# Consent to the Use and Disclosure of Health Information for Chiropractic Care, Payment, or Healthcare Operations by the office of:

**Tammy M. Kaminski, D.C.**

Cedarcrest Chiropractic * Kaminski Wellness Center

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, wellbeing, concerns, symptoms, examination and test results, diagnoses, care, and any plans for future care. I understand that this information serves as:

- a basis for planning my care
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and health information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail or Email a copy of any revised notice to the address I've provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out care, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

**I request the following restrictions to the use or disclosure of my health information:**

_____

_____

_____

**I consent to the use and disclosure of my health information for chiropractic care, payment, and healthcare operations as described in the notice of information practices.**

_____ _____

Signature of Patient or Legal Representative | Witness

_____ September 23, 2013

Date | Notice Effective Date

_____Accepted _____Denied

_____ _____ _____

Dr.'s Signature | Title | Date

**Dr. Tammy M. Kaminski**
*Holistic Family Care * Wellness Education*
**www.KaminskiWellness.com**
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616 Bloomfield Ave., Ste. 3C, West Caldwell, NJ 07006

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**CHILD HEALTH HISTORY**

| | | |
|---|---|---|
| Name of Patient | Date | |
| Gender ☐ Male ☐ Female | Date of Birth / / | Age |
| Address | | |
| Address | Phone Number | |
| Parent(s) Name | | Age |
| Education Level Attained | | |
| Parent(s) Name | | Age |
| Education Level Attained | | |
| Legal Guardian | | |
| Person completing form | | |

**FAMILY HISTORY**

Family history can often be helpful in understanding a child's problems.
**Please check any box that applies:**

| ***Has anyone in the family had:*** | ***Siblings*** | ***Parents*** | ***Extended Family*** |
|---|---|---|---|
| Motor problems | | | |
| Reading problems | | | |
| Speech/language problems | | | |
| School/learning problems | | | |
| Alcohol/drug problems | | | |
| Anxiety, depression, other psychological disorders | | | |
| Seizures/epilepsy | | | |
| Attention problems/hyperactivity | | | |

Please list all family members (in or out of house) and other people currently in the house:

| NAME | RELATIONSHIP | AGE | CURRENTLY IN HOUSE? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Parents are: Married ☐ Living together ☐ Divorced ☐ Separated ☐ Widowed ☐



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## BIRTH HISTORY

How would you describe your pregnancy? _____

Did you experience complications? If so, please list: Example, Gestational Diabetes, Pre-eclampsia, high blood pressure etc? _____

Did you receive any vaccinations while pregnant? ☐ Yes ☐ No

Was any dental work done while pregnant? ☐ Yes ☐ No If yes, what? _____

Did any stressful situations occur during pregnancy? Example, death in the family, loss of spouse's job, separation, etc?

_____

Please check what best describes your labour and birth of your child?

| | | |
|---|---|---|
| ☐ Normal (no interventions) | ☐ Rh Factor problems | ☐ Caesarian section |
| ☐ Mother was sick | ☐ Long/difficult labour | ☐ Forceps or suction used |
| ☐ Complications during birth | ☐ Epidural given | ☐ Induced |
| ☐ Problems with the umbilical cord | ☐ Facial/ breech/ brow presentation | |

Did your child have any of the following problems at birth:

| | | |
|---|---|---|
| ☐ Difficulty breathing | ☐ Heart problems | ☐ Infection |
| ☐ Low birth weight | ☐ Problems with bones/joints | ☐ Jaundice |
| ☐ Fever or seizures | ☐ Required blood transfusions | ☐ Intensive care |
| ☐ Bruised anywhere | ☐ Nerve Problems | |

Does this/ did this child have any birth defects? ☐ Yes ☐ No

If yes, list: _____

Describe what your child's temperament was like as an infant.

| | | | |
|---|---|---|---|
| ☐ Difficult | ☐ Calm | ☐ Sleepy | ☐ Hyper sensitive |
| ☐ Irritable | ☐ Active | ☐ Easily scared | ☐ Frequent crying |
| ☐ Sociable | ☐ Cranky | ☐ Happy | ☐ Alert |

