



Bringing Balance to your Brain and Body

PATIENT REGISTRATION

Who may we thank for referring you to New Life Chiropractic?			Date		
Full Name		DOB	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address					
City		State		Zip Code	
Home Telephone <input type="checkbox"/> Primary Contact		Work Telephone <input type="checkbox"/> Primary Contact		Mobile <input type="checkbox"/> Primary Contact	
Social Security Number			Email Address		
Emergency Contact Name		Relationship		Emergency Contact Number	

INSURANCE INFORMATION

MEDICARE

Primary Insurance Carrier		Group Number	ID Number
Primary Insured		Employer Name	
Business Address			
Employee Social Security Number		Employee Date of Birth	

FINANCIAL RESPONSIBILITY

Person Responsible for Account: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other	
Name	Social Security Number
Address	
Telephone	Email Address

OPTIONAL CREDIT CARD PAYMENT AUTHORIZATION

I _____, hereby authorize New Life Chiropractic and/or the staff at 146 Central Park West, NYC, NY 10023 and/or 323 Middle Country Road, Smithtown, NY 11787 to charge my credit card for services rendered and/or products supplied for a period of one year from the date below. It is my responsibility to notify New Life Chiropractic, PC any changes regarding this credit card authorization.

Name on Card		Signature/Date	
Credit Card Type <input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> Discover		Credit Card Number	
Expiration Date	Security Code	Billing Zip Code	

I attest, to the best of my knowledge, the above information is accurate and true.

Signature: _____ Date: _____



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**HIPAA NOTIFICATION
ELECTRONIC MAIL (EMAIL) COMMUNICATIONS**

The goal of New Life Chiropractic, PC is to make communication between you and our office as easy for you as possible. As such, you have the right to request that we communicate with you via electronic mail (email). However, prior to consenting to such communication, please take a moment to realize any and all privacy risks associated with this form of communication.

Email communications are two-way communication. However, responses and replies to emails sent to or received by either you or, New Life Chiropractic, PC may be hours or days apart. As such, acute conditions should never be addressed using email communications.

Although New Life Chiropractic, PC, will make every effort to maintain privacy, email messages, on any device, have inherent privacy risks, as there is no way to ensure an email is completely tamper-resistant. That being said, you should not use email to discuss anything you wish to remain entirely confidential.

In order to forward and/or process and/or respond to your email, individuals at New Life Chiropractic, PC, other than the intended recipient, may have access to or read your email message. Please remember, email communication is not a means of private communication.

This document, along with any and all email communications, may become part of your New Life Chiropractic, PC, medical record.

PATIENT REQUEST FOR EMAIL COMMUNICATION

Please complete the information below if you wish to communicate New Life Chiropractic, PC, via email, knowing there are inherent privacy risks.

Patient Name: _____ Date of Birth: _____

Email Address: _____

Please initial each line and sign below:

_____ The email address contained herein is accurate, and I accept full responsibility for messages sent to or from this address.

_____ I have read, reviewed, and received a copy of this HIPAA Notification: Electronic Mail Communications.

_____ I understand and acknowledge that there are inherent privacy risks when communication is over the Internet.

_____ I agree to hold *New Life Chiropractic, PC*, and its agents and representatives harmless from any and all claims and liabilities arising from or related to this Request for Email Communication.

Patient does not consent to email communication

Patient Signature: _____ Date: _____

Child Neurotransmitter & Nutrition Questionnaire (CNNQ)

Name: _____ Age: _____ Sex: _____ Date: _____

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION: GENERAL

- Does your child have any food sensitivities or allergies? (please list)

- List your child's 4 healthiest foods eaten regularly.

- List your child's 4 unhealthiest foods eaten regularly.

- How many times a week does your child eat candy? _____
- How many times a week does your child drink soda pop? _____
- Please list the top 4 foods your child craves regularly?

- List the medication(s) your child is currently prescribed and over the counter.

- Do you find it difficult as a parent to have your child on a special diet?

