

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- | | |
|---|--|
| <input type="checkbox"/> Irritable Bowel Syndrome _____ | <input type="checkbox"/> Gastritis or Peptic Ulcer Disease _____ |
| <input type="checkbox"/> Inflammatory Bowel Disease _____ | <input type="checkbox"/> GERD (reflux) _____ |
| <input type="checkbox"/> Crohn's _____ | <input type="checkbox"/> Celiac Disease _____ |
| <input type="checkbox"/> Ulcerative Colitis _____ | <input type="checkbox"/> Other _____ |

CARDIOVASCULAR

- | | |
|--|---|
| <input type="checkbox"/> Heart Attack _____ | <input type="checkbox"/> Hypertension (high blood pressure) _____ |
| <input type="checkbox"/> Other Heart Disease _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Mitral Valve Prolapse _____ |
| <input type="checkbox"/> Elevated Cholesterol _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Arrhythmia (irregular heart rate) _____ | |

METABOLIC/ENDOCRINE

- | | |
|---|---|
| <input type="checkbox"/> Type 1 Diabetes _____ | <input type="checkbox"/> Weight Gain _____ |
| <input type="checkbox"/> Type 2 Diabetes _____ | <input type="checkbox"/> Weight Loss _____ |
| <input type="checkbox"/> Hypoglycemia _____ | <input type="checkbox"/> Frequent Weight Fluctuations _____ |
| <input type="checkbox"/> Metabolic Syndrome _____
(Insulin Resistance or Pre-Diabetes) | <input type="checkbox"/> Bulimia _____ |
| <input type="checkbox"/> Hypothyroidism (low thyroid) _____ | <input type="checkbox"/> Anorexia _____ |
| <input type="checkbox"/> Hyperthyroidism (overactive thyroid) _____ | <input type="checkbox"/> Binge Eating Disorder _____ |
| <input type="checkbox"/> Endocrine Problems _____ | <input type="checkbox"/> Night Eating Syndrome _____ |
| <input type="checkbox"/> Polycystic Ovarian Syndrome (PCOS) _____ | <input type="checkbox"/> Eating Disorder (non-specific) _____ |
| <input type="checkbox"/> Infertility _____ | <input type="checkbox"/> Other _____ |

CANCER

- | | |
|---|--|
| <input type="checkbox"/> Lung Cancer _____ | <input type="checkbox"/> Prostate Cancer _____ |
| <input type="checkbox"/> Breast Cancer _____ | <input type="checkbox"/> Skin Cancer _____ |
| <input type="checkbox"/> Colon Cancer _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Ovarian Cancer _____ | |

GENITAL AND URINARY SYSTEMS

- | | |
|--|---|
| <input type="checkbox"/> Kidney Stones _____ | <input type="checkbox"/> Frequent Yeast Infections _____ |
| <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Erectile Dysfunction or Sexual Dysfunction _____ |
| <input type="checkbox"/> Interstitial Cystitis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Frequent Urinary Tract Infections _____ | |

MUSCULOSKELETAL/PAIN

- | | |
|---|---|
| <input type="checkbox"/> Osteoarthritis _____ | <input type="checkbox"/> Chronic Pain _____ |
| <input type="checkbox"/> Fibromyalgia _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Headaches _____ | |

INFLAMMATORY/AUTOIMMUNE

- | | |
|--|--|
| <input type="checkbox"/> Chronic Fatigue Syndrome _____ | <input type="checkbox"/> Poor Immune Function _____
(frequent infections) |
| <input type="checkbox"/> Autoimmune Disease _____ | <input type="checkbox"/> Food Allergies _____ |
| <input type="checkbox"/> Rheumatoid Arthritis _____ | <input type="checkbox"/> Environmental Allergies _____ |
| <input type="checkbox"/> Lupus SLE _____ | <input type="checkbox"/> Multiple Chemical Sensitivities _____ |
| <input type="checkbox"/> Immune Deficiency Disease _____ | <input type="checkbox"/> Latex Allergy _____ |
| <input type="checkbox"/> Herpes-Genital _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Severe Infectious Disease _____ | |

MEDICAL HISTORY (CONTINUED)

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

RESPIRATORY DISEASES

- Asthma _____
- Chronic Sinusitis _____
- Bronchitis _____
- Emphysema _____
- Pneumonia _____
- Tuberculosis _____
- Sleep Apnea _____
- Other _____

