Chiropractic Neurology & Wellness Center

Comprehensive Patient History

Today's Date: _____
MONTH/DAY/YEAR

Date of Birth: _____ Age: _____
MONTH/DAY/YEAR

Legal Name: _____ Gender: _____

Preferred Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____
AREA CODE + NUMBER AREA CODE + NUMBER

Marital Status: ☐ Single ☐ Divorced ☐ Widowed ☐ Married: Spouse's Name: _____

Please list your children and their ages:

_____ _____

_____ _____

_____ _____

_____ _____

Work Status: ☐ Employed ☐ Retired ☐ Disabled ☐ Student (School Name): _____

Occupation: _____

Employer: _____ Employer Phone: (_____) _____

Name/Phone Number of Emergency Contact: _____

Who referred you to our office? _____

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

SLEEP HABITS

I go to bed at _____ PM. I usually have difficulty falling asleep ☐ Yes ☐ No

I frequently wake up in the middle of the night, between 1:00AM to 3:00AM ☐ Yes ☐ No

I typically wake up to start my day at _____ AM.

After waking, I usually feel… ☐ Well Rested ☐ Tired ☐ Exhausted Do you snore? ☐ Yes ☐ No

I have had a sleep study performed and the doctor diagnosed me with Sleep Apnea ☐ Yes ☐ No

The Sleep Study was performed: When? _____

by whom: _____

I use a sleep aid (C-PAP or medication): ☐ Yes ☐ No

EATING HABITS

I typically eat breakfast at _____ AM and it usually consists of _____

_____

My morning routine does/does not include cigarettes. My morning routine includes coffee. ☐ Yes ☐ No

I have a morning snack at _____ AM and it consists of _____

_____

I eat lunch at _____ PM and it consists of _____

_____

I have an afternoon snack at _____ PM and it consists of _____

_____

I eat dinner at _____ PM and it consists of _____

_____

I have an evening snack at _____ PM and it consists of _____

_____

I eat out _____ times/week. I eat fish _____ times/week. I eat raw nuts/seeds _____ times/week.

The three *worst foods* I eat during the average week _____

_____

The three *healthiest foods* I eat during the average week: _____

_____

Have you ever had a nutritional 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

Check all that apply:

☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ Dairy-Free ☐ Soy-Free

☐ Gluten-Free ☐ Vegetarian ☐ Vegan ☐ Organic

☐ Special Program for Weight Loss/Maintenance Type: _____

EATING HABITS, contd.

Daily Fluid Intake:
I typically consume: _____ glasses/bottles of water daily _____ cups of tea (black/green/herbal)
_____ cups of coffee / choose one: ☐ decaf ☐ regular ☐ Starbucks's_____
_____ soft drinks (diet/decaf/regular);_____ energy drinks; _____ alcoholic beverages/week.

Daily Routine:
I begin work at _____ ☐ am ☐ pm and typically finish by _____ ☐ am ☐ pm
My occupational stress level is _____ (List 1 to 10, with 0 = no stress and 10 = severe stress).
My personal stress level is _____ (List 1 to 10, with 0 = no stress and 10 = severe stress).
My exercise level is: ☐ Non-Existent ☐ Minimal (1-2 days/wk)
☐ Moderate (3-4 days/wk) ☐ Intense (5 days/wk)

Type of Exercise
☐ Walking ☐ Running ☐ Biking ☐ Weight Training ☐ Aerobic ☐ Pilates ☐ Yoga ☐ Golf
Other Exercise:_____

Currently Smoking? ☐ Yes ☐ No How many years?_____ Packs per day:_____ Attempts to quit: _____
Previous Smoking? How many years? _____ Packs per day: _____ Second-hand smoke? ☐ Yes ☐ No

SUPPLEMENTS
Please list the supplements/vitamins you currently take.

	Supplement	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					

MEDICATIONS
Please list the Prescribed and Over-the-Counter medications you currently take.

	Medication	Dose	Frequency	Start Date	Reason
1.					
2.					
3.					
4.					
5.					
6.					

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____

MEDICATIONS, contd.

Do you have any allergies to medications? ☐ yes ☐ no If yes, please list below.

_____

_____

Have you had prolonged or regular use of any of the following (select all that apply).

