



DIRECTIONS

(Across the street from the Marshalls, Panera Bakery and Blockbuster strip mall and right next to the Staples and the Shrewsbury Library. Avenue At The Commons is right off Route 35.)

If you are taking route 35 coming from the South

You would make a right onto Avenue At The Commons right before you reach the Staples on Route 35.

You will see a sign for building #179. You can pull in there or make a left at the entrance after the building #179 entrance. Park anywhere in front of building #167 (the sign is on the front of the building) and take the elevator to the second floor. Then, just follow the hallway signs to our office.

If you are coming from the North on Route 35

You would make a left onto Avenue At The Commons right after you reach the Staples on Route 35.

You will see a sign for building #179. You can pull in there or make a left at the entrance after the building #179 entrance. Park anywhere in front of building #167 (the sign is on the front of the building) and take the elevator to the second floor. Then, just follow the hallway signs to our office.

And, just in case you were wondering, our office offers...

➤ Chiropractic Biophysics Technique	➤ Wellness and Lifestyle Programs
➤ Spinal Curve Restoration Traction Therapy	➤ Massage Therapy
➤ Egoscue Method™ Exercise Therapy	➤ Nutrition and Dietary Patient Education
➤ Spinal Decompression Therapy	
➤ Cold Laser Therapy	

Our phone number is... **732 542-2000**



See you at the office!!!



Help Us Understand Your Health And Wellness Goals

Choosing Chiropractic care is an exciting step towards regaining or improving your health and wellness. Old injuries, emotional tension, work and family situations along with poor dietary choices add to your daily stress load. This can cause muscles to overreact and joints within the spine to lock. However, our greatest concern is when those ongoing stressful habits affect the inner nerve connections, leaving you at risk for deeper health problems. Unwinding harmful spinal stress while coaching you towards a strong and vibrant lifestyle is what we love to do!

Our office uses a sophisticated scanning system to detect hidden stress patterns. This accurate, computer-based analysis rates your stress on a scale from 0-100 and is known as the **COREscore™**.

Please answer the following questions so we may better understand how to help you:

1. On a scale of 1 to 10 (10 being the most important) how important is your health to you? _____

On the COREscore™ chart to the right:

2. Please put an 'X' to score where you think you are today.

3. Please circle where you would like to be (your goal).

4. How long do you think it might take to get to where you circled? _____

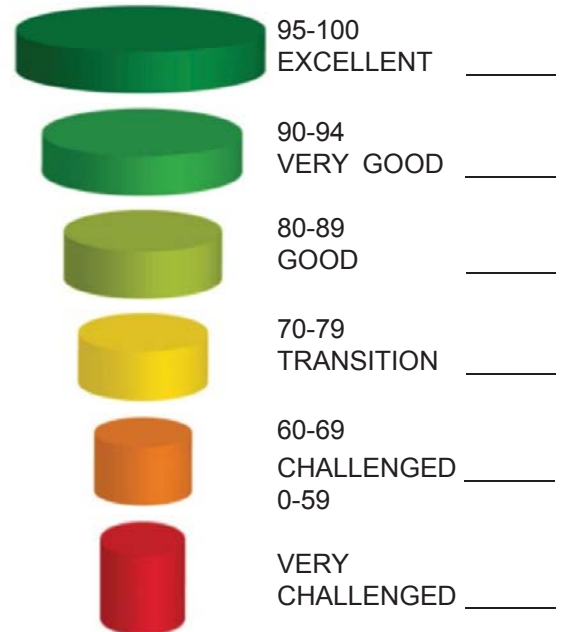
5. What things might you need to change to help you reach your goal (lifestyle changes)?

- a. _____
- b. _____
- c. _____
- d. _____

6. If we could make recommendations that would not only address your main concerns, but could also help you with improving your overall health, would you be willing to follow our recommendations?

_____yes _____no

On a scale of 1-10 (10 being totally committed) _____



CHIROPRACTIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
LAST NAME

FIRST NAME MIDDLE INITIAL

Address _____

City _____ State _____

Home Phone _____

Cell Phone _____

Email _____

Sex M F Age _____ Birthday _____

Married Widowed Single Minor

Separated Divorced Partnered

Employer / School _____

Occupation _____

Spouse's Name _____

Spouse's Employer _____

Spouse's Occupation _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Contact Number _____

Who may we thank for referring you? _____

HOW CAN WE HELP YOU?

