NAME:______________________ DATE:______________

BIO-MECHANICAL STRESS SURVEY

Please answer the following questions to the best of your ability. The information you provide will give the Center a better understanding of your overall ***physical condition,*** *in general, and as it relates to your* ***Nervous System,*** *in particular.*

(Circle One Y= yes, N=No. For explanations, continue on back of survey)

1. Y N Do you know if you were a difficult or Breach birth?
2. Y N Have you ever been knocked unconscious? If yes, how and when:______________
3. Y N Have you broken any bones? If yes, please explain:______________
4. Y N Have you ever had a major fall? If yes, please ______________
5. YN Have you ever been in an automobile accident? If yes, please explain:__________

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6. Y N Do you wear out the heels of your shoes unevenly?
7. Y N Do you have back stiffness/pain when standing?
   If yes, how long does it last?__________
8. Y N Do you experience back stiffness/pain when walking?
   If yes, how long does it take to begin?__________

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9. Y N Do you currently or have you ever used a waterbed? If so, how long?_______
10. Y N Do you have a firm mattress? How old is it?___________
11. Y N Do you sleep on your stomach?
    If yes, what percentage during the night?________
12. Y N Do you use a neck support pillow while you sleep?
    If yes, what type?_________________
    If no, what type of pillow do you use?___________
13. Y N Is it difficult for you to sit up straight without thinking about it?
14. Y N Do you feel your posture is good?

Other information that you would like the doctor to be aware of:______________________

Thank you !

BIO-CHEMISTRY STRESS SURVEY

Please answer the following questions to the best of your ability. The information you provide will give the doctor a better understanding of your overall state of ***digestive health****, in general, and as it relates to your* ***Nervous System****, in particular.*

(Circle One Y= yes, N = No)

1. Y N Do you suffer from allergies? If yes, to what? ______________________
2. Y N Do you crave sweets?
3. Y N Do you crave chocolate?
3. Y N Do you crave breads and pasta?
4. Y N Do you clench or grind your teeth at night that you are aware of?
5. Y N Do you have sinus congestion in the morning?
6. Y N Do you get headaches in the middle of the night or in the morning?
7. Y N Do you get leg cramps at night?
8. Y N Are your feet stiff upon arising and walking?
9. Y N Do you need to take a warm shower to loosen up in the morning?
10. Y N Have you ever traveled out of the country?
If yes, how many times? 1-3? Y N, 4-6? Y N, 7 or more times? Y N
11. Y N Have you ever lived on a farm or been around livestock?
12. Y N Do you have pets? If no, have you ever had pets? Y N
13. Y N Do you use antibiotics? If yes, rarely? Y N, occasionally? Y N, often? Y N
14. Y N Is it difficult for you to lose weight?
15. Y N Are you tired upon waking, even after 8 hours of sleep?
16. Y N Do you frequently toss and turn restlessly during the night?
17. Y N Do you get skin eruptions or itch frequently?
18. Y N Do you have 3 bowel movements a day? If no, how many _______?
19. Y N Do you have difficulty digesting certain foods?
20. Y N Are you consistently bloated and/or have gas?
21. Y N Are you allergic to any foods? If yes, please list:________________________
22. Y N Do you have varicose veins or hemorrhoids?
23. Y N Do you take prescribed medication or have you taken it in the past? If so, please list:___________ How long:___ For what:____ Dosage:_____ (continue on back, if necessary >>>>>)
24. Y N Do you regularly take over-the-counter medications? If yes, for what?___ (continue on back, if necessary)
25. Y N Have you ever had mononucleosis?
26. Y N Are you allergic to bee stings?
27. Y N Is your cholesterol high?
28. Y N Do greasy foods bother you?
29. Y N Do spicy foods such as onions, garlic bother you?

Other information that you would like the doctor to be aware of:____________________

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