During the first twelve months, was this child:

| | | | | | |
|---|---|---|---|---|---|
| Difficult to get to sleep | ☐ Yes | ☐ No | Irritable | ☐ Yes | ☐ No |
| Difficult to be put on a schedule | ☐ Yes | ☐ No | Alert | ☐ Yes | ☐ No |
| Easy to comfort | ☐ Yes | ☐ No | Affectionate | ☐ Yes | ☐ No |
| Overactive/in constant motion | ☐ Yes | ☐ No | Sociable | ☐ Yes | ☐ No |
| Was the child breast fed? | ☐ Yes | ☐ No | For how long? | _____ | |

When was solid food introduced? _____

Was there any evidence of food intolerances? ☐ Yes ☐ No

If so, to what? _____



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**DEVELOPMENTAL HISTORY:**

| How old was the child when (s)he: | Average Age | Approximate Age | If not sure, please estimate | | |
|---|---|---|---|---|---|
| Sat | 4-7 mos | | Early | Average | Late |
| Walked | 12-17 mos | | Early | Average | Late |
| Toilet Trained | 18-36 mos | | Early | Average | Late |
| Said first words | 12-17 mos | | Early | Average | Late |
| Began using sentences | 36-60 mos | | Early | Average | Late |

**SPEECH AND LANGUAGE**

Has his/her hearing ever been tested? ☐ Yes ☐ No

Does this child have a history of frequent ear infections? ☐ Yes ☐ No

Has (s)he ever had tubes placed in her/his ears? ☐ Yes ☐ No

Last hearing/audiology evaluation: PLACE _____ DATE: _____

Does this child have:

Any speech problems/difficulty speaking? ☐ Yes ☐ No

Have trouble understanding what is being said to him/her? ☐ Yes ☐ No

Has (s)he ever had a Speech and Language Evaluation? ☐ Yes ☐ No

If yes, where? _____ When? _____

RESULTS _____

Has (s)he ever had Speech/Language Therapy? ☐ Yes ☐ No

Is (s)he currently receiving Speech/Language Therapy? ☐ Yes ☐ No

If yes, where? _____ Frequency: _____

**MOTOR SKILLS**

Does this child have fine motor problems (writing, drawing)? ☐ Yes ☐ No

Has (s)he ever had Occupational Therapy (OT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving OT services? ☐ Yes ☐ No

If yes, where? _____ Frequency: _____

Does (s)he have any gross motor problems (walking, running)? ☐ Yes ☐ No

Has (s)he ever had a Physical Therapy (PT) evaluation? ☐ Yes ☐ No

Is (s)he currently receiving PT services? ☐ Yes ☐ No

If yes, where? _____ Frequency: _____

Does this child use any adaptive devices (braces)? ☐ Yes ☐ No

If yes, please describe: _____



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## VISION

Has this child ever been to an eye doctor? ☐ Yes ☐ No

Most recent date: _____

Does this child wear glasses? ☐ Yes ☐ No

If yes, why? _____

Has this child ever been assessed for / diagnosed with:

☐ Binocular Vision ☐ Convergence Insufficiency

☐ Other Convergence Issues ☐ Fixation Issues

**IMPORTANT: if a child wears glasses, please bring them to the appointment**

## MEDICAL HISTORY

Is the child regularly checked by the following:

☐ Medical Doctor ☐ Chiropractor ☐ Osteopath

☐ Naturopath ☐ Dentist ☐ Other

Has the child had the following childhood or other diseases?

