# Conﬁdential Patient Information

Name Date

Address

City

State

Zip

Home Phone Cell Phone Work Phone Email Would you like to receive information via email? Y N Date of Birth Sex M F SS# Marital Status M S W D

Spouses Name # of Children

Emergency Contact Phone Insurance Name Id# Phone Subscriber or Insured Name Subscriber Date of Birth Parent or Legal Guardian if under 18 Address if diﬀerent than above

Employer Phone

Address Job Title

How did you hear about our oﬃce?

## Current Condition

Present Complaints

On a scale of 1-10, please rate the severity of your symptoms (10 is most severe) When did this condition begin? Have you had or been treated for same or similar condition before? Yes No

Describe Have you ever seen a chiropractor before? Yes No Who? Have you seen another doctor about your present symptoms? Yes No

Name Treatment Have you been hospitalized for this condition? Yes No When Hospital List medications you are taking List supplements you are taking

# Conﬁdential Patient Information Continued

Is your condition the result of an accident/injury? Yes No Date Describe Were you hurt on the job? Yes No Describe

Are you covered by Worker’s Compensation? Yes No

Do you have a claim open? Yes No Where? Claim # Are you unable to work due to present condition? Yes No Since Are you experiencing other restrictions due to present condition? Yes No

Describe

## Health History

Have you had any major surgeries? Yes No Please indicate date(s) and procedures:

Have you had any prior injuries or accidents? Yes No Please give date(s) and descriptions: Please indicate any other health problems below. Circle **C** for current, **P** for past and **F** for family.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Heart or Circulatory Problems | C | P | F |  |
| Digestive or Bowel Problems | C | P | F |  |
| Respiratory Problems | C | P | F |  |
| Eye, Ear, Nose Throat Problems | C | P | F |  |
| Tooth or Jaw Problems | C | P | F |  |
| Skin Problems | C | P | F |  |
| Allergies | C | P | F |  |
| Numbness or Tingling | C | P | F |  |
| Confusion or Depression | C | P | F |  |
| Kidney or Urinary Problems | C | P | F |  |
| Recurrent Infections/Fevers | C | P | F |  |
| Arm or Leg Pain | C | P | F |  |
| Back or Neck Pain | C | P | F |  |
| Menstrual Problems | C | P | F |  |
| Prostate Problems | C | P | F |  |
| Cancer | C | P | F |  |

Comments

# Nutritional Survey

### Name Date

#### Point Scale

1. Never
2. Rarely (1-6x/yr)
3. Occasionally (6-12x/yr)
4. Frequently (once per week or more)
5. Constantly

#### Section One Section Four

Bloated after eating rF equent colds/ﬂu

Gas shortly after eating Allergies

Burning stomach relieved by eating Red, itchy eyes

Indigestion shortly after eating Wounds heal slowly

Coated tongue Gums bleed easily

Indigestion relieved by antacids, Sinus congestion, post nasal drip milk or carbonated beverages Excessive hair loss

### TOTAL TOTAL

#### Section Two Section Five

Burning or itching feet

Recurring skin rashes

Chronic Fatigue

Weakness, dizziness

Fats and greasy food upset digestion Increased perspiration

Pain between shoulder blades Crave salt

Constipation or diarrhea Arthritic symptoms

Light colored stools

Nightmares, bad dreams

### TOTAL

**TOTAL**

#### Section Three Section Six

Crave sweets or coﬀee in afternoon Joint pain

Feel shaky or irritable if meals are Depression/mood swings

missed or delayed Reduced sex drive

Feel hungry between meals Night sweats

Fatigue relieved by eating Fatigue easily

Awaken after a few hours of sleep, Weight gain

diﬃcult to get back to sleep Women: menstrual symptoms

Confusion, poor memory, faintness, Men: prostate problems, diﬃcult Dizziness or frequent urination, esp. at night

