Center For
CNS
NEUROSOMATIC
STUDIES
13825 Icot Blvd, Suite 604, Clearwater, FL 33760
727-491-0511

# Welcome to the CNS Student Clinic!

By coming here you have decided to take an active role in maintaining your most important asset - Your Health! Our students are in the process of becoming some of the best therapists in the world and are dedicated to help you attain a pain-free and healthy life. It is our pleasure to serve you.

"The doctor of the future will give no medicine, but will interest his patients in the care of the human body, in diet, and in the cause and prevention of disease."
Thomas Edison

Initial Appointment Date_____

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____ Country_____

Home Phone (____)_____ Work (____)_____ Cell (____)_____

E-mail (office use only)_____ Fax (____)_____

Local Contact Information (if different) _____

Occupation_____

Date of Birth _____ Height_____ Weight_____ Sex _____

Marital Status: Single Married Divorced Separated Widow(er)

Spouse's Name (if applicable) _____

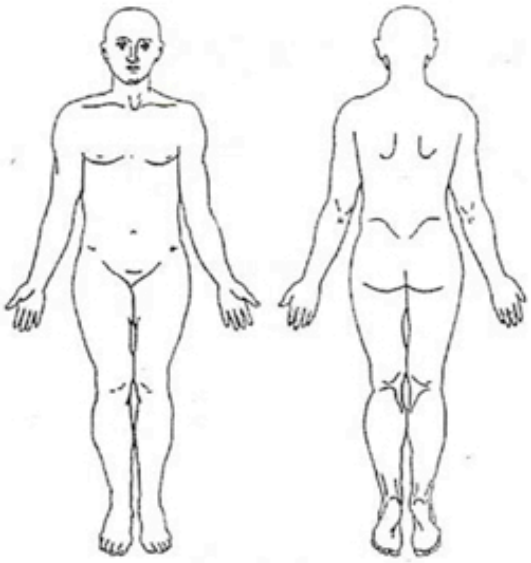
Spouse's Occupation _____

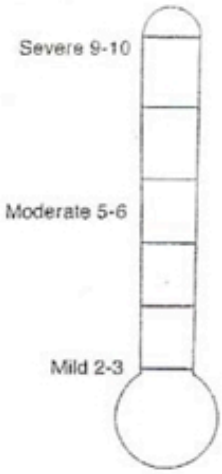
How did you find out about us? _____

Where exactly is the problem?  Mark the figure below to specify.

Rate the recent level of pain by shading in the thermometer below.

Has it been getting better or worse? (Circle one)






Have you ever been treated for the same condition?

Were you admitted to the hospital?

Describe how it feels: (aching, cramping, dull, sore, deep, sharp, shooting, stabbing, stinging, tingling, burning, numbness, radiating - if so where?)

How did it start the first time and this time, if this is not the first? (Sudden or gradual onset and mechanism of injury)

How often does it bother you? (Constant all the time, everyday, __x per week __x per month)

How long does it last once it is there? (Always there, __ minutes/hours, no pattern)

What specifically makes it worse? (Certain movements/activities, stress, time of day, no pattern)

What makes it feel better? (Certain movements/activities, heat/ice, time of day, therapies, nothing)

Do you have a diagnosis from a Doctor? If, yes list it and name of the doctor.

Other therapies/remedies tried and results:

Have you ever had any surgeries and were they beneficial at the time?

List any other health problems for which you are being treated:

Do you have any pre-existing conditions that relate to this present injury? YES☐ NO ☐

If yes, please explain:

Current Medications:

## Activities of Daily Living

In this section, the idea is to get a sense of what type and to what intensity and frequency of activities/movements, postures/positions, and exercise you get a regular basis.

Job/Work Duties:

Household Duties:

Regular Activities/Hobbies:

Exercise:

Sleeping Position:

Other:

What do you believe caused or is causing this condition?

Do you believe it is possible to heal 100%? If not, what %?

How long do you feel it will take?

On a scale of 0-10, how much effort are you willing to put in to achieve maximum healing? 1 2 3 4 5 6 7 8 9 10

Circle the level of stress you are experiencing on a regular basis on a scale of 1 to 10

(1 being the lowest): 1 2 3 4 5 6 7 8 9 10

**Medical History**
□ Arthritis
□ Allergies/hayfever
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Autoimmune Disease
□ Blood pressure problems
□ Bronchitis
□ Cancer
□ Chronic fatigue syndrome
□ Carpal Tunnel syndrome
□ Cholesterol, elevated
□ Circulatory problems
□ Colitis
□ Dental Problems
□ Depression
□ Diabetes
□ Diverticular Disease
□ Drug addiction
□ Eating Disorder
□ Epilepsy
□ Emphysema
□ Eyes, ears, nose, throat problems
□ Environmental sensitivities
□ Fibromyalgia
□ Food intolerance
□ Gastroesophageal reflux disease
□ Genetic Disease
□ Glaucoma
□ Gout
□ Heart Disease
□ Infection, chronic
□ Inflammatory Bowel Disease
□ Irritable Bowel Syndrome
□ Kidney or Bladder Disease
□ Learning Disabilities
□ Liver or gallbladder disease (stones)
□ Mental Illness
□ Migraine Headaches
□ Neurological problems (paralysis, Parkinson's)
□ Sinus Problems
□ Stroke
□ Thyroid trouble
□ Obesity
□ Osteoporosis
□ Pneumonia
□ Sexually Transmitted Disease
□ Seasonal Affective Disorder
□ Skin Problems
□ Tuberculosis
□ Ulcer
□ Urinary Tract Infection
□ Varicose Veins
□ Other ___