☐ Bronchitis ☐ Allergies ☐ Abdominal Pains ☐ Pertussis ☐ Scarlet Fever

☐ Bed Wetting ☐ Asthma ☐ Croup ☐ Measles ☐ Meningitis

☐ Seizures ☐ Chronic Colds ☐ Colic ☐ Mumps ☐ Rubella

☐ Chicken Pox ☐ Ear Infections

Does this child have/had braces on his/her teeth? ☐ Yes ☐ No

Does this child have any amalgam fillings? How many? ☐ Yes ☐ No

How many continuous hours is the child sleeping? _____

Is she/he well rested in the morning? ☐ Yes ☐ No

Does the child suffer from sleep difficulties? ☐ Yes ☐ No

Does the child have problems with food/eating? ☐ Yes ☐ No

Is the child a fussy eater? ☐ Yes ☐ No

Does the child have issues with hygiene/cleanliness? ☐ Yes ☐ No

Does the child complain of any ongoing physical pains? (headaches, tummy aches, muscle/joint aches, or growing pains) ☐ Yes ☐ No

Does the child suffer from dry skin, dandruff, hard skin on elbows, bumps on the outside of the arms, cracked heels, excessive thirst/urination? ☐ Yes ☐ No

Has this child received any vaccines? ☐ Yes ☐ No

If yes, please list: _____

Were there any of the following adverse reactions noticed? ☐ Yes ☐ No

☐ Inconsolable crying ☐ High fever ☐ Sleep disruptions afterward

☐ Lethargy ☐ Irritability ☐ Developed allergies

How many courses of antibiotics has this child received? _____



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Has this child taken any other prescription medication in the past? ☐ Yes ☐ No

If yes, what were/are they? _____

Is the child exposed to a toxic environment (including passive smoking)? ☐ Yes ☐ No

Has the child had any serious falls, physical traumas, or physical injuries? ☐ Yes ☐ No

Please list: _____

## SCHOOL HISTORY

Does the child like/enjoy school? ☐ Yes ☐ No

If not, why not? _____

Beside each subject, indicate whether it is an academic Strength or Weakness of your child:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| English | S ☐ W ☐ | Math | S ☐ W ☐ | Music | S ☐ W ☐ |
| History | S ☐ W ☐ | Science | S ☐ W ☐ | Creative Writing | S ☐ W ☐ |
| Gym/Sports | S ☐ W ☐ | Other languages | S ☐ W ☐ | Other: | S ☐ W ☐ |
| Art | S ☐ W ☐ | | | | |

Beside each domain, indicate whether it seems a Strength or a Weakness in your child:

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Concentration | S ☐ W ☐ | Organization | S ☐ W ☐ | Test Preparation | S ☐ W ☐ |
| Handwriting | S ☐ W ☐ | Planning | S ☐ W ☐ | "Good" behaviour | S ☐ W ☐ |
| Memorizing | S ☐ W ☐ | Reading quickly | S ☐ W ☐ | Vocabulary and Expression | S ☐ W ☐ |
| Paying attention | S ☐ W ☐ | Spelling | S ☐ W ☐ | Creative Writing | S ☐ W ☐ |
| Reading comprehension | S ☐ W ☐ | Getting assignments done on time | S ☐ W ☐ | Understanding concepts | S ☐ W ☐ |

Is getting homework done a struggle? ☐ Yes ☐ No

## BEHAVIOUR/MENTAL HEALTH

Describe any sports or activities the child is involved in: _____

Indicate how many hours a week of "screen time" the child uses:

Computer _____ Smart Device (phone, iPad, etc.) _____

Computer games (DS, etc.) _____ Television _____



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Describe the child's family relationships; with parents and siblings:

_____

_____

Does your child have many friends? ☐ Yes ☐ No

Does the child appear to excel at or struggle to build relationships with their peers? ☐ Excel ☐ Struggle ☐ Neither

If they struggle, why do you think that is?

_____

_____

What problems does the child have with peers, if any?

☐ None ☐ Bragging to peers ☐ Being Teased

☐ Being physically attacked ☐ Rejected by peers ☐ Overly physically affectionate

☐ Being bullied ☐ Jealous of peers

Does this child have self-esteem issues? ☐ Yes ☐ No

Which of the following has the child experienced in the last 12 months?