SKIN DISEASES

- Eczema _____
- Psoriasis _____
- Acne _____
- Melanoma _____
- Skin Cancer _____
- Other _____

NEUROLOGIC/MOOD

- Depression _____
- Anxiety _____
- Bipolar Disorder _____
- Schizophrenia _____
- Headaches _____
- Migraines _____
- ADD/ADHD _____
- Autism _____
- Mild Cognitive Impairment _____
- Memory Problems _____
- Parkinson's Disease _____
- Multiple Sclerosis _____
- ALS _____
- Seizures _____
- Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- Full Physical Exam _____
- Bone Density _____
- Colonoscopy _____
- Cardiac Stress Test _____
- EBT Heart Scan _____
- EKG _____
- Hemocult Test-stool test for blood _____
- MRI _____
- CT Scan _____
- Upper Endoscopy _____
- Upper GI Series _____
- Ultrasound _____

INJURIES

Check box if yes: Back Injury Head Injury Neck Injury Broken Bones _____
Other _____

SURGERIES

Check box if yes and provide date of surgery

- Appendectomy _____
- Hysterectomy +/- Ovaries _____
- Gall Bladder _____
- Hernia _____
- Tonsillectomy _____
- Dental Surgery _____
- Joint Replacement -Knee/Hip _____
- Heart Surgery-Bypass Valve _____
- Angioplasty or Stent _____
- Pacemaker _____
- Other _____
- None _____

HOSPITALIZATIONS

- None

Date:	Reason:

GYNECOLOGIC HISTORY (FOR WOMEN ONLY)

OBSTETRIC HISTORY (Check box if yes and provide number)

- Pregnancies _____ Caesarean _____ Vaginal deliveries _____
 Miscarriage _____ Abortion _____ Living Children _____
 Post Partum Depression Toxemia Gestational Diabetes
 Breast Feeding For how long? _____

MENSTRUAL HISTORY

- Age at First Period: _____ Menses Frequency: _____ Length: _____ Pain: Yes No Clotting: Yes No
Has your period ever skipped? _____ For how long? _____
Last Menstrual Period: _____
Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring
How long? _____
Do you use contraception? Yes No
 Condom Diaphragm IUD Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

- Fibrocystic Breasts Endometriosis Fibroids Infertility
 Painful Periods Heavy periods PMS
Last Mammogram: _____ Breast Biopsy/Date: _____
Last PAP Test: _____ Normal Abnormal
Last Bone Density: _____ Results: High Low Within Normal Range
Are you in menopause? Yes No
Age at Menopause _____
 Hot Flashes Mood Swings Concentration/Memory Problems
 Vaginal Dryness Decreased Libido
 Heavy Bleeding Joint Pains Headaches Weight Gain
 Loss of Control of Urine Palpitations
 Use of hormone replacement therapy? How long? _____

MEN'S HISTORY (FOR MEN ONLY)

- Have you had a PSA done? Yes No
PSA Level: 0-2 2-4 4-10 >10
 Prostate Enlargement Prostate infection Change in Libido Impotence
 Difficulty Obtaining an Erection Difficulty Maintaining an Erection
 Nocturia (urination at night) How many times at night? _____
 Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

GI HISTORY

- Foreign Travel? Yes No Where? _____
Wilderness Camping? Yes No Where? _____
Have you ever had severe: Gastroenteritis Diarrhea Heartburn Reflux Food Poisoning
Do you feel like you digest your food well? Yes No
Do you feel bloated after meals? Yes No
Do you have frequent gas? Yes No If yes, does it have a foul order? Yes No
How would you describe your bowel habits: Daily; _____ times per day Weekly; _____ times per week
How would you best describe the consistency of your stools: formed/log like formed/snake like pellets loose
Do your stools frequently have a foul smell? Yes No

PATIENT BIRTH/CHILDHOOD HISTORY

Term Premature

Pregnancy Complications: _____

Birth Complications: _____

Adopted: Yes No

Breast Fed How long? _____ Bottle Fed

Age at introduction of: Solid Foods: _____ Dairy: _____ Wheat: _____

Did you eat a lot of candy or sugar as a child? Yes No

Were you sickly as a child? Yes No Explain: _____

Were you placed on antibiotics frequently as a child? Yes No

DENTAL HISTORY

Silver Mercury Fillings How many? _____

Gold Fillings

Root Canals How many? _____

Implants

Tooth Pain

Bleeding Gums

Gingivitis

Problems with Chewing

Do you floss regularly? Yes No

WELLNESS CARE

Have you ever been under the care of Doctor of Chiropractic? Yes No

Was the treatment beneficial? Yes No Explain _____

Was your care solely for pain or for **nervous system wellness care**? _____

When was your last visit to your chiropractor? _____

Name of your current/previous chiropractor _____

How often do you generally visit your chiropractor? _____

Does/did your chiropractor use their hands to adjust your spine or an instrument? _____