☐ NSAIDS (Advil, Aleve, Aspirin) ☐ Tylenol ☐ Allergy shots ☐ Acid Blocking Drugs (Prilosec, Zantac)

☐ Antibiotics more than 3 times/year ☐ Corticosteroids (prednisone, etc.)

Do you use creams or lotions of any kind? ☐ Facial/Eye ☐ Revitalizing ☐ Hormones

Do you use oral contraceptives? ☐ Yes ☐ No

MEDICAL HISTORY

Current Physician _____Phone _____

Have you benefitted from previous Chiropractic care? ☐ Yes ☐ No

When was your last adjustment?_____

Please list all other chiropractors/physicians/physical therapists/massage therapists you have seen for your current complaints:

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Preventive Tests and Date of Last Test. Check box if yes and provide date of test.

☐ Full Physical _____ ☐ Blood Test _____ ☐ Bone Density _____

☐ Colonoscopy _____ ☐ EKG _____ ☐ Stool Test _____

☐ CT Scan _____ ☐ X-Rays _____ ☐ Upper GI Series _____

☐ Ultrasound _____ ☐ Urine _____ ☐ Cardiac Stress _____

☐ Salivary Hormones _____ ☐ Endoscopy _____ ☐ MRI _____

☐ Other: _____

Surgeries. Check box if yes and provide date of surgery

☐ Appendectomy_____ ☐ Hysterectomy +/- Ovaries _____ ☐ Gall Bladder _____

☐ Hernia _____ ☐ Tonsillectomy _____ ☐ Dental Surgery _____

☐ Joint Replacement _____ ☐ Heart Surgery _____ ☐ Angioplasty/Stent _____

☐ Pacemaker _____

☐ Other: _____

MEDICAL HISTORY, contd.

Please list and date your significant infections, traumas, and accidents.

1. _____

2. _____

3. _____

4. _____

5. _____

Recent Trips? _____

Foreign Travel? ☐ Yes ☐ No Where? _____

Wilderness Camping? ☐ Yes ☐ No Where? _____

Have you been DIAGNOSED with any of the following diseases?

Gastrointestinal

☐ Irritable Bowel Syndrome ☐ Inflammatory Bowel Disease ☐ Crohn's ☐ Ulcerative Colitis
☐ Gastritis or Peptic Ulcer ☐ GERD (reflux) ☐ Celiac Disease
☐ Other _____

Cardiovascular

☐ Heart Attack ☐ Stroke ☐ Elevated Cholesterol ☐ Elevated Triglycerides
☐ Arrhythmia ☐ High Blood Pressure ☐ Rheumatic Fever ☐ Mitral Valve Prolapse ☐ Anemia
☐ Other _____

Cancer

☐ Asthma ☐ Breast Cancer ☐ Colon ☐ Ovarian Cancer ☐ Prostate ☐ Skin Cancer
☐ Other _____

Metabolic/Endocrine

☐ Type I Diabetes ☐ Type II Diabetes ☐ Hypoglycemia ☐ Metabolic Syndrome
☐ Insulin resistance or Pre-Diabetic ☐ Hypothyroidism (low thyroid) ☐ Hyperthyroidism (overactive thyroid)
☐ Hoshimoto's Autoimmune Thyroid ☐ Polycystic Ovarian Syndrome ☐ Infertility
☐ Weight Loss ☐ Weight Gain ☐ Frequent Weight Fluctuations ☐ Bulimia ☐ Anorexia
☐ Binge Eating Disorder ☐ Night Eating Disorder ☐ Eating Disorder (Non-Specific)

MEDICAL HISTORY, contd.

Genital and Urinary Systems

☐ Kidney Stones ☐ Gout ☐ Interstitial Cystitis ☐ Frequent Urinary Tract Infections ☐ Frequent Yeast Infections
☐ Erectile Dysfunction or Sexual Dysfunction
☐ Other _____

Inflammatory/Autoimmune

☐ Chronic Fatigue Syndrome ☐ Autoimmune Disease ☐ Rheumatoid Arthritis ☐ Lupus (SLE)
☐ Severe Infectious ☐ Poor Immune /Function ☐ Frequent Infections ☐ Food Allergies
☐ Environmental Allergies ☐ Multiple Chemical Sensitivities
☐ Other _____

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 Disease ☐ Schizophrenia ☐ Headaches
☐ Migraines ☐ ADD/ADHD ☐ Autism ☐ Mild Cognitive Impairment ☐ Memory Problems
☐ Parkinson's Disease ☐ Multiple Sclerosis ☐ ALS ☐ Seizures
☐ Other _____

Musculoskeletal/Pain

☐ Osteoarthritis ☐ Fibromyalgia ☐ Chronic Pain
☐ Other _____

Women Only

Obstetric History (Check box if yes and provide number; females only)

Are you pregnant? ☐ Yes ☐ No How many weeks? _____

☐ Pregnancies _____ ☐ Caesarean _____ ☐ Vaginal Deliveries _____ ☐ Miscarriage _____
☐ Abortion _____ ☐ Post-Partum Depression _____ ☐ Toxemia_____
☐ Gestational Diabetes _____ ☐ Breast Feeding for how long? _____

MEDICAL HISTORY, contd.

Menstrual History
Age at First Period: _____ Menses Frequency: _____ Length: _____
Pain? ☐ Yes ☐ No Clotting? ☐ Yes ☐ No
Has your period ever skipped? ☐ Yes ☐ No How Long? _____ Last menstrual period: _____
Use of hormonal contraception such as: ☐ Birth control Pill ☐ Patch ☐ NuvaRing ☐ How Long?_____
Do you use contraception? ☐ Yes ☐ No; ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy ☐ Tubal Ligation

Women's Disorders – Hormonal Imbalances
☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Painful Periods ☐ Heavy Periods ☐ PMS
Last Mammogram: _____ Breast Biopsy/Date: _____ BRCA Gene Test? ☐ (+) ☐ (-)
Last PAP Test: _____ ☐ Normal ☐ Abnormal
Last Bone Density Test: _____ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in menopause? ☐ Yes ☐ No Age when menopause began: _____
Do you suffer any of these menopausal symptoms? ☐ Hot Flashes ☐ Mood Swings ☐ Concentration decreased ☐ Vaginal Dryness ☐ Decreased Libido ☐ Loss of Control of Urine ☐ Use of hormone replacement therapy. If yes, type: _____

Men Only
Male Disorders
Date of your last PSA Test: _____ PSA level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10 ☐ Never had Test
Have you had any of the following in the last year? ☐ Prostate Enlargement ☐ Prostate infection
☐ Prostate Cancer ☐ Prostate "shots" (I.e. Eligard) ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Decreased Frequency of Morning Erections ☐ Enlarged breasts
☐ Fluid Discharge from Nipples ☐ Nocturia (Urination at night) ☐ Urgency/Hesitancy/Change in Urinary Stream
☐ Loss of Control of Urine

Women & Men
Environmental & Detoxification Assessment
Do you have known adverse food reactions or sensitivities? ☐ Yes ☐ No
If yes, describe symptoms: _____

Do you have any adverse reaction to caffeine? ☐ Yes ☐ No
When you drink caffeine do you feel: ☐ Irritable or Wired ☐ Acne & Pains
Do you adversely react to (Check all that apply):
☐ MSG ☐ Aspartame (NutraSweet) ☐ Bananas ☐ Garlic ☐ Onion ☐ Cheese ☐ Citrus ☐ Chocolate
☐ Alcohol/Red Wine ☐ Sulfites (Wine, dried fruit, salad bars) ☐ Preservatives (i.e., sodium benzoate)
☐ Other: _____

Which of these significantly affect you? (Check all that apply):
☐ Cigarette Smoke ☐ Perfumes/Colognes ☐ Auto Exhaust Fumes ☐ Other: _____

ENVIRONMENTAL FACTORS

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

☐ Chemicals ☐ Electromagnetic Radiation ☐ Mold ☐ Well Water

Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No

Have you ever been told you have Gilbert's Syndrome or a Liver Disorder? ☐ Yes ☐ No

Explain: _____

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

☐ Herbicides ☐ Insecticides/Pesticides ☐ Organic Solvents ☐ Heavy Metals

Chemical name, date, & length of exposure:_____

Do you dry clean your clothes frequently? ☐ Yes ☐ No

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

Review of Symptoms: (Please check all boxes that apply)