☐ None ☐ Mother pregnant ☐ Parents separation/divorce

☐ Change of school ☐ Birth of a sibling ☐ Move to a new home

☐ Parent losing a job ☐ Death of immediate family member ☐ Serious illness/injury in immediate family

☐ Other: _____

Do you feel that this child exhibits any of the following symptoms more often than is typical for a child of his/her age? (Please put a check in front of any that apply)

☐ Often touchy/easily annoyed ☐ Often bullies/threatens ☐ Often irritable

☐ Often defies adult rules ☐ Initiates physical fights ☐ Changes in appetite

☐ Often angry/resentful ☐ Ever been arrested ☐ Diminished interest

☐ Often argues with adults ☐ Physically cruel to others ☐ Sleep problems

☐ Often loses temper ☐ Physically cruel to animals ☐ Restlessness or slowed down

☐ Blames other for mistakes ☐ Motor or vocal tics ☐ Fatigues/low energy

☐ Deliberately annoys ☐ Destroys property ☐ Feels worthless

☐ Often spiteful/vindictive ☐ Deliberately sets fires ☐ Becomes tearful easily

☐ Refuses to go to school ☐ Lies often ☐ Often sad

☐ Repeated nightmares ☐ Steals ☐ Indecisive/can't think

☐ Unusual fears ☐ Has run away ☐ Thinks about death

☐ Panic attacks ☐ Extreme mood swings ☐ Talks about suicide

☐ Self-conscious/clings ☐ Does not show emotions ☐ Hurts self

☐ Excessive need for reassurance ☐ Overreacts to touch/noise ☐ Currently uses drugs

☐ Self-injurious behaviour ☐ Strange or bizarre ideas ☐ Currently drinks beer or alcohol

☐ Worry of future events ☐ Used drugs in the past ☐ Used beer or alcohol in the past

☐ Repeats certain actions ☐ Poor social interactions ☐ Can't stop thinking about things

☐ Somatic complaints (headache/stomach) ☐ Gets upset by changes in routine ☐ Excessive preoccupation with objects or ideas

☐ Difficulty maintaining friendships



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| Please place a check mark in the column which best describes the child: | Not at all | Just a little | Pretty much | Very much |
|---|---|---|---|---|
| Often fails to give close attention to details or makes careless mistakes in schoolwork or other activities. | | | | |
| Often has difficulty sustaining attention in tasks or play activities. | | | | |
| Often does not seem to listen when spoken to directly. | | | | |
| Often does not follow through on instructions and fails to finish schoolwork, or chores (not due to oppositional behavioural failure to understand directions). | | | | |
| Often has difficulty organizing tasks and activities. | | | | |
| Often avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (such as schoolwork or homework) | | | | |
| Often loses things necessary for tasks or activities (toys, school assignments, pencils or books) | | | | |
| Is often easily distracted by extraneous stimuli | | | | |
| Is often forgetful in daily activities | | | | |
| Often fidgets with hands or feet or squirms in seat | | | | |
| Often leaves seat in classroom or in other situation in which remaining seated is expected | | | | |
| Often runs about or climbs excessively in situation where it is inappropriate (in adolescents, may be limited to subjective feelings of restlessness) | | | | |
| Often has difficulty playing or engaging in leisure activities quietly | | | | |
| Is often "on the go" or often acts as if "driven by a motor" | | | | |
| Often talks excessively | | | | |
| Often blurts out answers before questions have been completed | | | | |
| Often has difficulty waiting turn | | | | |
| Often interrupts or intrudes on others (butts into conversations or games) | | | | |



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**REASON FOR ASSESSMENT**

Please describe in your own words what concerns you have about this child. Also, please add any additional information that you feel is important and may be helpful in our assessment.

What specific **question** do you have that you hope an evaluation will answer?

Your name _____ Relationship to child _____

Date:___/_____/_____



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Name: _____ Patient #: _____ Age: _____ Date: _____

Address: _____
Residence and mailing City State Zip/Postal Code

Home Telephone ( ) _____ Work Phone ( ) _____ Cell # ( ) _____

Preferred contact number(s) _____

Email Address: _____ Male ____ Female _____ Birthdate _____

Occupation/Employer's Name and address _____

Single ____ Married ____ Divorced ____ Widowed ____ Your Social Security # (optional): _____

No. of children: _____ Spouse's Occupation/Employer: _____

Reason for consulting our office? _____

Who may we "Thank" for referring you to our office? _____

# YOUR HEALTH PROFILE

## WHY THIS FORM IS IMPORTANT

As a Chiropractic office specializing in Holistic Family Care, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Often the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