Are you under the care of any other alternative medicine practitioner? Yes No If so, specialty _____

Do you have a lifestyle/wellness practitioner or coach? Yes No Explain _____

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

PREVIOUS MEDICATIONS: *Last 10 years*

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)

SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR)	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? Yes No

Describe: _____

Have you had prolonged or regular use of NSAIDS? (Advil, Aleve, etc.,) Motrin, Aspirin? Yes No

Have you had prolonged or regular use of Tylenol? Yes No

Have you had prolonged or regular use of Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc.) Yes No

Frequent antibiotics > 3 times/year? Yes No

Long term antibiotics Yes No

Use of steroids (prednisone, nasal allergy inhalers) in the past? Yes No

Use of oral contraceptives? Yes No

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No

Describe: _____

Do you currently follow a special diet or nutritional program? Yes No

Describe: _____

Check all that apply:

Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy

No Wheat Gluten Restricted Vegetarian Vegan

Specific Program for Weight Loss/Maintenance Type: _____

Other _____

Height (feet/inches) _____ Current Weight _____

Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____

Highest adult weight _____ Lowest adult weight _____

Weight Fluctuations (> 10 lbs.) Yes No Body Fat % _____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you avoid any particular foods? Yes No

If yes, types and reason _____

List your three most favorite foods:

Do you grocery shop? Yes No

If no, who does the shopping? _____

Do you read food labels? Yes No

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

Fast eater

Erratic eating pattern

Eat too much

Late night eating

Dislike healthy food

Time constraints

Eat more than 50% meals away from home

Travel frequently

Non-availability of healthy foods

Do not plan meals or menus

Reliance on convenience items

Poor snack choices

Significant other or family members don't like healthy foods

Significant other or family members have special dietary needs or food preferences

Love to eat

Eat because I have to

Have a negative relationship to food

Struggle with eating issues

Emotional eater (eat when sad, lonely depressed, bored)

Eat too much under stress

Eat too little under stress

Don't care to cook

Eating in the middle of the night

Confused about nutrition advice

Do you skip meals? Yes No If so, what meals? _____

The most important thing I should change about my diet to improve my health is:

SMOKING

Currently Smoking? Yes No

How many years? _____ Packs per day: _____ Attempts to quit: _____

Previous Smoking: How many years? _____ Packs per day? _____

Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits

None 1-3 4-6 7-10 > 10 If "None," skip to Other Substances

Previous alcohol intake? Yes (Mild Moderate High) None

Have you ever been told you should cut down your alcohol intake? Yes No

Do you get annoyed when people ask you about your drinking? Yes No

Do you ever feel guilty about your alcohol consumption? Yes No

Do you ever take an eye-opener? Yes No

Do you notice a tolerance to alcohol (can you "hold" more than others)? Yes No

Have you ever been unable to remember what you did during a drinking episode? Yes No

Do you get into arguments or physical fights when you have been drinking? Yes No

Have you ever been arrested or hospitalized because of drinking? Yes No

Have you ever thought about getting help to control or stop your drinking? Yes No

OTHER SUBSTANCES

Caffeine Intake: Yes No

Coffee cups/day: 1 2-4 > 4 | Tea cups/day: 1 2-4 > 4

Soda Intake: Yes No Caffeinated Yes No Diet Yes No

12-ounce can/bottle: 1 2-4 > 4 per day

List favorite type (Ex. Diet Coke, Pepsi, etc.): _____

Are you currently using any recreational drugs? Yes No

Type: _____

Have you ever used IV or inhaled recreational drugs? Yes No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity:	Type:	Frequency per Week:	Duration in Minutes:
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotomics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity:

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe:

Do you usually sweat when exercising? Yes No

PSYCHOSOCIAL

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you ever experienced major losses in your life? Yes No

Do you spend the majority of your time and money to fulfill responsibilities and obligations? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

