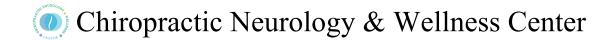
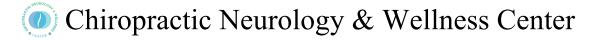


## Comprehensive Patient History

Today's Date:		
MONTH/DAY/YEAR		
Date of Birth: Age:		
Legal Name:		Gender:
Preferred Name:	SSN:	
Address:		
City:	State:	Zip:
Phone:Cell:	Email:	
Marital Status: ☐ Single ☐ Divorced ☐ W	Vidowed □ Married: Spouse's Na	me:
Please list your children and their ages:		
Work Status: ☐ Employed ☐ Retired ☐ D	Disabled   Student (School Name	e):
Occupation:		
Employer:	Employer Frione. (_	)
Name/Phone Number of Emergency Contact	ct:	
Who referred you to our office?		
Time referred year to our effice.		
Please list your 5 major health concerns in	order of importance:	
Thouse not your o major health concerns in	order of importance.	
1		
2		
3		
4		
5		
<del>-</del> -		



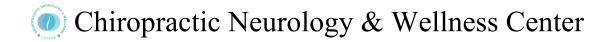
SLEEP HABITS
I go to bed at PM. I usually have difficulty falling asleep ☐ Yes ☐ No
I frequently wake up in the middle of the night, between 1:00AM to 3:00AM    Yes    No typically wake up to start my day atAM.
After waking, I usually feel $\square$ Well Rested $\square$ Tired $\square$ Exhausted Do you snore? $\square$ Yes $\square$ 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 atPM and it consists of
I eat dinner atPM 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 <i>healthiest foods</i> 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. Dose Frequency Start Date Reason **MEDICATIONS** Please list the Prescribed and Over-the-Counter medications you currently take. Medication Dose Frequency Start Date Reason 3.

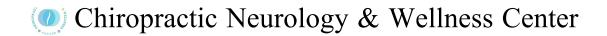
Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No

Describe:



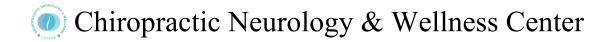
#### MEDICATIONS, contd.

Do you have any allergies t	o medications? □ yes □ no If yes, pl	ease list below.
<ul><li>□ NSAIDS (Advil, Aleve, Ast</li><li>□ Antibiotics more than 3 to</li></ul>	regular use of any of the following (select spirin)   Tylenol   Allergy shots   Allergy shots   Allergy shots   Facial/year   Revitives?   Yes   No	Acid Blocking Drugs (Prilosec, Zantac) one, etc.)
MEDICAL HISTORY		
Current Physician		Phone
When was your last adjustn Please list all other chiropra	revious Chiropractic care?   Yes   Note that the representation of	
current complaints:		
1	5	
2	6	
3	7	
4	8	
Preventive Tests and Date	of Last Test. Check box if yes and provice	de date of test.
□ Full Physical	□ Blood Test	□ Bone Density
□ Colonoscopy		□ Stool Test
□ CT Scan	□ X-Rays	☐ Upper GI Series
□ Ultrasound		□ Cardiac Stress
☐ Salivary Hormones	□ Endoscopy	□ MRI
□ Other:		
Surgeries. Check box if yes	and provide date of surgery	
-	Hysterectomy +/- Ovaries	□ Gall Bladder
• • •	☐ Tonsillectomy ☐	
	☐ Heart Surgery	
□ Pacemaker	• ,	<b>.</b> , ———
□ Other:		



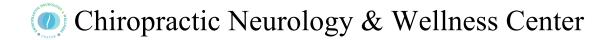
#### MEDICAL HISTORY, contd.

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
<ul> <li>□ Heart Attack</li> <li>□ Stroke</li> <li>□ Elevated Cholesterol</li> <li>□ Elevated Triglycerides</li> <li>□ Arrhythmia</li> <li>□ High Blood Pressure</li> <li>□ Rheumatic Fever</li> <li>□ Mitral Valve Prolapse</li> <li>□ Anemia</li> <li>□ Other</li> </ul>
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	nfec
□ 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 Ap	nea
□ 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?	
□ Programation □ Concernan □ Vaginal Polivarian □ Miccorrian	
□ Pregnancies □ □ Caesarean □ □ Vaginal Deliveries □ □ Miscarriage □ □ Abortion □ □ Post-Partum Depression □ □ Toxemia □ □ Toxemia □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □	



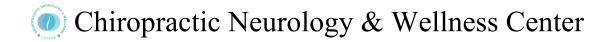
#### MEDICAL HISTORY, contd.