SECTION: A (K52)

- Does your child eat pasta, breads, and breaded foods? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating wheat foods? 0 1 2 3
- Does your child eat dairy products? 0 1 2 3
- Does your child have symptoms (fatigue, hyperactivity, etc.) after eating dairy products? 0 1 2 3

SECTION: B (K53)

- Does your child eat fried fish? 0 1 2 3
- Does your child eat roasted nuts or seeds? 0 1 2 3
- Is your child **missing** essential fatty acid rich foods in his/her diet? (for example: avocados, flax seeds, olives) (mark "0" if present, "3" if missing) 0 1 2 3
- Does your child eat *fried* foods? 0 1 2 3

SECTION: C (K34)

- Is your child's mental speed slow? 0 1 2 3
- Does your child have difficulty with learning or memory? 0 1 2 3
- Does your child have difficulty with balance and coordination? 0 1 2 3

SECTION: D (K16)

- Does your child have stress? 0 1 2 3
- Does your child **not** have enough sleep and rest? (mark "3" if not enough) 0 1 2 3
- Does your child **not** have regular exercise? (mark "3" if no exercise) 0 1 2 3
- Does your child feel overly worried and scared? 0 1 2 3

SECTION: E (K16, K51)

- Does your child have temper tantrums? 0 1 2 3
- Does your child exhibit wild behavior? 0 1 2 3
- Does your child frequently yell or scream for unnecessary reasons? 0 1 2 3

- Does your child have an **inability** to nap or sleep when physically exhausted? (mark "3" if unable) 0 1 2 3
- Is your child overly talkative? 0 1 2 3
- Does your child fidget and squirm when seated? 0 1 2 3
- Does your child run and climb excessively when it is inappropriate? 0 1 2 3
- Does your child have difficulty playing quietly or engaging in leisure activities? 0 1 2 3

SECTION: F (K51)

- Does your child get excited easily? 0 1 2 3
- Does your child have anxiousness and panic for minor reasons? 0 1 2 3
- Does your child feel overwhelmed for minor reasons? 0 1 2 3
- Does your child find it difficult to relax when she/he is awake? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: G (K50)

- Does your child seem depressed? 0 1 2 3
- Does your child have mood changes with overcast weather? 0 1 2 3
- Does your child have symptoms of inner rage? 0 1 2 3
- Does your child seem uninterested in games or hobbies? 0 1 2 3
- Does your child have difficulty falling into deep restful sleep? 0 1 2 3
- Does your child seem uninterested in friendships? 0 1 2 3
- Does your child have symptoms of unprovoked anger? 0 1 2 3
- Does your child seem uninterested in eating? 0 1 2 3

SECTION: H (K49)

- Does your child have difficulty handling stress? 0 1 2 3
- Does your child have anger and aggression while being challenged? 0 1 2 3
- Does your child feel tired even after long sleeps? 0 1 2 3
- Does your child tend to isolate from others? 0 1 2 3
- Does your child get distracted easily? 0 1 2 3
- Does your child have constant need and desire for candy and sugar? 0 1 2 3
- Does your child have disorganized attention? 0 1 2 3

SECTION: I (K48)

- Does your child have difficulty with visual memory? 0 1 2 3
- Does your child have difficulty remembering locations? 0 1 2 3
- Does your child have fatigue or low endurance for learning activities? 0 1 2 3
- Does your child have difficulty with attention or low attention span or endurance? 0 1 2 3
- Does your child have slow or difficult speech? 0 1 2 3
- Does your child have uncoordinated or slow movement? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only

PERSONAL INFORMATION (continued)

Describe your child to me, including his/her history. Please be as detailed as possible.

▪ **When did you first notice your child's problem?**

▪ **What did you first notice?**

▪ **Was the onset of your child's problem sudden or gradual?**

▪ **Was there any event or illness that you or others think brought on your child's symptoms?**

Please make notation of any other event, action, etc. that you think may have some bearing/relationship to your child's condition. Again, be as detailed as possible and do not hesitate to mention anything, no matter how small or insignificant, that you believe is related to your child's problem(s).

CHILD'S MEDICAL HISTORY

PRIMARY DOCTOR(S)

Name	Phone Numbers	City

THERAPIST(S)

Speech – Occupational - Physical - Other

Name	Type of Therapist	Phone	City	Hours/Week	Date of Evaluation

OTHER CARE GIVERS

Name	Type of Care Giver	Phone	City	Hours/Week	Date of Evaluation
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Naturopath(s) / Homeopath(s)

Nutritionist

Other

DIETARY/NUTRITIONAL HISTORY

Breast-fed? Yes/No (Circle One): If yes, how long?

Bottle-fed? Brand of formula? _____ **Begun at what age?** _____ **For how long?** _____

Foods? Begun at what age?