What brings you in today? _____

If you are already experiencing a symptom, what is it? _____

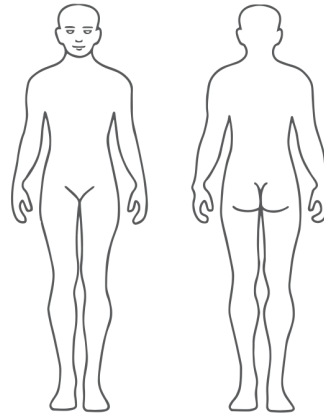
How bad is it? How intense are your symptoms? (circle)

0 1 2 3 4 5 6 7 8 9 10
NO SYMPTOMS INTENSE SYMPTOMS

Please circle areas to the right where you have pain or other symptoms:

What does it feel like? (check where appropriate)

- Numbness
- Sharp
- Tingling
- Shooting
- Stiffness
- Burning
- Dull
- Throbbing
- Aching
- Stabbing
- Cramping
- Swelling
- Nagging
- Other _____



IMPACT OF YOUR SYMPTOMS

How is this symptom / condition interfering with your life? (check where appropriate)

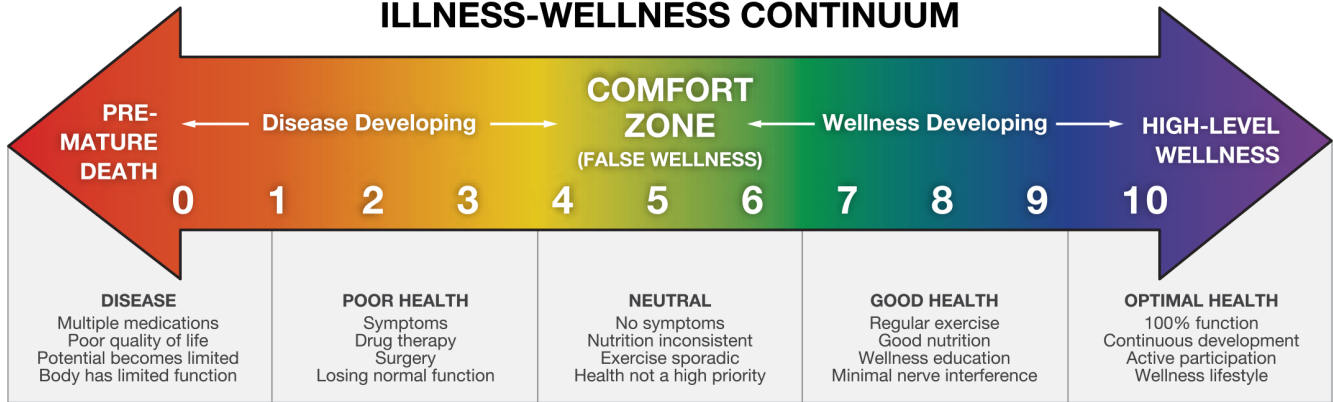
	No Effect	Mild Effect	Moderate Effect	Severe Effect		No Effect	Mild Effect	Moderate Effect	Severe Effect
Work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Attitude	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Patience	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationships	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Productivity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Creativity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Self-Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How committed are you to correcting this issue?

0 1 2 3 4 5 6 7 8 9 10
NOT COMMITTED VERY COMMITTED

PATIENT WELLNESS ASSESSMENT

ILLNESS-WELLNESS CONTINUUM



On the arrow diagram above:

A. What number do you think represents your health today? _____

B. In what direction is your health currently headed? _____

What are your health goals?

IMMEDIATE _____

SHORT TERM _____

LONG TERM _____

CHILDREN & PREGNANCY

How many children do you have? _____

Are you currently pregnant? No Yes, I am due _____

Childrens' ages? _____

Number of past pregnancies? _____

Childrens' health concerns? _____

Health concerns regarding this pregnancy? _____

HEALTH & ILLNESS HISTORY

Please check the box beside any condition that you have or have had.

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Circulation Issues | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Childhood Illness | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Shoulder Issues |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hip Issues | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Digestive Issues
(Constipation/Diarrhea/GERD/IBS) | <input type="checkbox"/> Immune Issues | <input type="checkbox"/> TMJ Issues |
| <input type="checkbox"/> Asthma/Allergies | <input type="checkbox"/> Elbow/Wrist/Hand Issues | <input type="checkbox"/> Lymphatic Issues | <input type="checkbox"/> Urinary Issues |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Endocrine Issues (Thyroid) | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cardiovascular Issues | <input type="checkbox"/> Foot/Ankle Issues | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Reproductive Issues | _____ |

ALLERGIES, MEDICATIONS & SUPPLEMENTS

ALLERGIES (list)

MEDICATIONS (list)

SUPPLEMENTS (list)