STRESS/COPING

Have you ever sought counseling? Yes No

Are you currently in therapy? Yes No

Describe: _____

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Daily Stressors: Rate on scale of 1-10

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

Do you practice meditation or relaxation techniques? Yes No How often? _____

Check all that apply: Yoga Meditation Imagery Breathing Tai Chi Prayer

Other: _____

Have you ever been abused, a victim of a crime, or experienced a significant trauma? Yes No

SLEEP/REST

Average number of hours you sleep per night: >10 8-10 6-8 < 6

Do you have trouble falling asleep? Yes No

Do you have trouble staying asleep? Yes No

Do you wake consistently at the same time during the night? Yes No Time: _____

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No

Explain: _____

ROLES/RELATIONSHIP

Marital status:

Single Married Divorced Gay/Lesbian Long Term Partnership Widow

List Children:

Child's Name:	Age:	Gender:

Who is Living in Household? Number: _____

Names: _____

Their employment/Occupations: _____

Resources for emotional support?

Check all that apply:

Spouse Family Friends Religious/Spiritual Pets Other: _____

Are you satisfied with your sex life? Yes No

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? Yes No

If yes, describe symptoms: _____

Do you have any food allergies or sensitivities? Yes No

If yes, list all: _____

Do you have an adverse reaction to caffeine? Yes No

When you drink caffeine do you feel: Irritable or wired Aches & Pains

Do you adversely react to (Check all that apply):

Mono-sodium glutamate (MSG) Aspartame (Nutrasweet) Caffeine Bananas

Garlic Onion Cheese Citrus Foods Chocolate Alcohol Red Wine

Sulfite Containing Foods (wine, dried fruit, salad bars) Preservatives (ex. sodium benzoate) Dyes

Other: _____

Which of these significantly affect you? Check all that apply:

Cigarette Smoke Perfumes/Colognes Auto Exhaust Fumes Other: _____

In your work or home environment, are you exposed to:

Chemicals Electromagnetic Radiation Mold

Have you ever turned yellow (jaundiced)? Yes No

Have you ever been told you have a liver disorder? Yes No

Explain: _____

Do you have a known history of significant exposure to any harmful chemicals such as the following:

Herbicides Insecticides (frequent visits of exterminator) Pesticides & Organic Solvents Heavy Metals

Other: _____

Chemical Name, Date, Length of Exposure: _____

Do you dry clean your clothes frequently? Yes No

Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? Yes No

Do you have any pets or farm animals? Yes No

Do you live on farmland or near farmland? Yes No

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past the 6 months.

GENERAL

- Cold Hands & Feet
- Cold Intolerance
- Low Body Temperature
- Low Blood Pressure
- Daytime Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Heat Intolerance
- Night Waking
- Nightmares
- No Dream Recall

HEAD, EYES & EARS

- Conjunctivitis
- Distorted Sense of Smell
- Distorted Taste
- Ear Fullness
- Ear Pain
- Ear Ringing/Buzzing
- Lid Margin Redness
- Eye Crusting
- Eye Pain
- Hearing Loss
- Hearing Problems
- Headache
- Migraine
- Sensitivity to Loud Noises
- Vision problems
(other than glasses)
- Macular Degeneration
- Vitreous Detachment
- Retinal Detachment

MUSCULOSKELETAL

- Back Muscle Spasm
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Stiffness

Muscle Twitches:

- Around Eyes
- Arms or Legs
- Muscle Weakness
- Neck Muscle Spasm
- Tendonitis
- Tension Headache
- TMJ Problems

MOOD/NERVES

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Black-out
- Depression

Difficulty:

- Concentrating
- With Balance
- With Thinking
- With Judgment
- With Speech
- With Memory
- Dizziness (Spinning)
- Fainting
- Fearfulness
- Irritability
- Light-headedness
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor/Trembling
- Visual Hallucinations

EATING

- Binge Eating
- Bulimia
- Can't Gain Weight
- Can't Lose Weight
- Can't Maintain Healthy Weight
- Frequent Dieting
- Poor Appetite
- Salt Cravings
- Carbohydrate Craving
(breads, pastas)
- Sweet Cravings
(candy, cookies, cakes)
- Chocolate Cravings
- Caffeine Dependency

