JACKSONVILLE HEALTH AND WELLNESS / CASE HISTORY

PATIENT INFORMATION

Name_____ Date _____ Sex M F Age _____ Height_____ Weight_____
Birthdate_____ Social Security # _____
[ ] Married [ ] Widowed [ ] Single [ ] Minor [ ] Separated [ ] Divorced [ ] Partnered for _____ years
Address_____
City_____ State_____ Zip _____
Occupation_____ Patient Employer/School_____

SPOUSE/PARTNER

Name_____ Birthdate_____
Social Security #_____ Employer_____

PHONE NUMBERS/CONTACT INFORMATION

Home Phone (____) _____ Cell Phone (_____) _____
Work Phone (_____) _____
Best time to call and reach you_____ E-Mail address_____
In case of emergency contact:
Name_____Relationship_____ Phone_____

PRIMARY MEDICAL DOCTOR

Doctor Name_____ Practice Name _____
Phone Number_____
Address_____

REFFERAL

How were you referred to our office_____

INSURANCE

Who is responsible for this account and relationship to patient?_____
Primary Insurance Co. _____Policy #_____ Group #_____
Secondary Insurance Co._____ Policy #_____ Group# _____
Subscriber's Name_____ D.O.B._____ Social Security #_____

ACCIDENT INFORMATION

Is condition due to accident? [ ]Yes [ ]No Date of Accident_____ Type of accident [ ] Auto [ ]Work [ ] Home
Attorney Name(if applicable)_____Have you reported your accident and to whom? _____
Location of Accident_____
Insurance Co. _____ Address_____
Phone #_____ Policy #_____ Claim #_____ Adjuster's Name_____

PATIENT CONDITION

Reason for visit _____
Location/Description of Complaint_____
Complaint Began when and how?_____
Please circle quality of complaint/pain: dull ache sharp shooting burning throbbing deep other_____
Does the complaint/pain radiate or travel (shoot) to any areas of your body? Where? _____
Do you have any numbness or tingling in your body? Where? _____
Grade Intensity/Severity (No complaint/pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst possible pain imaginable)
Is the complaint/pain [ ] constant [ ] come and go
How long does it last?_____
Does anything aggravate the complaint? _____
Does anything make the complaint better? _____

JACKSONVILLE HEALTH AND WELLNESS / CASE HISTORY

PATIENT CONDITION CONTINUED

What treatment have you already received for your condition?
[ ] None [ ] Surgery [ ] Medications [ ] Physical Therapy [ ] Massage [] Yoga [] Meditation [] Nutrition Counseling
[ ] Chiropractic - When?_____ [ ] Other _____

PAST/ CURRENT MEDICAL HISTORY

******IMPORTANT****YOUR CURRENT OR PAST HEALTH, SURGERIES, & MEDICATION WILL EFFECT THE TYPE OF TREATMENT YOU RECEIVE AT OUR OFFICE**

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Work_____MRI_____

Please list **ALL PAST and CURRENT MEDICAL Problems and Conditions**

Please list **ALL surgeries**

Please list ALL **Medications and/or Vitamins and Herbs AND THE REASON FOR TAKING THEM**

Allergies

FAMILY HISTORY

Family Member_____ Medical Condition_____
Family Member_____ Medical Condition_____

JACKSONVILLE HEALTH AND WELLNESS / CASE HISTORY

CURRENT LIFESTYLE

Please describe your current OR past exercise regimen (if applicable) _____

_____

Work Activity: [ ] Sitting [ ] Standing [ ] Light Labor [ ] Heavy Labor [ ] Student
Habits: [ ] Smoking; Packs/Day _____ [ ] Alcohol;Drinks/Week _____ [ ] Coffee; Cups/Day_____
Stress Level: [ ] High [ ] Medium [ ] Low Reason?_____
Dietary Habits: Glasses of Water _____ Daily; Carbonated Beverages _____ Daily; Dairy_____ Daily
Please list typical: Breakfast _____
Lunch _____
Dinner _____
Snacks_____
Sleeping Pattern: [ ] Inability to Fall Asleep [ ] Wake up Often [ ] Other _____

WELLNESS GOALS

Are you interested in achieving (Please check one)?
[] Symptomatic Relief – relief of your signs and symptoms (pain, heartburn, etc.)
[] Symptomatic Relief & Corrective Care – relief of signs and symptoms as well as correcting the cause of the symptom
[] Symptomatic Relief, Corrective Care & Optimal Health – addition of physical, mental, & chemical well being; prevention; & improving quality and quantity of life.

