CONFIDENTIAL PATIENT CASE HISTORY

Name _____ Date _____

Phone _____ Work Phone _____

Email _____

Address _____ City/State/Zip _____

Date of Birth _____ Age _____ M ____ F ____ Occupation _____

Married ____ Single ____ Divorced ____ Widowed ____ Spouse Name _____ Number of Children _____

When was your last medical care _____ Where _____

When was your last chiropractic care _____ Where _____

When was your last dental care _____ Where _____

Referred by _____

Payment is due at the time of service. We gladly accept Cash, Check, Debit or Credit Card. Additional financial arrangements are available through Care Credit. Please Initial _____

Because we are out of network for all insurance companies, we do not submit claims through our office. We are happy to provide you with a super bill that you may use to submit a claim to your insurance company. Please ask at checkout for this form.

What Is Your Major Complaint? _____

How Long Have You Had This Condition? _____ Getting Worse? _____ Constant? _____

Pain Comes/Goes? _____ What Aggravates It? _____ Similar Conditions In Past? _____

List Previous Diagnosis/Treatments You Have Received For This Condition _____

What Do You Believe Is Wrong With You? _____

Other Complaints? _____

List Surgeries And Dates _____

Do You Have A History Of Antibiotic Therapy? _____ Any Allergies? Food _____ Drugs _____

Have You Been In An Auto Accident In The Last Year? _____ 5 Years? _____ Ever? _____

	ALCOHOL	COFFEE	TOBACCO	DRUGS	EXERCISE	SLEEP
HEAVY						
MODERATE						
NONE						

Please list all medications and over the counter supplements or herbs you are currently taking:

_____

_____

List Below The Conditions You Have Been Treated For In The Past Ten Years Or Any Other Health Information You Feel Important:

_____

_____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** ____ **Date:** _____

PART I

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

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

PART II

Please circle the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
use laxatives frequently	0	1	2	3
Category II				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3
Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids?	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category IV				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes		No	
Category VI				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category VII				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VIII				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

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

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

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

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

Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI				
Are you perimenopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 32 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

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

PART III

How many alcohol beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Weight: _____ Date: _____

PATIENT DIAGNOSTIC QUESTIONNAIRE

Name_____ How old are you? _____ (001)

YOUR CHIEF COMPLAINTS

Please mark with an (X) the principle or major conditions which you are concerned about, would like eliminated, or desire treatment for:

002 ( ) Overweight
003 ( ) Underweight
004 ( ) Sexual Problems
005 ( ) Menopause Problems
006 ( ) Heart Condition
007 ( ) Blood Pressure Problems
008 ( ) Digestion Trouble
009 ( ) Gall Bladder Problems
010 ( ) Diabetes Mellitus
011 ( ) Skin Disorder
012 ( ) Ear or Hearing Disorder
013 ( ) Sinus Infections
014 ( ) Nervous/Emotional Trouble
015 ( ) Allergies to Food
016 ( ) Nutritional Evaluation
017 ( ) Arthritis/Rheumatism
018 ( ) Headaches
019 ( ) Female Problems
020 ( ) Extreme Fatigue
021 ( ) Cancer
022 ( ) Circulatory Problems
023 ( ) Lung and/or Breathing
024 ( ) Stomach and/or Gall Bladder
025 ( ) Intestine or Bowel Troubles
026 ( ) Neck and/or Spine Problems
027 ( ) Eye Condition
028 ( ) Nose/Throat/Mouth Problems
029 ( ) Dizziness/Balance Disorder
030 ( ) Kidney/Bladder/Urinary
031 ( ) Allergies in General
032 ( ) Thorough Diagnostic Checkup
033 ( ) Alcohol or Tobacco Addiction

PLEASE FOLLOW THESE INSTRUCTIONS CAREFULLY WHEN COMPLETING THIS QUESTIONNAIRE:

Read each question carefully and mark with an (X) only those statements which are true for you (a yes answer). If a question does not apply to you, or you do not recognize the terminology or disease, or if you are not sure and have a doubt about a question, then do not check the box, simply leave it blank.

GENERAL

034 ( ) Are you overweight?
035 ( ) Are you underweight?
036 ( ) Are your fingernails ridged or have spots?
037 ( ) Do you sleep less than seven hours per night?
038 ( ) Do you rarely exercise?
039 ( ) Do you smoke over 9 cigarettes each day or inhale pipe/cigars?
040 ( ) Do you drink alcoholic beverages each day?
041 ( ) Do you usually drink less than 8 glasses of water each day ?
042 ( ) Are you sensitive to chemical, paint, exhaust fumes, cologne?
043 ( ) Are you unable to recall your dreams the next day?

