Center For Chiropractic Wellness

167 Avenue At The Commons

2nd Floor, Suite 12

Shrewsbury, NJ 07702

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 Eduction
➢ 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.

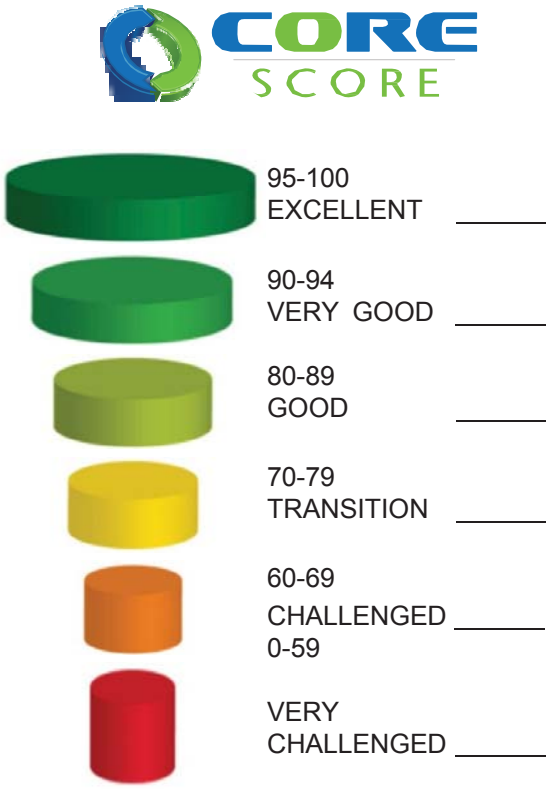
3. Please circle where you would like to be (your goal).

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) _____



CLA
CHIROPRACTIC LEADERSHIP ALLIANCE

www.MyCOREscore.com

Engineered Solutions for the Chiropractic Profession

PEDIATRIC INTAKE & HISTORY

PATIENT INFORMATION

Patient Name _____
Address _____
City _____ State _____
Home Phone _____
Cell Phone _____
Email _____
Sex ❑ M ❑ F Age _____ Birthday _____

IN CASE OF EMERGENCY, CONTACT

Name _____
Relationship _____
Contact Number _____

Mother's Name _____
Mother's Occupation _____
Mother's Phone _____
Mother's Email _____

Father's Name _____
Father's Occupation _____
Father's Phone _____
Father's Email _____

Who may we thank for referring you?

_____

HOW CAN WE HELP YOUR CHILD?

❑ Wellness Checkup ❑ Other: _____

If your child is already experiencing a symptom, please describe it:

Has your child been treated on an emergency basis? ❑ Yes ❑ No

Please describe: _____

PREGNANCY HISTORY

Did you experience any complications during your pregnancy? (check all that apply)

❑ Back/Other Pain ❑ Gestational Diabetes ❑ Pre/Eclampsia ❑ Strep B ❑ Nauseau/Vomitting
❑ Pre-Term ❑ Fatigue ❑ Swelling ❑ Other (please describe) _____

BIRTH HISTORY

Type of birth (check all that apply):

❑ Hospital ❑ Birth Center ❑ Home ❑ Normal / Vaginal ❑ Breech
❑ Cesarean ❑ Scheduled/Induced ❑ Epidural

Problems during labor / delivery? _____

❑ Antibiotics ❑ Congenital Anomalies ❑ Failure to Thrive ❑ Jaundice ❑ Meconium
❑ Respiratory Distress ❑ Extended Hospitalization ❑ Other _____

GROWTH & DEVELOPMENT

Infant feeding: ❑ Breast ❑ Bottle ❑ Formula

Number of hours of sleep each night: _____ Quality of sleep: _____

At what age did the child:

Respond to sound: _____ Crawl: _____ Hold head up: _____

Stand: _____ Sit unsupported: _____ Walk unsupported: _____

CHILDHOOD DISEASES, ILLNESSES & VACCINATIONS

Has your child had (check all that apply)?:

❑ Chicken Pox ❑ Measles ❑ Rubeola

❑ Mumps ❑ Rubella ❑ Pertussis/Whooping Cough

Has your child ever suffered from (check all that apply)?:

❑ Allergies
❑ Anemia
❑ Arm Problems
❑ Asthma
❑ Back Aches
❑ Bed Wetting
❑ Behavioral Problems
❑ Broken Bones
❑ Chronic Ear Aches
❑ Colds/Flu
❑ Colic
❑ Convulsions/Seizures
❑ Delayed Speech
❑ Diabetes
❑ Digestive Issues (constipation/diarrhea)
❑ Dizziness
❑ Fainting
❑ Headaches
❑ Heart Trouble
❑ Hyperactivity
❑ Hypertension
❑ Jeuvenile Rheumatroid Arthritis
❑ Joint Problems
❑ Leg Problems
❑ Neck Problems
❑ Neuritis
❑ Orthopedic Problems
❑ Paralysis
❑ Poor Appetite
❑ Ruptures/Hernias
❑ Sinus Trouble
❑ Tuberculosis
❑ Walking Problems

Have you vaccinated your child?

❑ No ❑ Yes ❑ As scheduled ❑ Delayed Schedule

ALLERGIES, MEDICATIONS, SURGERIES & FAMILY HISTORY

ALLERGIES (list)

_____

_____

MEDICATIONS (list)

_____

_____

SURGERIES (list)

_____

_____

FAMILY HISTORY (list)

_____

_____

SIBLINGS

How many children do you have? _____

Children's' Ages: _____

Childrens' health concerns: _____

_____

Number of pregnancies: _____

Are you currently pregnant? ❑ No ❑ Yes, I'm due: _____

Health concerns regarding this pregnancy? _____

_____

Authorization for Care of Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _____