

McAnsh LIFE-ENERGY Institute

Application for Brain STEM Chiropractic Care Form (Client Fills Out)

Today's Date: _____

Legal Name: _____ **Birthdate:** _____

Name you prefer to be called: _____

Address: _____ SSN#: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Age: _____ Marital status: _____ Gender: _____ Number of children: _____

Employer: _____ Work phone: _____

Type of work: _____

Name and city of medical practitioner: _____

E-MAIL ADDRESS (will NOT be given out or sold! It is for info and special offers from us only!): _____. Providing the above contact info constitutes permission for us to communicate with you via these means.

Best phone number to call regarding appointments reminders/info: _____

Can we leave a message at that number you provided?: Y N

Spouses Name: _____ Spouses Birthdate: _____

Spouses Employer: _____ Work phone: _____

Type of work: _____

Please list 1 – 3 things you are hoping we can help you with as a result of improving your POTENTIAL for success:

- 1) _____
- 2) _____
- 3) _____

How would you feel emotionally if by improving your POTENTIAL for success your body WAS NOT able to help one or all of the things you listed above, but WAS able to help your energy levels; sleep; mood & attitude; sense of “well-being”; relationships; memory, thoughts, dreams and goals in life; ability to improve at your chosen hobby or sport?...

How would you feel emotionally if by improving your POTENTIAL for success your body WAS NOT able to help one or all of the things you listed above, but WAS able to help you avoid or delay having surgery to replace a knee or hip?: _____

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Before you noticed your current reduction in your POTENTIAL for success were there **ANY** previous ACCIDENTS, INJURIES, FALLS, BUMPS, JARS or other INJURIES?:

- 1) _____
- 2) _____
- 3) _____

Since the time you first noticed the start of reduction in your POTENTIAL for success, **what things have you tried to do to help improve your POTENTIAL for success that hasn't worked as well as you had hoped?** Example: positive thinking, prayer, meditation, visualization, yoga, ice, heat, stretching, exercise, vitamins, Over-the-Counter medications, prescription drugs, physical therapy, surgery, radiation, etc.:

While those things you listed above **may** have helped a little **temporarily**, do you see that they **haven't truly improved your POTENTIAL for success yet?**: Y N

How does it make you **feel emotionally** to **still** be trying to improve your POTENTIAL for success with the methods you have tried so far?: _____

Have you been adjusted by a Doctor of Chiropractic before?: Y N

Reason for those visits: _____

Previous chiropractor: _____ Date of **last** visit: _____

Did your previous chiropractor recommend a care program to help you improve your POTENTIAL for success **year round?**: Y N

What **life "passions", sports or hobbies** do you enjoy outside of work?: _____

On a scale of 1 – 10 (with 10 being the most) how much does your current reduction in your POTENTIAL for success interfere with your ability to **enjoy your** life "passions", sports or hobbies?: _____

Is there **anything else** you would **do more** or even just **enjoy more** if it wasn't for your current reduction in your POTENTIAL for success?: _____

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At this point, would you agree that it's time to try a **new approach** to improving your POTENTIAL for success?: Y N

On a scale of 1 – 10 (with 10 being the highest), **how much do you want to improve your POTENTIAL for success?:** 1 2 3 4 5 6 7 8 9 10 (circle one)

What **dreams/aspirations/goals** for the remainder of your life?: _____

Please list ALL **DRUGS (Medications)**: _____

Please list ALL **ALLERGIES**: _____

Please list ALL **SURGERIES** with **dates**: _____

Please list ALL **NUTRITIONAL SUPPLEMENTS** (vitamins, minerals, herbs, etc.): _____

Please describe your **exercise program/routine**: _____

Please describe your **diet** that you follow: _____

How **water** do you drink each day on average: _____

Source of water: city bottled well filtered distilled (circle one or more)

Blood: PRESSURE: L N H **SUGAR:** L N H **TYPE:** O A B AB (circle if known)

Please explain any difficulties that you have been made aware of during your childbirth?:

Do you wear: **heel lifts** or insoles?: Y N **If so, are they the same thickness?:** Y N

For Women Only:

Are you pregnant?: Y N Do you have 28 day cycles?: Y N

Are you nursing?: Y N Do you have breast implants?: Y N

Are you taking birth control?: Y N Do you experience painful periods?: Y N

Did you know that your Brain (technically, your Brain STEM or “Medulla Oblongata”) controls your POTENTIAL for success... in ALL areas of life?: Y N