THE DRUGLESS DOCTORS
Chiropractic, Family Health, and Wellness

**Drs. Anthony, Bob and Casen DeMaria**
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Name: ______________________________ File Number: ____________ Date: ______________

**Please CIRCLE a number to rate each function below.**

| | 0= **BEST** | | | | | | | | | | 10=**WORST** |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Overall Quality of Life: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 2. Sleep Habits: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 3. Energy Levels: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 4. Behavior: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5. Attention: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 6. Activity Levels: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 7. Co-ordination: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 8. Appetite: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 9. Digestion/Bowel (BM): | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 10. # of complaints: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 11. Colds/Infections: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 12. Breathing: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Questions/Concerns/Other: ____________________________________________

This section is to indicate areas of DISCOMFORT and DYSFUNCTION in the body.

Please use the letter **N** for **NECK**, **M** for **MID BACK**, and **L** for **LOW BACK**. If you have challenges in other areas, please write the letter **X**, and indicate that body region here: ____________(ex: X=Shoulder). For each of the 11 scenarios below, rate your discomfort in each body region by writing the letters **N**, **M**, and **L** (and **X** if applicable)—**even if you have no discomfort/dysfunction in that area**. See example below.

**EXAMPLE:**
**Travel (Driving, etc.)** 0___M (Mid back)___2__________4___N (Neck)___6__________8___L (Low back)___10__________
No discomfort — Some — Mild — Moderate — Severe — Worst discomfort

| Scenario | 0 — 2 | 2 — 4 | 4 — 6 | 6 — 8 | 8 — 10 | 10 — |
|---|---|---|---|---|---|---|
| **1. Discomfort Intensity** | No discomfort | Some | Mild | Moderate | Severe | Worst discomfort |
| **2. During Sleep** | Perfect sleep | Occasionally disturbed | Mildly disturbed | Moderately disturbed | Greatly disturbed | Cannot sleep |
| **3. Personal Care** (Washing, Dressing, etc.) | No challenges | Can do < 100% | Can do 75% | Can do 50% | Need assistance | Cannot do at all |
| **4. Travel (Driving, etc.)** | No discomfort | Some | Mild | Moderate | Severe | Worst discomfort |
| **5. Work** | Can do 100% + extra | Can do 100% | Can do 75% | Can do 50% | Can do 25% | Cannot work at all |
| **6. Recreation** | Can do all + more | Can do 100% | Can do 75% | Can do 50% | Can do 25% | Cannot do any activities |
| **7. Discomfort Frequency** | No discomfort | Infrequently | Occasionally | Intermittently | Frequently | Constant discomfort |
| **8. Lifting** | No restrictions | Some trouble | Cannot lift heavy | Cannot lift moderate | Cannot lift light | Cannot lift any weight |
| **9. Walking** | Can walk any distance | Challenge > 2 miles | Challenge > 1mile | Challenge > ½ mile | Challenge > ¼ mile | Cannot walk |
| **10. Standing** | No challenge > 3+hrs | Challenge > 3+ hrs | Challenge > 2 hrs | Challenge > 1hr | Challenge > 30min | Cannot stand |
| **11. Sitting** | No challenge > 3+hrs | Challenge > 3+ hrs | Challenge > 2 hrs | Challenge > 1hr | Challenge > 30min | Cannot sit |

Practice Member Signature: ______________________________ Date: ______________

Dr. Signature: ______________________________ Date: ______________
Robert DeMaria/Anthony DeMaria/Casen DeMaria

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# Progressive Care Assessment

What are the reasons you are seeking care from The Drugless Doctors? Circle all that apply

A) Wellness
B) Pediatrics
C) Male Health
D) Mental Health
E) Better Sleep
F) Decreasing Pain
G) Prevention
H) Improved Performance
I) Sports Performance
J) Concentration
K) Weight Loss
L) Family Health
M) Headache Reduction
N) Early Detection
O) Female Hormones
P) Increased Energy
Q) Nutrition
R) Immune Function
S) Fertility
T) Depression
U) Digestion
V) Decreasing Stress
W) Improving Quality of Life
X) Education
Y) Location
Z) Advanced Technology

Other reasons for seeking care: ____________________________________________________________________________

Do you have any questions regarding your care?_______________________________________________________________

Are you satisfied with the current direction of your health since starting care with The Drugless Doctors? **Y** or **N**

If no, Please explain: __________________________________________________________________________________

Would you like any more information on incorporating proper diet and nutrition choices in your life? **Y** or **N**

Changes(s) of address **Y** or **N**______________________ Employment **Y** or **N**________________ Phone # **Y** or **N**_________________

Get Married **Y** or **N**, Change in insurance **Y** or **N, Other** life events since last assessment:_______________________________________

**Present Health Concerns – If none present please proceed to Chemical Stresses**

Major_______________________________________________________________________________________________

Minor_______________________________________________________________________________________________

When did this problem begin?____________________________________________________________________________

Is it? Occasional Frequent Constant Intermittent (Please Circle One)

Does the problem travel/radiate anywhere? **Y** or **N**, If yes where?__________________________________________________

What makes this worse? _____________________________________________Better?_______________________________________

Is the problem worse during a certain time of day? **Y** or **N**, If yes when?_____________________________________________

Does it interfere with: Sleep Exercise Energy Daily Routine (Circle all that Apply)

Is it becoming better or worse? Please circle one and explain: ___________________________________________________

**Chemical Stresses:**

Are you currently taking any prescription or over the counter medication? **Y** or **N**, If yes please indicate what you are taking and why

____________________________________________________________________________________________________

Are you currently taking any supplements other than ones from this office? **Y** or **N**, if yes, which ones?

____________________________________________________________________________________________________

Are you currently drinking half your body weight in ounces of water? **Y** or **N**, if no how many ounces? _________________________

Do you eat organic? **Y** or **N** or **Occasionally** Are you exposed to chemicals, strong smells, or aerosols? **Y** or **N**

Do you have a shower dechlorinator? **Y** or **N** Do you drink filtered or reverse osmosis water? **Y** or **N**

**Mental/Emotional Stresses:**

Since psychological stress has been shown to effect numerous body functions including our nervous and immune system, please indicate how you are coping with life. Rank from 1 to 10, with 1 being optimal and 10 being extreme, for the following areas:

_____Life in general _____Work and Career _____Relationships _____Financial Stress

_____Time management _____Sports and Hobbies _____Health _____Well-Being

If you are experiencing significant or ongoing stress please explain: _____________________________________________________

Practice Member Signature: ______________________________________________________ Date:_______________

Dr. Signature: ___________________________________________________________________ Date: _______________