First foods? _____

Whole milk? Yes/No (Circle One)

If yes, begun at what age? _____

Known allergies to food? (Please list): _____

Suspected sensitivities to foods? (Please list): _____

Food cravings? (Please list): _____

Foods my child eats: (Place ✓ in appropriate column)

FOOD	Daily	3 - 5 times/ week	1 - 3 times/ week	Never or almost never	Used to eat a lot but no longer does
Cookies:					
Candy:					
Sweet foods:					
Caffeine (soda, tea, etc.):					
Chocolate:					
Milk: Whole:					
2 % :					
1 % :					
Skim:					
Cheese:					
Ice Cream:					
Salty Foods:					
Meat:					
Pasta:					
Bread: White:					
Wheat:					
Other:					

DIETARY/NUTRITIONAL HISTORY (continued)

Check (✓) the most appropriate description below of your child's diet:

_____ Mostly baby foods

_____ Mostly carbohydrates (bread, pasta, etc.)

_____ Mostly dairy (milk, cheese, etc.)

_____ Mostly meat

_____ Mostly vegetarian (vegetables, fruits, grains, etc.)

_____ Other – describe:

Please describe your child's stool pattern (*Examples: daily, foul, large, mushy, etc.*):

Please list the foods and beverages normally consumed by your child for three typical days:

DAY 1

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 2

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

DAY 3

Breakfast:

Morning snack(s):

Lunch:

Afternoon snack(s):

Dinner:

Other:

FAMILY HISTORY

List any allergies, major illnesses, genetic diseases or problems for each of the following family members of your child:

Mother:

Father:

Siblings:

Maternal Grandparents:

Paternal Grandparents:

Others:

SOCIAL HISTORY

Who lives in the home with your child:

Are any children in your family adopted?

Pets in the house:

Caregivers besides parents:

List the people most important in your child's life:

Recent changes, losses, births, deaths, divorce, remarriage or moves:

Recent travel:

Child's response to these changes:

Is your child involved in any sports, music or other activities? Please describe:

How does your child interact with other children?

- **With adults?**
- **What makes your child happy?**
- **Sad?**
- **Angry?**
- **Stressed?**
- **How do you as a parent deal with these emotions in your child?**

ENVIRONMENTAL HISTORY

**Do you, your child or any family members practice any relaxation/stress management techniques?
Please describe:**

CIRCLE THE APPROPRIATE ANSWERS TO THE FOLLOWING QUESTIONS:

Location of home: city/suburban/wooded/farm/other (if other please describe):

Water: city/well Purification system: yes/no If yes, please describe:

Type of heat: electric/gas/oil /other (if other please describe):

Do you live near water: swamp/river/ocean/other(if other please describe):

**Does your home have a lot of dust/mold/down or feather items (pillows, upholstery, stuffed animals?)
If so, please give details:**

Describe your child's bedroom (circle appropriate responses):

- **BEDDING:** synthetic/down/feather mattress cover: yes/no crib/junior bed/adult bed

- **FLOORING:** carpet: wall to wall /area rug? Wood? Glued down? Synthetic pad?

- **WINDOW TREATMENT:** shades/blinds/thin curtain/valance/other? (If other, please describe:)

- **OTHER ITEMS IN ROOM** (including furniture, toys, stuffed animals). Please describe:

Flooring in other rooms:

- **Children's bathroom?**

- **Living room?**

- **Family room/Play room?**

**Is your child sensitive to or bothered by any of the following? Please check (✓) where appropriate
and list specific products if possible:**

_____ **Perfumes/Cosmetics?**

_____ **Mold?**

_____ **Cleaning Products?**

_____ **Pollens/Grasses?**

_____ **Soaps?**

_____ **Animals (dander)?**

_____ **Detergents?**

_____ **Gasoline?**

_____ **Dust?**

_____ **Paint?**

_____ **Other?**

Please list known allergies:

DEVELOPMENTAL HISTORY

Please list age when the following skills were mastered and any problems associated with these skills:

First words: (Age: _____)

Phrases or sentences: (Age: _____)

Pulling to stand: (Age: _____)

Walking: (Age: _____)

Sitting up: (Age: _____)

Crawling: (Age: _____)

Running: (Age: _____)

Walking up/down steps without help: (Age: _____)

Jumping: (Age: _____)

Learned to pedal: (Age: _____)

Rode 2 wheel bicycle: (Age: _____)

Put on clothing: (Age: _____)

MEDICAL HISTORY

Please mark which tests have been done and provide date and results

EVALUATION/TEST	DATE	RESULTS (normal, abnormal or unsure)
24 Hour Amino Acids		
Amino Acid Screen		
Blood Chemistry Screen		
Blood Count (CBC)		
Blood Test—Fatty Acid		
Blood Test—Food Allergies		
CT Scan (specify area)		
Colonoscopy		
DMSA Loading Study		
EEG		
Folic Acid		
Fragile X Chromosome Study		
Hair Elements		
Hearing Test		
Immune Profile		
Intestinal Permeability		
Liver Detox Profile		
MRI (specify area)		
Organic Acids—fungal/bacteria		
Organic Acids—Metabolism		
PET Scan		