Menstrual History	Menses Frequency:	Longth
Pain? ☐ Yes ☐ No Cl	·	Lengui.
	· ·	Last menstrual period:
	•	Patch □ NuvaRing □ How Long?
	•	aphragm □ IUD □ Partner Vasectomy □ Tubal Ligation
Women's Disorders – Ho	ormonal Imbalances	
$\hfill\Box$ Fibrocystic Breasts $\hfill\Box$	Endometriosis $\Box$ Fibroids $\Box$ Infertili	ty □ 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 menopaus	se began:
Do you suffer any of thes	e menopausal symptoms?   Hot F	lashes ☐ Mood Swings ☐ Concentration
•	yness □ Decreased Libido □ Loss o	of Control of Urine □ Use of hormone replacement
Men Only Male Disorders		
	st:PSA level: [	$\square$ 0-2 $\square$ 2-4 $\square$ 4-10 $\square$ >10 $\square$ Never had Test
•	following in the last year? □ Prostat	
☐ Prostate Cancer [	□ Prostate "shots" (I.e. Eligard) □ C	Change in Libido □ Impotence
☐ Difficulty Obtaining an	Erection □ Decreased Frequency o	f Morning Erections □ Enlarged breasts
☐ Fluid Discharge from N	Nipples □ Nocturia (Urination at nigh	nt) □ Urgency/Hesitancy/Change in Urinary Stream
☐ Loss of Control of Urin	e	
Women & Men Environmental & Detoxifi	cation Assessment	
•	erse food reactions or sensitivities? s:	
Do you have any adverse	e reaction to caffeine? $\square$ Yes $\square$ No	
When you drink caffeine to you adversely react to	do you feel: $\Box$ Irritable or Wired $\Box$ $A$ o (Check all that apply):	Acne & Pains
$\square$ MSG $\square$ Aspartame (N	JutraSweet) □ Bananas □ Garlic I	□ Onion □ Cheese □ Citrus □ Chocolate
☐ Alcohol/Red Wine ☐ \$	Sulfites (Wine, dried fruit, salad bars	) 🗆 Preservatives (i.e., sodium benzoate)
□ Other:		
Which of these significan	tly affect you? (Check all that apply)	:
□ Cigarette Smoke □ P	erfumes/Colognes   Auto Exhaust	Fumes   Other:



