



NETWORK CARE CENTER

Dr. Anthony Posa B.Sc.(Hon), D.C., F.I.A.C.A.

Health and Healing...Naturally

Physical History

Each of the following traumas puts stress your nervous system. Please indicate which, if any, you have experienced either at presently or in the past.

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Falls	<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"/>
Physical fights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical/sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Repeated postural stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childhood injuries/Falls	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Motor Vehicle Accidents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please check yes or no to the following questions. If you check yes, please explain.

Have you ever been knocked unconscious? Yes No _____

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

Have you ever broken any bones? Yes No _____

Have you ever had an impact, fall or jolt that may have injured your spine? Yes No _____

Have you ever been hospitalized? Yes No Where and when? _____

Have you had surgery? Yes No When and for what? _____

Have you had? Spinal x-rays Cat scans MRI imaging Spinal brace Neck collar
 Heel lift Orthotic Traction Spinal Tap Traction

During the day do you: sit stand do phone work do deskwork
 drive walk mechanical work heavy lifting

Chemical History

Please grade any dietary selection that is appropriate for you using the following scale

X = do not consume this **1** = consume this rarely **2** = consume this weekly **3** = consume this daily or more

___ alcohol	___ fried foods	___ beef
___ coffee	___ cooked, canned vegetables	___ poultry
___ tobacco	___ dairy (milk products)	___ fish
___ artificial sweeteners	___ eggs	___ seafood
___ soft drinks	___ whole grains	___ fasting
___ diet food	___ fruit	___ organic foods
___ refined sugar	___ raw vegetables	___ vitamins/ supplements

Do you or have you work with any chemical, fume, dust, powder, smoke etc. for long periods?

Please list any medications you are presently using: _____

Please list any herbs, nutritional supplements or natural remedies you take regularly: _____



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Emotional History

Please indicate which of the following you are experiencing at present or have experienced in the past.

	Mild		Moderate		Extreme	
	Past	Present	Past	Present	Past	Present
Childhood 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"/>
Family stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relationship stress	<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"/>
Stress of a loved one being sick	<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"/>
Stress of commuting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of a loved one	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in life-style	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Change in career	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abuse (emotional/physical/sexual)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Are there aspects of your life that bring you joy or help you to feel better about yourself? _____

When you are stressed, how do you "center" yourself or "re-group"? _____

Previous Therapeutic Modalities

Have you had experience with any of the following health, treatment or healing modalities? If so, please describe when and for how long you went and the results:

- Ayurvedic medicine _____
- Bodywork/ Massage _____
- Breathwork _____
- Emotional Therapy/ Psychotherapy _____
- Homeopathy/ Herbalist _____
- Meditation/ Prayer _____
- Movement/ Exercise _____
- Music/ Sound/ Light/ Aromatherapy _____
- Nutritional Counseling/ Therapy _____
- Oriental Medicine/ Acupuncture _____
- Osteopathy/ Cranial Work _____
- Somato Respiratory Integration _____
- Yoga/ Movement/ Dance/ Tai Chi/ Chi Gong _____
- Other: _____

Has your spine ever been professionally adjusted? Yes No How long ago? _____

By whom? _____ Are you still going? _____

For what did you seek treatment? _____

Were you pleased? _____

Does your family receive Chiropractic care? _____

What would motivate you to tell others about the care you receive in this office, and encourage them to receive care? _____