EYES

044 ( ) Are you near sighted (can't see things at a distance)?
045 ( ) Are you far sighted (can't read small print without glasses)?
046 ( ) Do your eyes frequently itch?
047 ( ) Do you suffer from cross eyes?
048 ( ) Do you have or have you had cataracts?
049 ( ) Do you experience pain in your eyes?
050 ( ) Are your eyes bloodshot?
051 ( ) Do your eyes water?
052 ( ) Do your eyes feel gritty?
053 ( ) Is your vision blurred?
054 ( ) Are you hard of hearing?
055 ( ) Are you experiencing any discharge from your ears?
056 ( ) Do you have ringing or noises in your ears?
057 ( ) Do you suffer from recurrent ear infection?
058 ( ) Do you have a punctured ear drum?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

MOUTH and THROAT

059 ( ) Is your tongue badly coated?
060 ( ) Do you have bad breath?
061 ( ) Do you suffer from sores or cracks at corners of mouth?
062 ( ) Do you frequently experience canker sores (sore mouth)?
063 ( ) Are your gums sore?
064 ( ) Do you frequently suffer from fever blisters?
065 ( ) Do your gums bleed when you brush your teeth?
066 ( ) Do you have sore throats frequently?
067 ( ) Are your glands often swollen?
068 ( ) Do you suffer from toothaches?
069 ( ) Is your mouth often dry?
070 ( ) Do you have excessive saliva?
071 ( ) In the mornings do you have a bitter taste in your mouth?
072 ( ) Do you frequently have a sore tongue?

RESPIRATORY

073 ( ) Do you have frequent colds?
074 ( ) Do you suffer from nasal polyps?
075 ( ) Do you often have sinus infections?
076 ( ) Do you experience night sweats?
077 ( ) Do you have hay fever?
078 ( ) Do you wheeze?
079 ( ) Do you have Asthma?
080 ( ) Do you experience difficulty in breathing?
081 ( ) Do you have a chronic cough?
082 ( ) Do you spit up phlegm?
083 ( ) Do you spit up blood?
084 ( ) Do you have spells of sneezing?
085 ( ) Is your nose frequently stuffy?
086 ( ) Does your nose run constantly?
087 ( ) Do you have frequent nose bleeds?
088 ( ) Do you catch severe colds?
089 ( ) Do you have a chronic chest condition?
090 ( ) Do you have post nasal drip?

CARDIOVASCULAR

091 ( ) Do you have high blood pressure?
092 ( ) Do you have low blood pressure?
093 ( ) Do you have pains in the heart or chest?
094 ( ) Are you troubled with blood clots?
095 ( ) Do you have cold hands?
096 ( ) Are your feet frequently cold?
097 ( ) Do you have varicose veins?
098 ( ) Are your ankles frequently swollen?
099 ( ) Do you have an unusually slow pulse rate?
100 ( ) Do you experience spells of rapid heart beat?
101 ( ) Are you aware of your heart skipping beats?
102 ( ) Do you experience shortness of breath while sitting still?
103 ( ) Do you suffer from leg cramps after retiring to bed?
104 ( ) Do you suffer from leg cramps during the day?
105 ( ) Do you experience pain in your leg/hips when walking?

GASTROINTESTINAL

106 ( ) Is your appetite poor?
107 ( ) Do you have excessive hunger?
108 ( ) Do you experience fainting spells when hungry?
109 ( ) Does eating relieve fatigue?
110 ( ) Do you feel shaky when hungry?
111 ( ) Are you frequently drowsy after eating a meal?
112 ( ) Do you eat when nervous?
113 ( ) Do you frequently have diarrhea?
114 ( ) Do you have difficulty in swallowing?
115 ( ) Do you vomit frequently?
116 ( ) Are you frequently nauseated?
117 ( ) Are you bloated after eating?
118 ( ) Do you have abdominal gas?
119 ( ) Does eating greasy foods cause you to have indigestion?
120 ( ) Do you belch or burp after eating?
121 ( ) Do you have: indigestion immediately upon eating?
122 ( ) Indigestion within 1 hour after meals?
123 ( ) Indigestion 2 hours or more after meals?
124 ( ) Do you have loose bowel movements?
125 ( ) Have you ever had intestinal worms?
126 ( ) Do you have pale or yellow colored stools?
127 ( ) Do you suffer from constipation?
128 ( ) Do you have one or less bowel movements daily?
129 ( ) Are your stools bloody?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

130 ( ) Do you have black tarry stools?
131 ( ) Do you use laxatives?
132 ( ) Do you suffer from severe abdominal pains?
133 ( ) Do you have hemorrhoids (piles)?
134 ( ) Do you have stomach ulcers?
135 ( ) Do you have gall bladder disease?
136 ( ) Do you have liver disease?

NEUROMUSCULAR

137 ( ) Do you have neck pain?
138 ( ) Do you have pain between the shoulders?
139 ( ) Do you suffer from low back pain?
140 ( ) Do you have swollen joints?
141 ( ) Do you have a spinal curvature?
142 ( ) Do you suffer from muscle spasms?
143 ( ) Are your muscles frequently sore?
144 ( ) Do you have muscle weakness?
145 ( ) Are your joints stiff in the morning?
146 ( ) Do you have shoulder/arm pain?
147 ( ) Do you suffer from leg pain at rest?
148 ( ) Do you have rheumatism?
149 ( ) Does any part of your body experience numbness/tingling?
150 ( ) Do you have frequent headaches?

