Patient Name: ______________________________ Date: ______________________________

MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

- ☐ Irritable Bowel Syndrome ________________
- ☐ Inflammatory Bowel Disease _____________
- ☐ Crohn's ______________________________
- ☐ Ulcerative Colitis ______________________
- ☐ Gastritis or Peptic Ulcer Disease __________
- ☐ GERD (reflux) _________________________
- ☐ Celiac Disease _________________________
- ☐ Other ________________________________

CARDIOVASCULAR

- ☐ Heart Attack ___________________________
- ☐ Other Heart Disease _____________________
- ☐ Stroke ________________________________
- ☐ Elevated Cholesterol _____________________
- ☐ Arrhythmia (irregular heart rate) __________
- ☐ Hypertension (high blood pressure) _______
- ☐ Rheumatic Fever _______________________
- ☐ Mitral Valve Prolapse ___________________
- ☐ Other _________________________________

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes _________________________
- ☐ Type 2 Diabetes _________________________
- ☐ Hypoglycemia ___________________________
- ☐ Metabolic Syndrome _____________________
  (Insulin Resistance or Pre-Diabetes)
- ☐ Hypothyroidism (low thyroid) ____________
- ☐ Hyperthyroidism (overactive thyroid)______
- ☐ Endocrine Problems_____________________
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Infertility_____________________________
- ☐ Weight Gain___________________________
- ☐ Weight Loss ___________________________
- ☐ Frequent Weight Fluctuations____________
- ☐ Bulimia ______________________________
- ☐ Anorexia _____________________________
- ☐ Binge Eating Disorder___________________
- ☐ Night Eating Syndrome__________________
- ☐ Eating Disorder (non-specific ____________
- ☐ Other________________________________

CANCER

- ☐ Lung Cancer __________________________
- ☐ Breast Cancer _________________________
- ☐ Colon Cancer _________________________
- ☐ Ovarian Cancer ________________________
- ☐ Prostate Cancer ________________________
- ☐ Skin Cancer __________________________
- ☐ Other________________________________

GENITAL AND URINARY SYSTEMS

- ☐ Kidney Stones _________________________
- ☐ Gout ________________________________
- ☐ Interstitial Cystitis _____________________
- ☐ Frequent Urinary Tract Infections _________
- ☐ Frequent Yeast Infections ________________
- ☐ Erectile Dysfunction or Sexual Dysfunction _
- ☐ Other _______________________________

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis __________________________
- ☐ Fibromyalgia __________________________
- ☐ Headaches ____________________________
- ☐ Chronic Pain ___________________________
- ☐ Other ________________________________

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome _______________
- ☐ Autoimmune Disease ___________________
- ☐ Rheumatoid Arthritis ___________________
- ☐ Lupus SLE_ ___________________________
- ☐ Immune Deficiency Disease _____________
- ☐ Herpes-Genital _______________________
- ☐ Severe Infectious Disease ________________
- ☐ Poor Immune Function __________________
  (frequent infections)
- ☐ Food Allergies _________________________
- ☐ Environmental Allergies _________________
- ☐ Multiple Chemical Sensitivities ____________
- ☐ Latex Allergy __________________________
- ☐ Other ________________________________

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 _______________________________
- ☐ Hemoccult 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 fowl 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

FAMILY HISTORY

Check family members that apply	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems/Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Miscarrages												
Other												

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, gyrotonics, 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
___ Bloated 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:______

SPACE FOR ADDITIONAL NOTES