General

☐ Cold Hands & Feet	☐ Cold Intolerance	☐ Low Body Temp	☐ Low Blood Pressure
☐ Daytime Sleepiness	☐ Difficulty Falling Asleep	☐ Early Waking	☐ Fatigue
☐ Fever	☐ Flushing	☐ Heat Intolerance	☐ Night Walking
☐ 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 Degen.	☐ 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 Spasm	☐ Muscle Stiffness	☐ Muscle Weakness
☐ Tension Headaches	☐ TMJ Problems	☐ Neck Muscle Spasm	☐ Tendonitis
☐ Muscle Twitch Around Eyes		☐ Muscle Twitch Arms or Legs	

Mood/Nerves

☐ Agoraphobia	☐ Anxiety	☐ Black-outs	☐ Depression
☐ Dizziness	☐ Vertigo	☐ Fainting	☐ Fearfulness
☐ Irritability	☐ Light-Headedness	☐ Numbness	☐ Other Phobias
☐ Panic Attacks	☐ Paranoia	☐ Seizures	☐ Suicidal Thoughts
☐ Tingling	☐ Tremor/Trembling	☐ Visual or Auditory Hallucinations	

SYMPTOM HISTORY

Difficulty with…

☐ Concentrating ☐ Balance ☐ Thinking ☐ Judgment ☐ Speech ☐ Memory

Digestion

☐ Anal Spasms ☐ Bad Teeth ☐ Bleeding Gums ☐ Oral Blisters
☐ Blood in Stools ☐ Burping ☐ Canker Sores ☐ Cold Sores
☐ Cracking at the corners of lips ☐ Cramps ☐ Heartburn
☐ Dentures ☐ Diarrhea ☐ Fissures ☐ Nausea
☐ Dry Mouth ☐ Excess Flatulence/gas
☐ Hemorrhoids ☐ Indigestion ☐ Sore Tongue ☐ Difficulty Swallowing
☐ Vomiting ☐ Alternating Diarrhea/Constipation ☐ Periodontal Disease
☐ Constipation ☐ Lower Abdominal Pain ☐ Upper Abdominal Pain
☐ Strong Stool Odor ☐ Undigested Food in Stool ☐ Mucus in Stools

Bloating of …

☐ Lower Abdomen ☐ Whole Abdomen ☐ Bloating after meals

Intolerance to …

☐ Lactose ☐ All Dairy Products ☐ Gluten ☐ Corn
☐ Eggs ☐ Soy ☐ Fatty Foods ☐ Yeast

Skin Problems …

☐ Acne on Back ☐ Acne on Chest ☐ Acne on Face ☐ Acne on Shoulders
☐ Athlete's Foot ☐ Bumps on Back of Upper Arms ☐ Dark Circles under eyes
☐ Cellulite ☐ Ears get cold ☐ Easily Bruise ☐ Lack of Sweating
☐ Too Much Sweating ☐ Eczema ☐ Hives ☐ Jock Itch
☐ Lackluster Skin ☐ Moles w/Color/Size Changes ☐ Oily Skin
☐ Pale Skin ☐ Patchy Dullness ☐ Rash ☐ Red Face
☐ Sensitivity to Bites ☐ Shingles ☐ Sensitivity to Poison Ivy/Oak
☐ Skin Darkening ☐ Strong Body Odor ☐ Hair Loss ☐ Vitiligo

Itchy Skin…

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

Dryness of …

☐ Eyes ☐ Feet ☐ Hands (Cracks or Peel)
☐ Hair ☐ Mouth/Throat ☐ Scalp (Dandruff) ☐ Skin in General

SYMPTOM HISTORY, contd.