**Medical (Men)**
□ BPH
□ Prostate Cancer
□ Decreased sex drive
□ Infertility
□ STD
□ Other ___

**Medical (Women)**
□ Menstrual Irregularities
□ Endometriosis
□ Infertility
□ Fibrocystic breasts
□ Fibroids/ovarian cysts
□ PMS
□ Breast Cancer
□ Pelvic Inflammatory Disease
□ Vaginal Infections
□ Decreased Sex Drive
□ STD
□ Other ___
Age of first period: _
Date of last gynecological exam
Mammogram □ + □ –
PAP □ + □ –
Form of Birth Control _
# of Children
# of Pregnancies _
□ C-Section
□ Surgical Menopause
□ Menopause
Date of last menstrual cycle _
Length of Cycle:
_____Days
Interval of time between cycles:
_____Days
Any recent changes in normal menstrual flow (e.g. heavier, large clots) _

**Family Health History (Parents and Siblings)**
□ Arthritis, rheumatoid
□ Asthma
□ Alcoholism
□ Alzheimer's Disease
□ Cancer
□ Depression
□ Diabetes
□ Drug Addiction
□ Easting Disorder
□ Genetic Disorder
□ Glaucoma
□ Heart Disease
□ Infertility
□ Learning Disabilities
□ Mental Illness
□ Mental Retardation
□ Migraine Headaches
□ Neurological Disorders (Parkinson's, paralysis)
□ Obesity
□ Osteoporosis
□ Stroke
□ Suicide
0ther: ___

**Health Habits**
□ Tobacco
Cigarettes # /day _
Cigars #/day
□ Alcohol
Wine: # glasses/ d or wk _
Beer: # glasses/ d or wk _
Liquor: # ounces/ d or wk _
□ Caffeine
Coffee: # 6 oz cups/ d
Tea: # 6 oz cups/ d _
Soda w. Caffeine: # cans/ d _
Other Sources ___
□ Water: # glasses/ d

**Exercise**
□ 5-7 days per week
□ 3-4 days per week
□ 1-2 days per week
□ 45 minutes or more duration per work out
□ 30-45 minutes duration per workout
□ Less than 30 min
□ Walk
□ Run, Jog, Jump Rope
□ Weight Lift
□ Swim
□ Box
□ Yoga

**Nutrition and Diet**
□ Mixed food diet (animal and vegetable sources)
□ Vegetarian
□ Vegan
□ Salt Restriction
□ Fat Restriction
□Starch/Carbohydrate Restriction
□ The Zone Diet
□ Total Calorie Restriction
Specific Food Restrictions
□ Dairy □ Wheat
□ Eggs □ Soy
□ Corn □ Oil □ Gluten
Other: _

**Food Frequency**
Servings per day:
Fruits (citrus, melons etc.) _
Dark green or deep yellow/orange vegetables
Grains (unprocessed) _
Beans, Peas, Legumes _
Dairy/ Eggs
Meat, Poultry, Fish ___

**Eating Habits**
□ Skip Breakfast
□ Two meals/day
□ One meal/day
□ Graze (small freq. meals)
□ Food Rotation
□ Eat constantly whether hungry or not
□ Generally eat on the run
□ Add salt to food

**Current Supplements**
□ Multivitamins
□ Vitamin C
□ Vitamin E
□ EPA/DHA
□ Evening Primrose/ GIA
□ Calcium, source ___
□ Magnesium
□ Zinc
□ Minerals, describe _
□ Friendly Flora (acidophilus)
□ Digestive Enzymes
□ Amino Acids
□ CoQ10
□ Antioxidants (e.g. lutein, resveratrol, etc.)
□ Herbs (teas)
□Herbs-extracts
□ Chinese Herbs
□ Ayurvedic herbs
□ Homeopathy
□ Bach Flowers
□ Protein Shakes
□ Superfoods (e.g. bee pollen, phylonutrient blends)
□ Liquid Meals (e.g. Ensure)
Other: ____

**Would you like to:**
□ Have more energy
□ Be stronger
□ Have more endurance
□ Increase your sex drive
□ Be thinner
□ Be more muscular
□ Improve you complexion
□ Have stronger nails
□ Have healthier nails
□ Be less moody
□ Be less depressed
□ Be less indecisive
□ Feel more motivated
□ Be more organized
□ Think more clearly and be more focused
□ Improve memory
□ Do better on tests in school
□ Not be dependent on over-the-counter medications like aspirin, Tylenol Benadryl, Sleeping Aids
□ Stop using laxatives or stool softeners
□ Be free of pain
□ Sleep better
□ Have agreeable breath
□ Have agreeable body odor
□ Have stronger teeth
□ Get less colds/flus
□ Get rid of your allergies
□ Reduce your risk of inherited disease tendencies (e.g cancer, heart disease, diabetes, etc.)

# 24 Hour Cancellation Policy

I, _____, understand there is a 24 hour cancellation policy for appointments scheduled for less than 2 hours. When an appointment is scheduled for 2 hours or longer on the same day, a 48 hour cancellation policy is in effect. Cancellation of a scheduled appointment must be made by calling the Center for Neurosomatic Studies.

Failure to cancel without the minimum notice will result in the **full charge** for the cancelled/missed appointment. Cancellation for Mondays and the day after holidays must be made on the prior business day during normal business hours.

Payment for the entire amount of the scheduled appointment will be expected regardless of the patients' arrival time.

_____
Signature

_____
Print Name

_____
Date