Our treatment protocols incorporate a WHOLE BODY approach to health and wellness as we offer a comprehensive array of services for many health related problems. Therefore, by answering the following questions it will help us to individualize/customize your treatment plan.

Would you like help with:	NO	YES	Additional Health Goals or Comments
Exercise	[]	[]	_____
Nutrition & Eating Better	[]	[]	_____
Stress Reduction	[]	[]	_____
Weight Loss	[]	[]	_____
Decreased Reliance on Medication	[]	[]	_____
Improving Posture	[]	[]	_____
Flexibility	[]	[]	_____
Learning about wellness	[]	[]	_____
Energy Levels	[]	[]	

ACTIVITIES OF DAILY LIVING

Please grade the following activities on how they are impacted by your current health status/condition

	Unable to perform									Able to perform	
Personal Care	0	1	2	3	4	5	6	7	8	9	10
Lifting	0	1	2	3	4	5	6	7	8	9	10
Reading & Concentration	0	1	2	3	4	5	6	7	8	9	10
Work	0	1	2	3	4	5	6	7	8	9	10
Driving & Traveling	0	1	2	3	4	5	6	7	8	9	10
Sleeping	0	1	2	3	4	5	6	7	8	9	10
Recreation	0	1	2	3	4	5	6	7	8	9	10
Hand Coordination	0	1	2	3	4	5	6	7	8	9	10
Walking	0	1	2	3	4	5	6	7	8	9	10
Sitting	0	1	2	3	4	5	6	7	8	9	10
Standing	0	1	2	3	4	5	6	7	8	9	10
Social Life	0	1	2	3	4	5	6	7	8	9	10
Household Duties (laundry, etc.)	0	1	2	3	4	5	6	7	8	9	10
Exercising	0	1	2	3	4	5	6	7	8	9	10
Other:	0	1	2	3	4	5	6	7	8	9	10

Patient Signature and Date:_____

JACKSONVILLE HEALTH AND WELLNESS

AUTHORIZATION FOR TREATMENT
THIS CONSTITUTES INFORMED CONSENT FOR MASSAGE, PHYSICAL THERAPY, AND/OR CHIROPRACTIC
I hereby authorize the giving of treatment, performance of diagnostic procedures, examination and the administration of any other judgment by my physician that may be considered necessary or advisable for my diagnosis or treatment while a patient at Jacksonville Health and Wellness Center.
Female patients only **: I am not pregnant**.

PATIENT INITIAL_____

PAYMENT AGREEMENT
I acknowledge that I am financially responsible for non-covered services. I also understand that if I terminate my care and treatment, any fees for professional services rendered me at Jacksonville Health and Wellness Center will be immediately due and payable.

PATIENT INITIAL_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
By my signature on the bottom, I acknowledge that I have received a copy of the Notice of Privacy Practices.

PATIENT INITIAL_____

AUTHORIZATION , ASSIGNMENT AND RELEASE
I hereby assign, direct and authorize my insurance benefits to be paid by check made out and mailed directly to: C/O (in care of) Jacksonville Health and Wellness Center. If my current policy prohibits direct payment to doctor, then I hereby also instruct and direct you to make out the check to me and mail it as follows: C/O (in care of) Jacksonville Health and Wellness Center for professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY**. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand that there is a possibility that I will receive a payment from my insurance company for services rendered from this facility, thus, those payments will be rendered to said facility otherwise I will be billed. **A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.** I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. Patient/Policy Holder also authorizes the doctor to complain to the insurance commissioner for any reason. I hereby authorize my insurance carrier to release information regarding my insurance coverage

PATIENT INITIAL_____

JACKSONVILLE HEALTH AND WELLNESS

AUTHORIZATION AND ASSIGNMENT MEDICARE BENEFICIARY ONLY

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me, to release to the Social Security Administration, or its intermediaries or carriers any information needed for this or a related Medicare claim. I request payment of authorized Medicare benefits on my behalf for any servicres furnished me to Jacksonville Health and Wellness Center.