DIGESTION

- Anal Spasms
- Bad Teeth
- Bleeding Gums
- Bloating of:**
 - Lower Abdomen
 - Whole Abdomen
 - Bloating After Meals
- Blood in Stools
- Burping
- Canker Sores
- Cold Sores
- Constipation
- Cracking at Corner of Lips
- Cramps
- Dentures w/Poor Chewing
- Diarrhea
- Alternating Diarrhea and Constipation
- Difficulty Swallowing
- Dry Mouth
- Excess Flatulence/Gas
- Fissures
- Foods "Repeat" (Reflux)
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Upper Abdominal Pain
- Vomiting
- Intolerance to:**
 - Lactose
 - All Dairy Products
 - Wheat
 - Gluten (Wheat, Rye, Barley)
 - Corn
 - Eggs
 - Fatty Foods
 - Yeast
- Liver Disease/Jaundice
(Yellow Eyes or Skin)
- Abnormal Liver Function Tests
- Lower Abdominal Pain
- Mucus in Stools
- Periodontal Disease
- Sore Tongue
- Strong Stool Odor
- Undigested Food in Stomach

SYMPTOM REVIEW (continued)

SKIN PROBLEMS

- Acne on Back
- Acne on Chest
- Acne on Face
- Acne on Shoulders
- Athlete's Foot
- Bumps on Back of Upper Arms
- Cellulite
- Dark Circles Under Eyes
- Ears Get Red
- Easy Bruising
- Lack Of Sweating
- Eczema
- Hives
- Jock Itch
- Lackluster Skin
- Moles w/Color/Size Change
- Oily Skin
- Pale Skin
- Patchy Dullness
- Rash
- Red Face
- Sensitivity to Bites
- Sensitivity to Poison Ivy/Oak
- Shingles
- Skin Darkening
- Strong Body Odor
- Hair Loss
- Vitiligo

ITCHING SKIN

- Skin in General
- Anus
- Arms
- Ear Canals
- Eyes
- Feet
- Hands
- Legs
- Nipples
- Nose
- Penis
- Roof of Mouth
- Scalp
- Throat

SKIN, DRYNESS OF

- Eyes
- Feet
 - Cracking?
 - Peeling?
- Hair Unmanageable?
- Hands
 - Cracking?
 - Peeling?
- Mouth/Throat
- Scalp
 - Dandruff?
- Skin In General

LYMPH NODES

- Enlarged/neck
- Tender/neck
- Other Enlarged/Tender
- Lymph Nodes

NAILS

- Bitten
- Brittle
- Curve Up
- Frayed
- Fungus-Fingers
- Fungus-Toes
- Pitting
- Ragged Cuticles
- Ridges
- Soft
- White Spots/Lines

Thickening of:

- Fingernails
- Toenails

RESPIRATORY

- Bad Breath
- Bad Odor in Nose
- Cough-Dry
- Cough-Productive
- Hoarseness
- Sore Throat
- Hay Fever:**
 - Spring
 - Summer
 - Fall
 - Change Of Season
 - Nasal Stuffiness
 - Nose Bleeds
 - Post Nasal Drip
 - Sinus Fullness
 - Sinus Infection
 - Snoring
 - Wheezing
 - Winter Stuffiness

CARDIOVASCULAR

- Angina/chest pain
- Breathlessness
- Heart Murmur
- Irregular Pulse
- Palpitations
- Phlebitis
- Swollen Ankles/Feet
- Varicose Veins

URINARY

- Bed Wetting
- Hesitancy
 - (trouble getting started)
- Infection
- Kidney Disease
- Leaking/Incontinence
- Pain/Burning
- Prostate Infection
- Urgency

MALE REPRODUCTIVE

- Discharge From Penis
- Ejaculation Problem
- Genital Pain
- Impotence
- Prostate or Urinary Infection
- Lumps In Testicles
- Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE

- Breast Cysts
- Breast Lumps
- Breast Tenderness
- Ovarian Cyst
- Poor Libido (Sex Drive)
- Vaginal Discharge
- Vaginal Odor
- Vaginal Itch
- Vaginal Pain with Sex
- Premenstrual:**
 - Bloating Breast Tenderness
 - Carbohydrate Cravings
 - Chocolate Cravings
 - Constipation
 - Decreased Sleep
 - Diarrhea
 - Fatigue
 - Increased Sleep
 - Irritability
- Menstrual:**
 - Cramps
 - Heavy Periods
 - Irregular Periods
 - No Periods
 - Scanty Periods
 - Spotting Between