**TOTAL TOTAL**

# Nutritional Questionnaire

### Name: Date:

*To help me better understand how your eating practices may be aﬀecting your health, I would appreciate you taking a few minutes to complete this questionnaire. Please check oﬀ your answer to each question as accurately as you can. Thank you.*

***Questions Never Occasionally Regularly***

|  |  |  |  |
| --- | --- | --- | --- |
| Do you eat breakfast? |  |  |  |
| Do you eat lunch? |  |  |  |
| Do you eat dinner? |  |  |  |
| Do you follow a food combining program? |  |  |  |
| Do you eat red meat? |  |  |  |
| Do you eat white meat & ﬁsh? |  |  |  |
| Does your daily diet include fruit? |  |  |  |
| Does your daily diet include vegetables? |  |  |  |
| Do you drink soft drinks? |  |  |  |
| Do you drink diet soft drinks? |  |  |  |
| Do you use artiﬁcial sweeteners? |  |  |  |
| Do you drink coﬀee or tea? |  |  |  |
| Do you drink tap water? |  |  |  |
| Do you take prescription drugs? |  |  |  |
| Do you take over-the-counter medicines? |  |  |  |
| Do you take antacids? |  |  |  |
| Do you have sugar cravings? |  |  |  |
| Do you read labels for fat content? |  |  |  |
| Do you eat foods with MSG? |  |  |  |
| Do you take vitamin supplements? |  |  |  |
| Do you eat deep fried foods? |  |  |  |
| Do you eat chocolate? |  |  |  |
| Do you consume dairy products inc. ice  cream? |  |  |  |
| Do you snack on “junk foods”? |  |  |  |
| Do you drink alcoholic beverages? |  |  |  |
| Do you smoke or chew tobacco? |  |  |  |
| Are you exposed to second hand smoke? |  |  |  |
| Do you eat out in restaurants? |  |  |  |
| Do you have allergic reactions to foods? |  |  |  |
| Would you like to weigh less? |  |  |  |
| Would you like to weigh more? |  |  |  |
| Do you snack between meals? |  |  |  |
| Do you experience intestinal gas after  eating? |  |  |  |
| Do you experience any digestive discomfort? |  |  |  |

# Stress Questionnaire

### Name: Date:

*To help me understand how your stress level may be aﬀecting your health, I would appreciate you taking just a few minutes to complete this questionnaire. Please check oﬀ your answer to each question as accurately as you can as it applies to your life within the last 12 months. Thank you.*

#### Questions No Yes

|  |  |  |
| --- | --- | --- |
| Do you regularly perform aerobic exercise? |  |  |
| Do you feel stress is a big factor in your life? |  |  |
| Are you regularly exposed to airborne pollutants or toxins? |  |  |
| Do you use a computer? |  |  |
| Do you microwave your food? |  |  |
| Do you live or work near high voltage power lines? |  |  |
| Has a family member or friend died in the last year? |  |  |
| Have you married, separated or divorced in the last year? |  |  |
| Are you or a family member experiencing any health problems? |  |  |
| Do you have ongoing relationship challenges? |  |  |
| Are you experiencing ﬁnancial pressures? |  |  |
| Have you or a family member lost a job recently? |  |  |
| Have you moved to a new home or position at work? |  |  |
| Do you have boss or work challenges? |  |  |
| Are you retired or contemplating retirement? |  |  |
| Have you or a family member started a new job recently? |  |  |
| Have your sleep patterns changed? |  |  |
| Have your eating habits changed? |  |  |
| Are you starting or ending a school year? |  |  |
| Have you recently purchased or sold your home? |  |  |
| Have you assumed more or less responsibilities at work? |  |  |
| Has your social life changed signiﬁcantly? |  |  |
| Are you experiencing any legal problems? |  |  |
| Are you expecting or have a new baby in the family? |  |  |
| Have any older children left home? |  |  |
| Are vacations and holidays happy times? |  |  |
| Have your recreation patterns changed? |  |  |
| Can you relax after work? |  |  |
| Is substance abuse a factor in your or a family member’s life? |  |  |