MEDICAL HISTORY (continued)

Please mark which tests have been done and provide date and results

EVALUATION/TEST	DATE	RESULTS (normal, abnormal or unsure)
Pinworm Prep		
Plasma Amino Acids		
Plasma or Serum Zinc		
RBC Elements		
Serum Ferritin (Iron stores)		
Serum Methylmalonic Acid		
Serum Vitamin A		
Small Bowel Biopsy		
Stool Culture		
Stool Parasites		
Thyroid Profile		
Uric Acid (blood or urine)		
Urinary Peptides		
Urine Elements		
Urine Kryptopyrrole		
X-Rays (specify)		
Other:		

MEDICAL HISTORY (continued)

Major surgeries – Please describe and provide dates:

SURGERY	DATE(S)	RESULTS

Major injuries – Please describe and provide dates:

INJURY	DATE(S)	RESULTS

Illnesses – Please list appropriate dates and any complications:

ILLNESS	DATE(S)	COMPLICATIONS
Ear infections		
Sinus infections		
Bronchitis		
Pneumonia		
Thrush		
Chicken Pox		
Seizures		
Mono		
Other (Please list) :		

Immunizations

Please indicate date and any reactions for those immunizations that your child has received. If exact date isn't known, please approximate. "Bowel" refers to any bowel symptom such as diarrhea. "Swelling" refers to the site of the injection.

Diphtheria/Pertussis/Tetanus	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
DPT 1								
DPT 2								
DPT 3								
DPT 4								
DPT 5								
Adult Diptheris/Tetanus								
Pediatric Diptheris/Tetanus								
H Influenza Type B	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
Hib 1								
Hib 2								
Hib 3								
Hib 4								
Polio (circle oral or Injection.)	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
OPV 1 / Injection 1								
OPV 2/ Injection 2								
OPV 3/ Injection 3								
OPV 4/ Injection 4								
OPV 5/ Injection 5								
Measles/Mumps/Rubella	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
MMR 1								
MMR 2								
Hepatitis b Vaccine	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
HBV 1								
HBV 2								
HBV 3								
Prevnar (pneumococcal)								
Miscellaneous	Date	Bowel	Swelling	Crying	Seizure	Irritable	Fever	Other
Varivax (chicken Pox)								
Tine Test								
Flu Vaccine								
Other								

Parent's Last Name	
Child's First Name	

Medication or Supplements

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Clozaril (clozapine)							
		Haldol							
		Prolixin							
		Risperdal							
		Seroquel							
		Stelazine							
		Thorazine							
		Zyprexa							
		Clonidine							
		Cogentin							
		Deanol (deaner, DMAE)							
		Dextromethorphan							
		Lithium							
		Naltrexone							
		St. John's Wort							
		Anafranil							
		Depakene for behavior							
		Depakene for seizures							
		Depakote for behavior							
		Depakote for seizures							
		Dilantin							
		Felbatol							
		Gabitril							
		Keppra							
		Klonopin							
		Lamictal							
		Luvox							
		Mysoline							

Parent's Last Name

Child's First Name

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Central Nervous System							
		Neurontin							
		Paxil							
		Phenobarbital							
		Strattera							
		Tegretol							
		Topamax							
		Trileptal							
		Valium							
		Zarotin							
		Zonegran							
		Adderall							
		Prozac							
		Zoloft							
		Amphetamine							
		Cylert							
		Dexedrine, dextroamphetamine							
		Fenfluramine							
		Focalin							
		Ritalin							
		Buspar							
		Chloral hydrate							
		Valium							
		Desipramine							
		Mallaril							
		Tofranil							
		Klonopin							
		Antihistamines							
		Benadryl							

Parent's Last Name	
Child's First Name	

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		Claritin							
		Singulair							
		Zyrtec							
		<i>Digestive Flora</i>							
		Antibiotics (specify type and number of times)							
		Bactrim (sepra)							
		Diflucan							
		Humatin							
		Lamisil							
		Nizoral							
		Nystatin							
		Saccharomyces boulardii							
		Sporonax							
		Transfer Factor (oral)/ Colostrum							
		Yodoxin							
		<i>Digestion</i>							
		Bethenecol							
		Digestive enzymes							
		Pepsid							
		Peptidase enzymes							
		Probiotics							
		<i>Detoxification</i>							
		DMPS							
		DMSA (succimer, chemet)							
		Reduced glutathione (TTFD)							
		Reduced glutathione (IV)							
		Reduced glutathione (oral)							
		Folic Acid							
		Melatonin							