Lymph Nodes…

☐ Enlarged/Tender Neck ☐ Enlarged/Tender Axilla ☐ Enlarged/Tender Groin

Nails …

☐ Bitten ☐ Brittle ☐ Curved Up ☐ Frayed
☐ Fungus- Fingers ☐ White Spots/Lines ☐ Pitting ☐ Ragged Cuticles
☐ Ridges ☐ Soft ☐ Thickening of Fingernails or Toenails

Respiratory …

☐ Bad Breath ☐ Bad Odor in Nose ☐ Cough-Dry ☐ Cough – Productive
☐ Hoarseness ☐ Sore Throat ☐ Hay Fever ☐ Nasal Stuffiness
☐ Nose Bleeds ☐ Post Nasal Drip ☐ Sinus Fullness ☐ Sinus Infection
☐ Snoring ☐ Wheezing ☐ Winter Stuffiness

Cardiovascular …

☐ Angina/Chest Pain ☐ Shortness of Breath ☐ Heart Murmur ☐ Irregular Pulse
☐ Palpitations ☐ Phlebitis ☐ Swollen Ankles/Feet ☐ Varicose Veins

Urinary …

☐ Bed Wetting ☐ Hesitancy ☐ Infection ☐ Kidney Disease
☐ Leaking/Incontinence ☐ Pain/Burning ☐ Urgency

Male Reproductive …

☐ Penis discharge ☐ Ejaculation problems ☐ Genital pain ☐ Impotence ☐ Lumps in Testicles

Female Reproductive …

☐ Breast Cysts/Lumps ☐ Breast Tenderness ☐ Ovarian Cysts ☐ Poor Sex Drive
☐ Vaginal Odor ☐ Vaginal Discharge ☐ Vaginal Itch ☐ Vaginal Pain with Sex

Premenstrual …

☐ Bloating Breast Tenderness ☐ Carbohydrate Craving ☐ Constipation ☐ Decreased Sleep
☐ Diarrhea ☐ Fatigue ☐ Increased Sleep ☐ Irritability

Menstrual …

☐ Cramps ☐ Heavy Periods ☐ Irregular Periods ☐ No periods ☐ Scanty Periods
☐ Spotting Between Periods

SYMPTOM HISTORY, contd.

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

Category I	**0**	**1**	**2**	**3**
Feeling that bowels do not empty completely	☐	☐	☐	☐
Lower abdominal pain relieved by passing stool or gas	☐	☐	☐	☐
Alternating constipation and diarrhea	☐	☐	☐	☐
Diarrhea	☐	☐	☐	☐
Constipation	☐	☐	☐	☐
Hard, dry, or small stool	☐	☐	☐	☐
Coated tongue or "fuzzy" debris on tongue	☐	☐	☐	☐
Pass large amount of foul-smelling gas	☐	☐	☐	☐
More than 3 bowel movements daily	☐	☐	☐	☐
Use laxatives frequently	☐	☐	☐	☐

Category II	**0**	**1**	**2**	**3**
Excessive belching, burping, or bloating	☐	☐	☐	☐
Gas immediately following a meal	☐	☐	☐	☐
Offensive breath	☐	☐	☐	☐
Difficult bowel movements	☐	☐	☐	☐
Sense of fullness during and after a meals	☐	☐	☐	☐
Difficulty digesting fruits and vegetable (undigested foods in stool)	☐	☐	☐	☐

Category III	**0**	**1**	**2**	**3**
Stomach pain, burning, or aching 1-4 hour after eating	☐	☐	☐	☐
Use antacids	☐	☐	☐	☐
Feel hungry an hour or two after eating	☐	☐	☐	☐
Heartburn when lying down or bending forward	☐	☐	☐	☐
Temporary relief by using antacids, food, mild, or carbonated beverages	☐	☐	☐	☐
Digestive problems subside with rest and relaxation	☐	☐	☐	☐
Heartburn due to spicy foods, chocolate, citrus, pepper, alcohol, and caffeine	☐	☐	☐	☐

Category IV	**0**	**1**	**2**	**3**
Roughage and fiber cause constipation	☐	☐	☐	☐
Indigestion and fullness last 2-4 hours after eating	☐	☐	☐	☐
Pain, tenderness, soreness on left side under rib cage	☐	☐	☐	☐
Excessive passage of gas	☐	☐	☐	☐