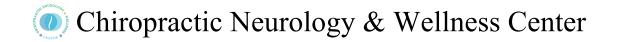
#### **ENVIRONMENTAL FACTORS**

In your work or home er  ☐ Chemicals ☐ Electro			Vell Water		
Have you ever turned ye	ellow (jaundiced)? □ Yo	es □ No			
Have you ever been told Explain:	•		r a Liver Disorder	? □ Ye	es □ No
Do you have a known h  ☐ Herbicides ☐ Insecti Chemical name, date, 8	icides/Pesticides □ Org	ganic Sol	vents □ Heavy N	<b>Metals</b>	ch as:
Do you dry clean your c Have you lived or worke Do you have any pets o	ed in a damp or moldy e	nvironme		nold exp	osures? □ Yes □ No
Review of Symptoms: (I	Please check all boxes t	hat apply	<b>'</b> )		
General					
□ Cold Hands & Feet	☐ Cold Intolerance		□ Low Body Te	mp	$\hfill\square$ Low Blood Pressure
□ Daytime Sleepiness	☐ Difficulty Falling Asle	еер	□ Early Waking		□ Fatigue
□ Fever	□ Flushing		☐ Heat Intolerance		□ Night Walking
□ Nightmares	□ No Dream Recall				
Head, Eyes & Ears					
□ Conjunctivitis	☐ Distorted Sense of S	Smell	□ Distorted Tas	te	☐ Ear Fullness
□ Ear Pain	☐ Ear Ringing/Buzzing	l	☐ Lid Margin Re	edness	□ Eye Crusting
□ Eye Pain	☐ Hearing Loss		☐ Hearing Prob	lems	☐ Headache
☐ Migraine	☐ Sensitivity to Loud N	loises	□ Vision Proble	ms (oth	er than glasses)
☐ Macular Degen.	☐ Vitreous Detachmen	t	☐ Retinal Detac	hment	
Musculoskeletal					
☐ Back Muscle Spasm	☐ Calf Cramps	□ Ches	st Tightness	□ Foot	Cramps
□ Joint Deformity	☐ Joint Pain	□ Joint	Redness	□ Joint	Stiffness
☐ Muscle Pain	☐ Muscle Spasm	□ Muse	cle Stiffness	□ Muse	cle Weakness
☐ Tension Headaches	□ TMJ Problems	□ Necl	Muscle Spasm	□ Tend	Ionitis
☐ Muscle Twitch Aroun	d Eyes	□ Muse	cle Twitch Arms	or Legs	
Mood/Nerves					
□ Agoraphobia	□ Anxiety	□ Blac	k-outs	□ Depr	ression
□ Dizziness	□ Vertigo	□ Fain	ting	□ Fear	fulness
□ Irritability	☐ Light-Headedness	□ Num	bness	□ Othe	r Phobias
□ Panic Attacks	□ Paranoia	□ Seiz	ures	□ Suici	dal Thoughts
☐ Tingling	□ Tremor/Trembling	□ Visu	al or Auditory Ha	llucinatio	ons



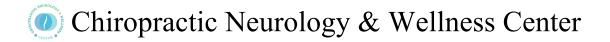
#### **SYMPTOM HISTORY**

Difficulty with					
□ Concentrating	☐ Balance ☐ Thi	inking	□ Judgment	□ Speech	□ Memory
Digestion					
☐ Anal Spasms	□ Bad Teeth	□ Blee	ding Gums	□ Oral Blisters	;
☐ Blood in Stools	□ Burping	□ Canl	ker Sores	□ Cold Sores	
☐ Cracking at the corne	ers of lips	□ Crar	nps	☐ Heartburn	
□ Dentures	□ Diarrhea	□ Fiss	ures	□ Nausea	
☐ Dry Mouth	☐ Excess Flatulence/	gas			
☐ Hemorrhoids	□ Indigestion	□ Sore	Tongue	□ Difficulty Sw	allowing
□ Vomiting	☐ Alternating Diarrhea	a/Constipa	ation	$\square$ Periodontal	Disease
□ Constipation	☐ Lower Abdominal P	Pain	□ Upper Abdo	minal Pain	
☐ Strong Stool Odor	☐ Undigested Food in	Stool	☐ Mucus in Sto	ools	
Bloating of					
☐ Lower Abdomen	☐ Whole Abdomen	□ Bloa	ting after meals		
Intolerance to					
□ Lactose	☐ All Dairy Products	☐ Glute	en □ Corr	า	
□ Eggs	□ Soy	□ Fatty	/Foods □ Yea	st	
Skin Problems					
☐ Acne on Back	□ Acne on Chest	□ Acne	e on Face	☐ Acne on Sho	oulders
□ Athlete's Foot	☐ Bumps on Back of	Upper Arr	ns	□ Dark Circles	under eyes
□ Cellulite	□ Ears get cold	□ Easi	ly Bruise	□ Lack of Swe	ating
$\hfill\Box$ Too Much Sweating	□ Eczema	□ Hive	s	☐ Jock Itch	
☐ Lackluster Skin	☐ Moles w/Color/Size	Changes		☐ Oily Skin	
□ Pale Skin	□ Patchy Dullness	□ Rasl	า	$\square$ Red Face	
□ Sensitivity to Bites	□ Shingles	□ Sens	sitivity to Poison	lvy/Oak	
☐ Skin Darkening	☐ Strong Body Odor	□ Hair	Loss	□ Vitiligo	
Itchy Skin					
$\ \square$ Skin in General	□ Anus	□ Arm	5	☐ Ear Canals	
□ Eyes	□ Feet	□ Han	ds	□ Legs	
□ Nipples	□ Nose	□ Peni	s	□ Roof of Mou	th
□ Scalp	□ Throat				
Dryness of					
□ Eyes	□ Feet	□ Han	ds (Cracks or Pe	eel)	
□ Hair	☐ Mouth/Throat	□ Scal	p (Dandruff)	☐ Skin in Gene	eral