PATIENT INITIAL_____

PATIENT RECORD OF DISCLOSURE

I wish to be contacted in the following manner (for emergency, non emergency, disclosure of testing/diagnostic results, scheduling of appointments, etc.) (check all that apply).

- ☐ Home Telephone
- ☐ Work Telephone
- ☐ Written communication

Date_____

_____ _____

Name of Patient (Please Print) Signature of Guardian (If Minor)

Date_____

_____ _____

Signature of Policy Holder Witness

You & Your Massage

Massage can be a very beneficial tool on your way to recovering and feeling better. Massage is an excellent stress buster and can relieve sore muscles. In order to maximize your treatment, listed below are the types of massage that we offer:

Swedish Massage

This form of massage is used to loosen muscles due to stress and overuse. Swedish is wonderful for relaxation and tension release. The pressure used is usually light to moderate.

Deep Tissue Massage

Deep tissue is just as it sounds. This is for someone with knotted muscles that can benefit from a massage that is given with a lot of pressure

Neuromuscular Therapy (NMT)

NMT is designed to zero in on one problem area. It targets a muscle or trigger point that is ultimately causing the pain and discomfort. The pressure is moderate to deep. This is to release the tight and knotted muscle (s).

Pregnancy Massage

Pregnancy Massage is very beneficial for the Mom-to-be. The Mom is positioned comfortably (usually lying on her side) and then given a light/moderate massage on the areas that are causing her discomfort.

Please indicate which massage you are interested in today:

Everyone is different and requires different pressure. Please indicate below the pressure that you would prefer so that we can make your massage the most comfortable for you. With 0 being the least amount of pressure and 10 being the most amount of pressure that you can withstand. Circle one below:

0 1 2 3 4 5 6 7 8 9 10

Thank you so much for entrusting us with your care and please let us know if there is anything we can do to make your Massage experience more pleasurable.

Patient Name:_____

Date:_____ / _____ / _____

JACKSONVILLE HEALTH & WELLNESS CANCELLATION POLICY

9957 Moorings Drive, Suite 403
Jacksonville, Fl 32257

DATE: _____

CANCELLATION POLICY

24-hour notice from time of scheduled appointment is required for:

1. Massage appointments (30 MINUTES OR GREATER) &
2. ALL NUTRITIONAL appointments

… to avoid a **$25.00 charge.**

With my signature below, I have been made aware of the 24-hour cancellation policy.

Printed Name: _____

Signature: _____

Nutritional Assessment Questionnaire 1.5

Name: _____ **Date:** _____/____/_____

Birth Date: _____ **Gender:** _____

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

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

Notes:

PART I

Read the following questions and circle the number that applies:

KEY: **0 = Do not consume or use** **2 = Consume or use weekly**
1 = Consume or use 2 to 3 times monthly **3 = Consume or use daily**

DIET

58

1. 0 1 2 3 Alcohol
2. 0 1 2 3 Artificial sweeteners
3. 0 1 2 3 Candy, desserts, refined sugar
4. 0 1 2 3 Carbonated beverages
5. 0 1 2 3 Chewing tobacco
6. 0 1 2 3 Cigarettes
7. 0 1 2 3 Cigars/pipes
8. 0 1 2 3 Caffeinated beverages
9. 0 1 2 3 Fast foods
10. 0 1 2 3 Fried foods
11. 0 1 2 3 Luncheon meats
12. 0 1 2 3 Margarine
13. 0 1 2 3 Milk products
14. 0 1 Radiation exposure (0=no, 1=yes)
15. 0 1 2 3 Refined flour/baked goods
16. 0 1 2 3 Vitamins and minerals
17. 0 1 2 3 Water, distilled
18. 0 1 2 3 Water, tap
19. 0 1 2 3 Water, well
20. 0 1 2 3 Diet often for weight control