Category IV, contd.	**0**	**1**	**2**	**3**
Nausea and/or vomiting	☐	☐	☐	☐
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increased thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category V	**0**	**1**	**2**	**3**
Greasy or high-fat foods cause distress	☐	☐	☐	☐
Lower bowel gas and/or bloating several hours after a meal	☐	☐	☐	☐
Bitter metallic taste in mouth, especially in the morning	☐	☐	☐	☐
Unexplained itchy skin	☐	☐	☐	☐
Yellowish cast to eyes	☐	☐	☐	☐
Stool color alternates from clay colored to normal brown	☐	☐	☐	☐
Reddened skin, especially palms	☐	☐	☐	☐
Dry or flaky skin and/or hair	☐	☐	☐	☐
History of gallbladder attacks or stones	☐	☐	☐	☐
Have you had your gallbladder removed?	☐	☐	☐	☐

Category VI	**0**	**1**	**2**	**3**
Crave sweets during the day	☐	☐	☐	☐
Irritable if meals are missed	☐	☐	☐	☐
Depend on coffee to keep going/get started	☐	☐	☐	☐
Get light-headed if meals are missed	☐	☐	☐	☐
Eating relieves fatigue	☐	☐	☐	☐
Feel shaky, jittery, or have tremors	☐	☐	☐	☐
Agitated, easily upset, nervous	☐	☐	☐	☐
Poor memory/forgetful	☐	☐	☐	☐
Blurred vision	☐	☐	☐	☐

Category VII	**0**	**1**	**2**	**3**
Fatigue after meals	☐	☐	☐	☐
Crave sweets during the day	☐	☐	☐	☐
Eating sweets does not relieve cravings for sugar	☐	☐	☐	☐
Must have sweets after meals	☐	☐	☐	☐
Waist girth is equal to or larger than hip girth	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Increase thirst and appetite	☐	☐	☐	☐
Difficulty losing weight	☐	☐	☐	☐

Category VIII	**0**	**1**	**2**	**3**
Cannot stay asleep	☐	☐	☐	☐
Crave salt	☐	☐	☐	☐
Slow starter in the morning	☐	☐	☐	☐
Afternoon fatigue	☐	☐	☐	☐
Dizziness when standing up quickly	☐	☐	☐	☐
Afternoon headaches	☐	☐	☐	☐
Headaches with exertion or stress	☐	☐	☐	☐
Weak nails	☐	☐	☐	☐

Category IX	**0**	**1**	**2**	**3**
Cannot fall asleep	☐	☐	☐	☐
Perspire easily	☐	☐	☐	☐
Under high amount of stress	☐	☐	☐	☐
Weight gain when under stress	☐	☐	☐	☐
Wake up tired even after 6 hours or more of sleep	☐	☐	☐	☐
Excessive perspiration or perspiration with little or no activity	☐	☐	☐	☐

Category X	**0**	**1**	**2**	**3**
Tired/sluggish	☐	☐	☐	☐
Feel cold-hands, feet, all over	☐	☐	☐	☐
Require excessive amount of sleep to function properly	☐	☐	☐	☐
Increase in weight even with low-calorie diet	☐	☐	☐	☐
Gain weight easily	☐	☐	☐	☐
Difficult, infrequent bowel movements	☐	☐	☐	☐
Depression/lack of motivation	☐	☐	☐	☐
Morning headaches that wear off as the day progresses	☐	☐	☐	☐
Outer third of eyebrow thins	☐	☐	☐	☐
Thinning of hair on scalp, face, or genitals, excessive hair loss	☐	☐	☐	☐
Dryness of skin and/or scalp	☐	☐	☐	☐
Mental sluggishness	☐	☐	☐	☐

Category XI	**0**	**1**	**2**	**3**
Heart palpitations	☐	☐	☐	☐
Inward trembling	☐	☐	☐	☐
Increased pulse even at rest	☐	☐	☐	☐
Nervous and emotional	☐	☐	☐	☐
Insomnia	☐	☐	☐	☐
Night sweats	☐	☐	☐	☐
Difficulty gaining weight	☐	☐	☐	☐

Category XII	**0**	**1**	**2**	**3**
Diminished sex drive	☐	☐	☐	☐
Menstrual disorders or lack of menstruation	☐	☐	☐	☐
Increased ability to eat sugars without symptoms	☐	☐	☐	☐

