___Breach ___Home birth ___Hospital birth
___Mother given drugs during delivery (Epidural, etc.) ___Was labor induced ___Premature?
Comments: ____

Your Growth & Development - Were you:
___Breast-fed ___Vaccinated?
Any major childhood illnesses?_____________________Accidents?_________________
Surgeries?_________________________Drugs/prescriptions?_________________
Child abuse?_________________________Physically disciplined?_________________
Other traumas? What? When?______________________________________
____

As you increased the layers of stresses you probably began to experience symptoms.

(Age 5 – Present)

Did/do you smoke?____________________Did/do you drink any alcohol?____________________
Diet (do you eat healthy foods)?________________Exercise regularly?____________________
Interrupted Sleep patterns?__________________________Sleeping posture: Side Stomach Back
Drugs? (Prescriptive or non-prescriptive)_________________________________
Did/do you have occupational stress?_________________________________
Physical stress?____
Mental/emotional stress?____
Have you been in accidents?____
Have you had surgery?____
Jaw/teeth problems?______________Eye problems?______________Hearing problems?______________
Hobbies/Sports injuries?________________________Other traumas?____________________
Comments: ____
____

Accumulations of physical, chemical and emotional stress can show up as acute or chronic symptoms.

Present Concern:

____

Concern began: ____

If there is pain associated with concern please elaborate.______________________

Is your concern progressing in any way?______________________________

Other Healthcare Providers seen for this concern?______________________

Any home remedies?____

Other symptoms/concerns: (Please Circle where Applicable)

Headaches	Stiff Neck	Pins & Needles in Legs	Pins & Needles in Arms
Numbness in Fingers	Numbness in Toes	Shortness of Breath	Buzzing in Ears
Fatigue	Depression	Lights Bother Eyes	Loss of Memory
Ears Ring	Neck Pain	Sleeping Problems	Back Pain
Nervousness	Tension	Irritability	Chest Pain
Dizziness	Fever	Fainting	Loss of Smell
Loss of Taste	Diarrhea	Constipation	Feet Cold
Hands Cold	Stomach Upset	Cold Sweats	Difficulty Balancing
Digestive Concerns	Nausea	Mood Changes	Cognitive Concerns

Have you sought medical care for any of the above?______________________

If so, how was the issue corrected?______________________________

If you are presently taking medications, Please List.______________________

Comments ____

____

Is there a family history of:	Heart Disease	Arthritis	Cancer	Diabetes	Other______
Father's Side	( )	( )	( )	( )	( )____________________
Mother's Side	( )	( )	( )	( )	( )____________________

As a result of becoming a practice member, I would like to (please check all that apply)

( ) Address my present concern only.
( ) Address my present concern and prevent its return.
( ) Work toward a healthier body by keeping my nerve system healthy
( ) Live an overall healthier lifestyle

Please rate your level of commitment to achieving your goals:

1 2 3 4 5 6 7 8 9 10

Not motivated Very Motivated

Patient
Signature______________________________ Date______________________