LIFESTYLE

12

21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS

Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes): 54

25. 0 1 Antacids
26. 0 1 Antianxiety medications
27. 0 1 Antibiotics
28. 0 1 Anticonvulsants
29. 0 1 Antidepressants
30. 0 1 Antifungals
31. 0 1 Aspirin/Ibuprofen
32. 0 1 Asthma inhalers
33. 0 1 Beta blockers
34. 0 1 Birth control pills/implant contraceptives
35. 0 1 Chemotherapy
36. 0 1 Cholesterol lowering medications
37. 0 1 Cortisone/steroids
38. 0 1 Diabetic medications/insulin
39. 0 1 Diuretics
40. 0 1 Estrogen or progesterone (pharmaceutical, prescription)
41. 0 1 Estrogen or progesterone (natural)
42. 0 1 Heart medications
43. 0 1 High blood pressure medications
44. 0 1 Laxatives
45. 0 1 Recreational drugs
46. 0 1 Relaxants/Sleeping pills
47. 0 1 Testosterone (natural or prescription)
48. 0 1 Thyroid medication
49. 0 1 Acetaminophen (Tylenol)
50. 0 1 Ulcer medications
51. 0 1 Sildenafal citrate (Viagra)

PART II: Key (0=No, symptom does not occur, 5=Severe symptom, occurs frequently)

Section 1

55

52. 0 1 2 3 Belching or gas within one hour after eating
53. 0 1 2 3 Heartburn or acid reflux
54. 0 1 2 3 Bloating within one hour after eating
55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
56. 0 1 2 3 Bad breath (halitosis)
57. 0 1 2 3 Loss of taste for meat
58. 0 1 2 3 Sweat has a strong odor
59. 0 1 2 3 Stomach upset by taking vitamins
60. 0 1 2 3 Sense of excess fullness after meals
61. 0 1 2 3 Feel like skipping breakfast
62. 0 1 2 3 Feel better if you don't eat
63. 0 1 2 3 Sleepy after meals
64. 0 1 2 3 Fingernails chip, peel or break easily
65. 0 1 2 3 Anemia unresponsive to iron
66. 0 1 2 3 Stomach pains or cramps
67. 0 1 2 3 Diarrhea, chronic
68. 0 1 2 3 Diarrhea shortly after meals
69. 0 1 2 3 Black or tarry colored stools
70. 0 1 2 3 Undigested food in stool

Section 2

68

71. 0 1 2 3 Pain between shoulder blades
72. 0 1 2 3 Stomach upset by greasy foods
73. 0 1 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of morning sickness (0 = no, 1 = yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia

Section 3

47

99. 0 1 2 3 Food allergies
100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
102. 0 1 2 3 Pulse speeds after eating
103. 0 1 2 3 Airborne allergies
104. 0 1 2 3 Experience hives
105. 0 1 2 3 Sinus congestion, "stuffy head"
106. 0 1 2 3 Crave bread or noodles
107. 0 1 2 3 Alternating constipation and diarrhea
108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)
109. 0 1 2 3 Wheat or grain sensitivity
110. 0 1 2 3 Dairy sensitivity
111. 0 1 Are there foods you could not give up (0=no, 1=yes)
112. 0 1 2 3 Asthma, sinus infections, stuffy nose
113. 0 1 2 3 Bizarre vivid dreams, nightmares
114. 0 1 2 3 Use over-the-counter pain medications
115. 0 1 2 3 Feel spacey or unreal

Section 4

58

116. 0 1 2 3 Anus itches
117. 0 1 2 3 Coated tongue
118. 0 1 2 3 Feel worse in moldy or musty place
119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
120. 0 1 2 3 Fungus or yeast infections
121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
123. 0 1 2 3 Stools hard or difficult to pass
124. 0 1 History of parasites (0=no, 1=yes)
125. 0 1 2 3 Less than one bowel movement per day
126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
127. 0 1 2 3 Stools are not well formed (loose)
128. 0 1 2 3 Irritable bowel or mucus colitis
129. 0 1 2 3 Blood in stool
130. 0 1 2 3 Mucus in stool
131. 0 1 2 3 Excessive foul smelling lower bowel gas
132. 0 1 2 3 Bad breath or strong body odors
133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
134. 0 1 2 3 Cramping in lower abdominal region
135. 0 1 2 3 Dark circles under eyes

Section 5

75

136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, "double jointed"
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis
150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell

Section 6

22

165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffer sun poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

Section 7

39

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

Section 8

81

186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heart beat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritates eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

Section 9

78

213. 0 1 2 3 Tend to be a "night person"
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up suddenly
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