Category XIII	**0**	**1**	**2**	**3**
Increased sex drive	☐	☐	☐	☐
Tolerance to sugars reduced	☐	☐	☐	☐
“Splitting” – headaches	☐	☐	☐	☐

Category XIV (Males only)	**0**	**1**	**2**	**3**
Urination difficulty or dribbling	☐	☐	☐	☐
Frequent urination	☐	☐	☐	☐
Pain inside of legs or heels	☐	☐	☐	☐
Feeling of incomplete bowel emptying	☐	☐	☐	☐
Leg twitching at night	☐	☐	☐	☐

Category XV (Males only)	**0**	**1**	**2**	**3**
Decreased libido	☐	☐	☐	☐
Decreased number of spontaneous morning erections	☐	☐	☐	☐
Decreased fullness of erections	☐	☐	☐	☐
Difficulty maintaining morning erections	☐	☐	☐	☐
Spells of mental fatigue	☐	☐	☐	☐
Inability to concentrate	☐	☐	☐	☐
Episodes of depression	☐	☐	☐	☐
Muscle soreness	☐	☐	☐	☐
Decreased physical stamina	☐	☐	☐	☐
Unexplained weight gain	☐	☐	☐	☐
Increased in fat distribution around chest and hips	☐	☐	☐	☐
Sweating attacks	☐	☐	☐	☐
More emotional than in the past	☐	☐	☐	☐

Category XVI (Menstruating Females only)	**0**	**1**	**2**	**3**
Perimenopausal	☐ Yes	☐ No		
Alternating menstrual cycle lengths	☐ Yes	☐ No		
Extended menstrual cycle (greater than every 32 days)	☐ Yes	☐ No		
Shortened menstrual cycle (less than 24 days)	☐ Yes	☐ No		
Pain and cramping during periods	☐	☐	☐	☐
Scanty blood flow	☐	☐	☐	☐
Heavy blood flow	☐	☐	☐	☐
Breast pain and swelling during menses	☐	☐	☐	☐
Pelvic pain during menses	☐	☐	☐	☐
Irritable and depressed during menses	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Hair loss/thinning	☐	☐	☐	☐

Category XVII (Menopausal Females only)	**0**	**1**	**2**	**3**
How many years have you been menopausal? _____				
Since menopause, do you ever have uterine bleeding?	☐ Yes	☐ No		
Hot flashes	☐	☐	☐	☐
Mental fogginess	☐	☐	☐	☐
Disinterest in sex	☐	☐	☐	☐
Mood swings	☐	☐	☐	☐
Depression	☐	☐	☐	☐
Painful intercourse	☐	☐	☐	☐
Shrinking breasts	☐	☐	☐	☐
Facial hair growth	☐	☐	☐	☐
Acne	☐	☐	☐	☐
Increased vaginal pain, dryness, or itching	☐	☐	☐	☐

Category S	**0**	**1**	**2**	**3**
Are you losing your pleasure in hobbies and interests?	☐	☐	☐	☐
How often do you feel overwhelmed with ideas to manage?	☐	☐	☐	☐
How often do you have feelings of inner rage (anger)?	☐	☐	☐	☐
How often do you have feelings of paranoia?	☐	☐	☐	☐
How often do you feel sad or down for no reason?	☐	☐	☐	☐
How often do you feel like you are not enjoying your life?	☐	☐	☐	☐
How often do you feel you lack artistic appreciation?	☐	☐	☐	☐
How often do you feel depressed in overcast weather?	☐	☐	☐	☐
How much are you losing you enthusiasm for your favorite activities?	☐	☐	☐	☐
How much are you losing enjoyment for your favorite foods?	☐	☐	☐	☐

Category S, contd.	**0**	**1**	**2**	**3**
How much are you losing your enjoyment of friendships and relationships?	☐	☐	☐	☐
How often do you have difficulty falling into deep restful sleep?	☐	☐	☐	☐
How often do you have feelings of dependency on others?	☐	☐	☐	☐
How often do you feel more susceptible to pain?	☐	☐	☐	☐
How often do you have feelings of unprovoked anger?	☐	☐	☐	☐
How much are you losing interest in life?	☐	☐	☐	☐