## THE BEGINNING YEARS (TO AGE 17)

Research is showing that many of the health challenges that occur later in life have their origins during the developmental years, some starting at birth. Please answer the following questions to the best of your ability.

| YOUR CHILDHOOD YEARS | YES | NO | UNSURE | | YES | NO | UNSURE |
|---|---|---|---|---|---|---|---|
| Did you have any childhood illnesses? | ___ | ___ | ___ | Did you take/use any drugs? | ___ | ___ | ___ |
| Did you have any serious falls as a child? | ___ | ___ | ___ | Did you have any surgery? | ___ | ___ | ___ |
| Did you play youth sports? | ___ | ___ | ___ | Were you vaccinated? | ___ | ___ | ___ |
| Have you fallen/jumped from a height over three feet? (i.e. crib, bunk bed, tree) | | | | | ___ | ___ | ___ |
| Were you involved in any car accidents as a child? | | | | | ___ | ___ | ___ |
| Was there any prolonged use of medicine such as antibiotics or an inhaler? | | | | | ___ | ___ | ___ |
| Did you suffer any other traumas? (physical or emotional) | | | | | ___ | ___ | ___ |
| As a child, were you under regular chiropractic care? | | | | | ___ | ___ | ___ |
| Was your childhood a happy one? | | | | | ___ | ___ | ___ |

**COMMENTS:** _____

_____

| ADULT – (18 TO PRESENT) | YES | NO |
|---|---|---|
| Do/did you smoke? | ___ | ___ |
| Do/did you drink alcohol? | ___ | ___ |
| Do/did you play any adult sports? | ___ | ___ |
| Do/did you participate in extreme sports? | ___ | ___ |

On a scale 0-10 describe your stress:

level (0=none/10=extreme)

Occupational_____ Personal _____

On a scale of Poor, Good or Excellent describe your:

Diet _____ Exercise _____ Sleep _____ General Health _____

# WHAT BROUGHT YOU TO OUR OFFICE?

**Chiropractic Wellness Care: _____**
Network Spinal Analysis (NSA), Somato Respiratory Integration (SRI) and ReOrganizational Healing (ROH) Education

**Specific Concerns: _____**
Please describe any concern(s) including symptom areas and the affect it has had on your life and your family.

_____
_____

If you are experiencing pain, is it
Sharp___ Dull___ Achy___ Comes & Goes___ Travels/Moves___ Changes___ Constant__ Unbearable___
Since the problem started, is it  About the same___ Getting Better___ Getting Worse___
What makes it worse: _____
Is it interfering with: Work___ Sleep___ Walking ___ Sitting___ Hobbies___ Leisure___ Life___
Other Doctors seen for this concern (please list)
Chiropractor _____
Medical Doctor _____
Other _____

Were X-Rays taken? _____ If not and if medically necessary, would you be opposed to having X-Rays taken? _____

Please check all symptoms you have ever had, even if they do not seem related to your current concern(s):

| | | | |
|---|---|---|---|
| ___ Headaches | ___ Sensitive Eyes | ___ Irritability | ___ Diarrhea |
| ___ Pins & Needles in Arms | ___ Fainting | ___ Fever | ___ Constipation |
| ___ Neck Pain | ___ Ringing in Ears | ___ Loss of Balance | ___ Pins & Needles in Legs |
| ___ Numbness in Fingers | ___ Loss of Taste | ___ Nervousness | ___ Numbness in Toes |
| ___ Fatigue | ___ Buzzing in Ears | ___ Upset Stomach | ___ Menstrual Pain |
| ___ Sleeping Problems | ___ Dizziness | ___ Tension | ___ Menstrual Irregularity |
| ___ Cold Hands | ___ Cold Sweats | ___ Hot Flashes | ___ Back Pain |
| ___ Stiff Neck | ___ Mood Swings | ___ Heartburn | ___ Problem Urinating |
| ___ Loss of Smell | ___ Depression | ___ Ulcers | ___ Cold Feet |

