



Select-Care Chiropractic, PC

Nutrition • Chiropractic • Wellness

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Patient Name: _____ Date: _____

PATIENT POSTURE AND ERGONOMIC EVALUATION

1. Do you sleep on: Your Stomach? Your Side? Your Back?
2. How many hours per night do you usually sleep? _____
3. Is your sleep interrupted during the night? Yes No
4. Do you wake up in the morning with: Lower Back Pain? Neck Pain? Tingling in fingers?
5. How old is your mattress? _____ years
6. What type of mattress do you sleep on? (please circle)
Spring Coil Pillow Top Water Bed Memory Foam Air Brand: _____
7. Do you feel that your mattress is comfortable? Yes No Supportive? Yes No
8. If applicable, is your spouse/partner happy with your present mattress? Yes No
9. How many pillows do you use under your head to sleep? _____
What *type* of pillow(s) do you use to sleep? _____
10. Does sitting for prolonged periods cause you Lower Back Pain? Yes No
Mid Back Pain? Yes No Neck Pain? Yes No
11. Does prolonged computer use cause you Neck Pain? Yes No
Mid Back Pain? Yes No Wrist Pain? Yes No
Headaches? Yes No Hand Tingling? Yes No
12. Do you utilize a lumbar back cushion when you sit? Yes No
13. Do your shoes wear unevenly? Yes No Do you "toe-out" when walking? Yes No
14. Do you have bunions, calluses, corns, or flat feet? Yes No
15. Is one of your legs shorter than the other? Yes No
16. Do you have foot, ankle, knee or hip pain while standing, walking or running? Yes No
17. Does your job or house work require you to do a lot of lifting? Yes No
18. Each day, do you eat fruits and vegetables, lean protein, omega-3 fats and do you drink 60 oz. of water?
 Yes No
19. Females only: Do you suffer from PMS and menstrual cramps? Yes No