Section 10

29

239. 0 1 Height over 6' 6" (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
245. 0 1 Height under 4' 10" (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

Section 11

48

252. 0 1 2 3 Sensitive/allergic to iodine
253. 0 1 2 3 Difficulty gaining weight, even with large appetite
254. 0 1 2 3 Nervous, emotional, can't work under pressure
255. 0 1 2 3 Inward trembling
256. 0 1 2 3 Flush easily
257. 0 1 2 3 Fast pulse at rest
258. 0 1 2 3 Intolerance to high temperatures
259. 0 1 2 3 Difficulty losing weight
260. 0 1 2 3 Mentally sluggish, reduced initiative
261. 0 1 2 3 Easily fatigued, sleepy during the day
262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
263. 0 1 2 3 Constipation, chronic
264. 0 1 2 3 Excessive hair loss and/or coarse hair
265. 0 1 2 3 Morning headaches, wear off during the day
266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

27

268. 0 1 2 3 Prostate problems
269. 0 1 2 3 Difficulty with urination, dribbling
270. 0 1 2 3 Difficult to start and stop urine stream
271. 0 1 2 3 Pain or burning with urination
272. 0 1 2 3 Waking to urinate at night
273. 0 1 2 3 Interruption of stream during urination
274. 0 1 2 3 Pain on inside of legs or heels
275. 0 1 2 3 Feeling of incomplete bowel evacuation
276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

60

277. 0 1 2 3 Depression during periods
278. 0 1 2 3 Mood swings associated with periods (PMS)
279. 0 1 2 3 Crave chocolate around periods
280. 0 1 2 3 Breast tenderness associated with cycle
281. 0 1 2 3 Excessive menstrual flow
282. 0 1 2 3 Scanty blood flow during periods
283. 0 1 2 3 Occasional skipped periods
284. 0 1 2 3 Variations in menstrual cycles
285. 0 1 2 3 Endometriosis
286. 0 1 2 3 Uterine fibroids
287. 0 1 2 3 Breast fibroids, benign masses
288. 0 1 2 3 Painful intercourse (dysparenia)
289. 0 1 2 3 Vaginal discharge
290. 0 1 2 3 Vaginal dryness
291. 0 1 2 3 Vaginal itchiness
292. 0 1 2 3 Gain weight around hips, thighs and buttocks
293. 0 1 2 3 Excess facial or body hair
294. 0 1 2 3 Hot flashes
295. 0 1 2 3 Night sweats (in menopausal females)
296. 0 1 2 3 Thinning skin

Section 14

30

297. 0 1 2 3 Aware of heavy and/or irregular breathing
298. 0 1 2 3 Discomfort at high altitudes
299. 0 1 2 3 "Air hunger" or sigh frequently
300. 0 1 2 3 Compelled to open windows in a closed room
301. 0 1 2 3 Shortness of breath with moderate exertion
302. 0 1 2 3 Ankles swell, especially at end of day
303. 0 1 2 3 Cough at night
304. 0 1 2 3 Blush or face turns red for no reason
305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
306. 0 1 2 3 Muscle cramps with exertion

Section 15

13

307. 0 1 2 3 Pain in mid-back region
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
309. 0 1 History of kidney stones (0=no, 1=yes)
310. 0 1 2 3 Cloudy, bloody or darkened urine
311. 0 1 2 3 Urine has a strong odor

Section 16

30

312. 0 1 2 3 Runny or drippy nose
313. 0 1 2 3 Catch colds at the beginning of winter
314. 0 1 2 3 Mucus producing cough
315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
318. 0 1 2 3 Acne (adult)
319. 0 1 2 3 Itchy skin (Dermatitis)
320. 0 1 2 3 Cysts, boils, rashes
321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

FOOD DIARY

NAME:

List 3 Typical (Breakfast Meals) **Approximate Time:_____**

List 3 Typical (Lunch Meals) **Approximate Time:_____**

List 3 Typical (Dinner Meals) **Approximate Time:_____**

Beverages :How many glasses? _____Water _____Soda _____Juice _____Coffee _____Tea _____Other:_____

Please List all Medication/Vitamins/Herbs as well as approximate time taken and if they were taken with/without meals.