READINESS ASSESSMENT

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

- Significantly modify your diet..... 5 4 3 2 1
- Take several nutritional supplements each day..... 5 4 3 2 1
- Keep a record of everything you eat each day..... 5 4 3 2 1
- Modify your lifestyle (e.g., work demands, sleep habits) 5 4 3 2 1
- Disengage in negative habits/relationships..... 5 4 3 2 1
- Practice a relaxation technique 5 4 3 2 1
- Engage in regular exercise 5 4 3 2 1
- Have periodic lab tests to assess your progress..... 5 4 3 2 1
- Maintain a chiropractic wellness program to ensure optimum nervous system function..... 5 4 3 2 1

Comments _____

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health related activities? 5 4 3 2 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 4 3 2 1

Comments: _____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

5 4 3 2 1

Comments: _____

Please list any other concerns that you feel may prohibit you from obtaining optimal health:

3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days **including one weekend day.**

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: _____ Date: _____

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____

Stress/Mood/Emotions: _____

Other Comments: _____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ DATE: _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for *ONLY* the last 48 hours.

POINT SCALE

- 0 = Never or almost never have the symptom
- 1 = Occasionally have it, effect is not severe
- 2 = Occasionally have, effect is severe
- 3 = Frequently have it, effect is not severe
- 4 = Frequently have it, effect is severe

KEY TO QUESTIONNAIRE

Add individual scores and total each group. Add each group score and give a grand total.

• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT

- ___ Nausea or vomiting
- ___ Diarrhea
- ___ Constipation
- ___ Bloating feeling
- ___ Belching or passing gas
- ___ Heartburn
- ___ Intestinal/Stomach pain

Total _____

EARS

- ___ Itchy ears
- ___ Earaches, ear infections
- ___ Drainage from ear
- ___ Ringing in ears, hearing loss

Total _____

EMOTIONS

- ___ Mood swings
- ___ Anxiety, fear or nervousness
- ___ Anger, irritability or aggressiveness
- ___ Depression

Total _____

ENERGY/ACTIVITY

- ___ Fatigue, sluggishness
- ___ Apathy, lethargy
- ___ Hyperactivity
- ___ Restlessness

Total _____

EYES

- ___ Watery or itchy eyes
- ___ Swollen, reddened or sticky eyelids
- ___ Bags or dark circles under eyes
- ___ Blurred or tunnel vision (does not include near or far-sightedness)

Total _____

HEAD

- ___ Headaches
- ___ Faintness
- ___ Dizziness
- ___ Insomnia

Total _____

HEART

- ___ Irregular or skipped heartbeat
- ___ Rapid or pounding heartbeat
- ___ Chest pain

Total _____

JOINTS/MUSCLES

- ___ Pain or aches in joints
- ___ Arthritis
- ___ Stiffness or limitation of movement
- ___ Pain or aches in muscles
- ___ Feeling of weakness or tiredness

Total _____

LUNGS

- ___ Chest congestion
- ___ Asthma, bronchitis
- ___ Shortness of breath
- ___ Difficult breathing

Total _____

MIND

- ___ Poor memory
- ___ Confusion, poor comprehension
- ___ Poor concentration
- ___ Poor physical coordination
- ___ Difficulty in making decisions
- ___ Stuttering or stammering
- ___ Slurred speech
- ___ Learning disabilities

Total _____

MOUTH/THROAT

- ___ Chronic coughing
- ___ Gagging, frequent need to clear throat
- ___ Sore throat, hoarseness, loss of voice
- ___ Swollen/discolored tongue, gum, lips
- ___ Canker sores

Total _____

NOSE

- ___ Stuffy nose
- ___ Sinus problems
- ___ Hay fever
- ___ Sneezing attacks
- ___ Excessive mucus formation

Total _____

SKIN

- ___ Acne
- ___ Hives, rashes or dry skin
- ___ Hair loss
- ___ Flushing or hot flushes
- ___ Excessive sweating

Total _____

WEIGHT

- ___ Binge eating/drinking
- ___ Craving certain foods
- ___ Excessive weight
- ___ Compulsive eating
- ___ Water retention
- ___ Underweight

Total _____

OTHER

- ___ Frequent illness
- ___ Frequent or urgent urination
- ___ Genital itch or discharge

Total _____

GRAND TOTAL: _____