Parent's Last Name

Child's First Name

Medication or Supplements (continued)

Please check (✓) substances taken now or in the past and mark the appropriate reaction

now	past	Medication or Supplement	Very Good	Good	None	Bad	Very Bad	Bad then Good	Comments
		<i>Nutrition and Metabolism</i>							
		Multivitamin (Specify)							
		Vitamin A							
		Vitamin C							
		Vitamin B3 (Niacin)							
		Vitamin B6							
		5 HTP							
		Alpha Keto Glutarate (AKG)							
		Amino Acid Mix							
		Deanol							
		Dimethylglycine (DMG)							
		GABA							
		Glutamine							
		SAMe (SAM, Samyr)							
		TMG							
		Taurine							
		Tryptophan							
		Tyrosine							
		Calcium							
		Magnesium							
		Manganese							
		Selenium							
		Zinc							
		Human Growth Factor							
		IV Immune globulin							
		Kutapressin							

Parent's Last Name	
Child's First Name	

SIGNS AND SYMPTOMS

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
1	Stimming (repetitive actions or movements)					
2	Rocking					
3	Head banging					
4	Self-mutilation					
5	Nail biting					
6	Hand/arm biting					
7	Nail/skin picking					
8	Aggressiveness (hitting, kicking, biting others)					
9	Mood swings					
10	Irritability/tantrums					
11	Fears/anxieties					
12	Hyperactivity					
13	Inability to concentrate/focus					
14	Always fidgety in his/her seat					
15	Impulsive					
16	Breath holding					
17	Dizziness					
18	Seizures					
19	Poor coordination					
20	Problems with buttons, ties, snaps or zippers					
21	Processing problems - visual, motor, language, etc.					
22	Problems with social interactions					
23	Sensitive to crowds					
24	Trouble remembering					
25	Low self esteem					
26	Fatigue					
27	Cold hands/feet					
28	Cold intolerance					
29	Heat intolerance					

SIGNS AND SYMPTOMS (continued)

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
30	Recurrent/chronic fever					
31	Flushing					
32	Difficulty falling to sleep					
33	Night waking					
34	Nightmares					
35	Difficulty waking					
36	Bed wetting/soiling					
37	Day time wetting/soiling					
38	Numbness/tingling in hands/feet					
39	Headache					
40	Blinking					
41	Tics					
42	Eye discharge					
43	Dark circles/puffiness under eyes					
44	Night-blindness in child/family					
45	Congestion					
46	Dripping nose					
47	Sensitivity to bright lights					
48	Earaches					
49	Ringing in ears					
50	Sensitive to sounds/noise					
51	Bad breath					
52	Nose bleeds					
53	Acute sense of smell					
54	Sore throats					
55	Hoarseness					
56	Cough					
57	Wheezing					
58	Geographic tongue					
59	Swollen gums					

SIGNS AND SYMPTOMS (continued)

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique details
60	Canker sores					
61	Dry lips/mouth					
62	Diarrhea					
63	Constipation					
64	Bloating					
65	Passing gas					
66	Belching					
67	Stomachache					
68	Refusal to eat					
69	Sensitive to texture of food					
70	Difficulty swallowing					
71	Food Craving					
72	Grinding teeth					
73	Mucous/blood in stools					
74	Anal itching					
75	Calf cramps					
76	Other muscle cramps/spasms					
77	Tremors					
78	Weakness					
79	Stiffness					
80	Eczema					
81	Psoriasis					
82	Hives					
83	Acne					
84	Seborrhea (cradle cap)					
85	Other rashes					
86	Easy bruising					
87	Itchy scalp					
88	Dry skin					
89	Oily skin					
90	Pale skin					

SIGNS AND SYMPTOMS (continued)

Please (✓) any signs/symptoms your child may demonstrate (note duration/details if appropriate):

No.	Description	Mild	Moderate	Severe	Duration	Unique Details
91	Sensitivity to insect bites					
92	Sensitive to texture of clothes					
93	Cracking/peeling hands					
94	Cracking/peeling feet					
95	Strong body odor					
96	Strong urine odor					
97	Strong stool odor					
98	Soft nails					
99	Thickening of nails					
100	Ridges/pitting of nails					
101	White spots/lines on nails					
102	Brittle nails					
103	Any OCD (obsessive compulsive) behaviors					
104	Strategies to put pressure on abdomen					
105	Reflux					
106	Persistent colic					
107	Toe walking					

