NeuroIntegration Therapy

Patient Name ____________________________________ **SS#**____________________
Parent/Guardian Name (If a minor)____________________ **Relationship** ____________
Address ______________________________ **City/State/Zip**______________________
Home Phone____________________ **Cell Phone**_____________ **Date of Birth** ______
Sex M F **Age** _________ **Email Address**____________________________________
How did you hear about our clinic?____

Primary health challenge: _____________________________ **Severity** 0-10_______
Secondary challenge (if any)_____________________________ **Severity** 0-10_______
Medications:____
Supplements:____

Please rate the following 0-10 (0 = not at all 10 = worst you can imagine)

____Anxiety
____Depression
____ADD / ADHD
____Fatigue
____Mood Swings
____Anger
____Learning Disorder
____Unable to Focus
____Memory Problems
____Headaches
____Ringing in Ears
____Poor Concentration
____Obsessive Behavior
____Insomnia (all night)
____Difficulty falling asleep
____Difficulty using body parts

Do you have family members with any of the above difficulties? Yes____ N____

If so, who?____

Have you had a seizure at any time? Yes___ No____ If so, when?_____________

Are your eyes sensitive to light? Yes____ No____

Have you had any head injuries (diagnosed or undiagnosed?) Yes____ No____

If yes, please explain____

How many Auto Accidents have you been in? (fender benders count)_____________

Please list any other accidents or falls____

____

Please list any surgeries____

____

What are your expectations with NeuroIntegration Therapy?__________________________

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Consent for Treatment of a Minor

I hereby authorize JMartin Family Chiropractic Center to administer treatment, as they deem necessary to:

____________________________________.
Child's Name

________________________ ____________________
Parent/Guardian Signature Date