List medications, duration, and reason for taking: _____
_____

**Family Health Profile:**
As a Holistic Family Care office, we are also interested in the well-being of your family and loved ones, including their health history. Please list below any health conditions/concerns or poor lifestyle choices for your:

Children _____
Spouse _____
Mother _____
Father _____
Siblings _____
Others _____

**Your Lifestyle:**
Do you drink water: YES___ NO___ How much:_____ Bottled:____ Filtered:_____
Do you belong to a health club:_____ Exercise on your own:_____ No Exercise:_____
Do you consume vitamins, minerals or supplements: YES___ NO___
Please list:_____
_____

Are you interested in receiving nutritional consult? _____

***The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:***

_____ _____
Signature Date

Dr. Tammy M. Kaminski * Cedarcrest Chiropractic * 616 Bloomfield Ave., Ste. 3C W. Caldwell NJ 07006 * (973) 228-6624

# THE STRESS TEST

Name: _____ Date: _____ Chart #: _____

The human body is designed to be healthy. Throughout life, events occur which suppress &/or damage your health expression and your body's ability to adapt. The information on this form will help uncover layers of damage, primarily to your nervous system, which have resulted in less than optimum health.

*Please circle when you experienced these stresses: C (child), T (teenager), A (adult), or N (not at all).*

| PHYSICAL STRESS: | | | | | EXPLAIN |
|---|---|---|---|---|---|
| Birth Traumas (as a mother or child) | C | T | A | N | _____ |
| Slips/Falls | C | T | A | N | _____ |
| Car Accidents | C | T | A | N | _____ |
| Sports Injuries | C | T | A | N | _____ |
| Physical Abuse | C | T | A | N | _____ |
| Work Injuries | C | T | A | N | _____ |
| Poor Posture | C | T | A | N | _____ |
| Sitting on your wallet for years | C | T | A | N | _____ |
| Sleeping Position Stomach | C | T | A | N | _____ |
| Extensive Computer Work | C | T | A | N | _____ |
| Carrying Heavy Purse/Book bag/Child | C | T | A | N | _____ |
| Repetitive Lifting/Bending | C | T | A | N | _____ |
| Driving for Many Hours | C | T | A | N | _____ |
| Continuous Hours Sitting/Standing | C | T | A | N | _____ |
| Bone Fracture | C | T | A | N | _____ |
| Surgery | C | T | A | N | _____ |
| EMOTIONAL STRESS: | | | | | |
| Relationships | C | T | A | N | _____ |
| Career | C | T | A | N | _____ |
| Children | C | T | A | N | _____ |
| Money | C | T | A | N | _____ |
| Fast-Paced Life | C | T | A | N | _____ |
| Hold in Feelings | C | T | A | N | _____ |
| Quick Tempered | C | T | A | N | _____ |
| Verbal Abuse | C | T | A | N | _____ |
| Perfectionist | C | T | A | N | _____ |
| Procrastinator | C | T | A | N | _____ |
| Sickness or Loss of Loved One | C | T | A | N | _____ |
| CHEMICAL STRESS: | | | | | |
| Environment (i.e. pollution) | C | T | A | N | _____ |
| Smoker Amount? | C | T | A | N | _____ |
| Second-hand Smoke | C | T | A | N | _____ |
| Poor Diet, Fast Food, Soda | C | T | A | N | _____ |
| Caffeine Amount? | C | T | A | N | _____ |
| Excessive Sugar | C | T | A | N | _____ |
| Artificial Sweeteners | C | T | A | N | _____ |
| Prescription Drugs | C | T | A | N | _____ |
| Over-The-Counter Drugs (ie Tyenol/Mortin) | C | T | A | N | _____ |

What do you feel is your primary stress? _____

Would you consider your life to be in order at this time? _____

Have you undergone any great change in the last year? _____

Are there any significant fears present in your life? _____

Are you satisfied with your job/relationships/achievement of goals? _____

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Dr. Tammy M. Kaminski * Cedarcrest Chiropractic * 616 Bloomfield Ave., Ste. 3C W. Caldwell NJ 07006 * (973) 228-6624