Category D	**0**	**1**	**2**	**3**
How often do you have feelings of hopelessness?	☐	☐	☐	☐
How often do you have self-destructive thoughts?	☐	☐	☐	☐
How often do you have an inability to handle stress?	☐	☐	☐	☐
How often do you have anger and aggression while under stress?	☐	☐	☐	☐
How often do you feel you are not rested even after long hours of sleep?	☐	☐	☐	☐
How often do you prefer to isolate yourself from others?	☐	☐	☐	☐
How often do you have unexplained lack of concern for family and friends?	☐	☐	☐	☐
How easily are you distracted from your tasks?	☐	☐	☐	☐
How often do you have an inability to finish tasks?	☐	☐	☐	☐
How often do you feel the need to consume caffeine to stay alert?	☐	☐	☐	☐
How often do you feel your libido has been decreased?	☐	☐	☐	☐
How often do you lose your temper for minor reasons?	☐	☐	☐	☐
How often do you have feelings of worthlessness?	☐	☐	☐	☐

Category G	**0**	**1**	**2**	**3**
How often do you feel anxious or panic for no reason?	☐	☐	☐	☐
How often do you have feelings of dread or impending doom?	☐	☐	☐	☐
How often do you feel knots in your stomach?	☐	☐	☐	☐
How often do you have feelings of being overwhelmed for no reason?	☐	☐	☐	☐
How often do you have feeling of guilt about everyday decisions?	☐	☐	☐	☐
How often does your mind feel restless?	☐	☐	☐	☐
How difficult is it to turn you mind off when you want to relax?	☐	☐	☐	☐
How often do you have disorganized attention?	☐	☐	☐	☐
How often do you worry about things you were not worried about before?	☐	☐	☐	☐
How often do you have feelings of inner tension and inner excitability?	☐	☐	☐	☐

Category ACH	0	1	2	3
Do you feel your visual memory (shapes & images) is decreased?	☐	☐	☐	☐
Do you feel your verbal memory is decreased?	☐	☐	☐	☐
Do you have memory lapses?	☐	☐	☐	☐
Has your creativity been decreased?	☐	☐	☐	☐
Has your comprehension been diminished?	☐	☐	☐	☐
Do you have difficulty calculating numbers?	☐	☐	☐	☐
Do you have difficulty recognizing objects & faces?	☐	☐	☐	☐
Do you feel like your opinion about yourself has changed?	☐	☐	☐	☐
Are you experiencing excessive urination?	☐	☐	☐	☐
Are you experiencing slow mental responses?	☐	☐	☐	☐

Chiropractic Neurology & Wellness Center

Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Psoriatic Arthritis	☐	☐	☐	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hoshimoto's Disease	☐	☐	☐	☐	☐	☐	☐	☐
Hypothyroidism	☐	☐	☐	☐	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐	☐	☐	☐	☐
Lupus (SLE)	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Food Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Environmental Allergies	☐	☐	☐	☐	☐	☐	☐	☐
Psoriasis/Eczema	☐	☐	☐	☐	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐	☐	☐	☐	☐
ALS	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disease	☐	☐	☐	☐	☐	☐	☐	☐
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐	☐	☐
Genetic Disorders	☐	☐	☐	☐	☐	☐	☐	☐
Scoliosis	☐	☐	☐	☐	☐	☐	☐	☐
Other								
Other								

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 (I.e. work demands, sleep habits).....	☐ 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

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 activites?.....	☐ 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?

_____

_____

SUPPORT FOR CHANGE

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

How supportive do you think the people in your household will be?.....	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Rate on a scale of **5** (very frequent contact) to **1** (very infrequent contact):
How much on-going support and contact (i.e., telephone & email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ..... ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments:

_____

_____

_____

_____

Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) to use their patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CNWB to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature:_____ Date: _____

Patient's Name:_____
PLEASE PRINT

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications that may arise during a Chiropractic adjustment. Those complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costrovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read ( ) or have had read to me ( ) the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Chiropractic Neurology & Wellness Center
618 Frederick St., Santa Cruz, CA 95062
831-460-9200

Name of Doctor Treating this Patient
James M. Cartwright, D.C., D.A.C.N.B.
www.cartwrightwellnes.com

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness Signature	Date