#### **SYMPTOM HISTORY, contd.**

Lymph Nodes			
☐ Enlarged/Tender Nec	ck □ Enlarged/Ter	nder Axilla 🗆 Enla	rged/Tender Groin
Nails			
□ Bitten	☐ Brittle	☐ Curved Up	□ Frayed
☐ Fungus- Fingers	☐ White Spots/Lines	□ Pitting	□ Ragged Cuticles
□ Ridges	□ Soft	☐ Thickening of Finger	nails 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	$\hfill\Box$ Shortness of Breath	☐ Heart Murmur	☐ Irregular Pulse
□ Palpitations	□ Phlebitis	☐ Swollen Ankles/Feet	□ Varicose Veins
Urinary			
□ Bed Wetting	☐ Hesitancy	□ Infection	☐ Kidney Disease
☐ Leaking/Incontinence	e □ Pain/Burning	□ Urgency	
Male Reproductive			
☐ Penis discharge	☐ Ejaculation problems	☐ Genital pain ☐ Impo	tence   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 Tend	erness   Carbohydrate	e Craving	tion ☐ Decreased Sleep
☐ Diarrhea ☐ Fatig	jue 🗆 Increased Sl	eep   Irritability	
Menstrual	D. C. J	la Destada	adala = 0 a la Bala
·		ular Periods □ No p	eriods
☐ Spotting Between Pe	riods		



#### **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				

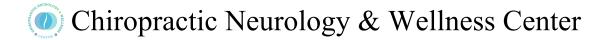
Category IV, contd.	0	1	2	3
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous like, greasy, or poorly formed				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				
Category V	0	1	2	3
Greasy or high-fat foods cause distress				
Lower bowel gas and/or 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?				
0.1	•	_	•	_
Category VI	0	1	2	3
Crave sweets during the day	<b>0</b>	1 	<b>2</b> □	<b>3</b> □
Crave sweets during the day				
Crave sweets during the day Irritable if meals are missed				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started				
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				
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				
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				
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				
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				
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				
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			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 Fatigue after meals	0 0 0 0 0			3 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 Fatigue after meals Crave sweets during the day	O O O			3 0
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 Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar	0 0 0 0 0			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 Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar Must have sweets after meals	0 0 0 0 0			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 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	0 0 0 0 0	1 0		3 0

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 Diminished sex drive	<b>0</b>	<b>1</b>	<b>2</b> □	<b>3</b> □
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				
Ostonova VIV (Mala a onla)	•	_	•	•
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	$\square$ No		
Extended menstrual cycle (greater than every 32 days)	□ Yes	$\square$ 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) How many years have you been menopausal?	0	1	2	3
Since menopause, do you ever have uterine bleeding?	□ Yes	$\square$ 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?	П	П	П	П



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 <b>5</b> (very willing) to <b>1</b> (not willing):					
In order to improve your health, how willing are you to:					
Significantly modify your diet	□ 5	□ 4	□ 3	□ 2	<b>□ 1</b>
Take several nutritional supplements each day	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Keep a record of everything you eat each day	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Modify your lifestyle (I.e. work demands, sleep habits)	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Practice a relaxation technique	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Engage in regular exercise	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Have periodic lab tests to assess your progress	□ 5	□ 4	□ 3	□ 2	□ 1
Rate on a scale of <b>5</b> (very confident) to <b>1</b> (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
SUPPORT FOR CHANGE					_
Rate on a scale of <b>5</b> (very supportive) to <b>1</b> (very unsupportive):					
How supportive do you think the people in your household will be?	□ 5	□ 4	□ 3	□ 2	□ <b>1</b>
Rate on a scale of <b>5</b> (very frequent contact) to <b>1</b> (very infrequent contact How much on-going support and contact (i.e., telephone & email corresp from our professional staff would be helpful to you as you implement		ce)			
your personal health program?	□ 5	□ 4	□ 3	□ 2	<b>□ 1</b>
Comments:					
					<del></del>

#### 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