FEET

151 ( ) Are you often dizzy?
152 ( ) Do you frequently feel faint?
153 ( ) Do you have epilepsy?
154 ( ) Do you bite your nails badly?
155 ( ) Do you stutter or stammer?
156 ( ) Are you a sleep walker?
157 ( ) Do you have rheumatoid arthritis?
158 ( ) Do you have osteoarthritis?
159 ( ) Do you suffer from motion sickness?
160 ( ) Do you suffer from painful feet?
161 ( ) Do you have frequent foot cramps?
162 ( ) Do you have plantar warts?
163 ( ) Do you have heel spurs?
164 ( ) Are you troubled with corns?

SKIN

165 ( ) Is your skin tender?
166 ( ) Does your skin itch?
167 ( ) Do you have skin eruptions?
168 ( ) Is your skin rough, especially on the back of your arms?
169 ( ) Do you have Psoriasis?
170 ( ) Do you bruise easily?
171 ( ) Do you have Acne?
172 ( ) Are you troubled with boils?
173 ( ) Do you have Eczema?
174 ( ) Are you aware of moles which are changing in size or color?
175 ( ) Do you frequently experience goose bumps?
176 ( ) Do you have hives (allergy reaction of the skin)?
177 ( ) Do you have excessive perspiration?
178 ( ) Do you get sores that are slow to heal?

URINARY

179 ( ) Do you have frequent urination?
180 ( ) Do you awaken at night to urinate?
181 ( ) Are you a bed wetter?
182 ( ) Do you dribble when sneezing or laughing?
183 ( ) Have you ever lost control of your bladder?
184 ( ) Do you have painful urination?
185 ( ) Do you have blood in your urine?
186 ( ) Are you troubled by urgent urination?
187 ( ) Do you have difficulty in starting the stream?
188 ( ) Do you have frequent bladder infections?
189 ( ) Do you have frequent kidney infections?
190 ( ) Do you have kidney stones?

ENDOCRINE

191 ( ) Do you have excessive thirst?
192 ( ) Do you frequently feel cold?
193 ( ) Do you frequently feel hot?
194 ( ) Are you unusually tired most of the time?
195 ( ) Are you unusually jumpy or nervous?
196 ( ) Is your hair coarse?
197 ( ) Is your skin coarse?
198 ( ) Are you diabetic?
199 ( ) Do you get lightheaded when standing quickly?

PATIENT DIAGNOSTIC QUESTIONNAIRE (cont'd)

FOR WOMEN ONLY

200 ( ) Do you have painful periods?
201 ( ) Do you have an excessive flow?
202 ( ) Do you have irregular cycles?
203 ( ) Do you suffer from menstrual cramps?
204 ( ) Do you have hot flashes?
205 ( ) Do you have vaginal discharge?
206 ( ) Do you have a bloody spotting discharge?
207 ( ) Have you had a hysterectomy?
208 ( ) Do you retain fluid during your periods?
209 ( ) Have you ever miscarried?
210 ( ) Do you have Acne worse at menstruation?
211 ( ) Do you have tender breasts?
212 ( ) Do you have frequent yeast infections?
213 ( ) Do you have lumps in your breasts?
214 ( ) Do you have heavy hair growth on face or body?
215 ( ) Do you take birth control pills?
216 ( ) Do you have pre-menstrual depression?
217 ( ) Is intercourse painful for you?
218 ( ) Do you have a diminished sex desire?
219 ( ) Do you have poor or infrequent orgasm?

FOR MEN ONLY

220 ( ) Do you have painful genitals?
221 ( ) Do you have prostate troubles?
222 ( ) Do you have lumps in your testicles?
223 ( ) Do you have a discharge from the urethra?
224 ( ) Do you have sores on external genitalia?
225 ( ) Do you have difficulty getting or keeping an erection?
226 ( ) Do you have difficulty completing intercourse?
227 ( ) Have you had difficulty fathering children?

BEHAVORIAL

228 ( ) Do you have difficulty falling asleep?
229 ( ) Do you have difficulty staying asleep?
230 ( ) Do you have recurrent bad dreams?
231 ( ) Do you have difficulty in concentrating?
232 ( ) Is your memory poor?
233 ( ) Do strange people or places make you afraid?
234 ( ) Are you scared to be alone?
235 ( ) Do you always need someone to advise you?
236 ( ) Are you afraid to eat anywhere except at home?
237 ( ) Are you unhappy when others are happy?
238 ( ) Are you usually unhappy and depressed?
239 ( ) Do you often cry?
240 ( ) Are you frequently miserable or blue?
241 ( ) Do you sometimes wish you were dead and away from it all?
242 ( ) Are your feelings easily hurt?
243 ( ) Does criticism always upset you?
244 ( ) Do people usually misunderstand you?
245 ( ) Do you have to be on guard even with your friends?
246 ( ) Do people often annoy you?
247 ( ) Are you easily angered?
248 ( ) Do you frequently become scared for no reason?
249 ( ) Do you feel you are under considerable emotional stress?

Thank you for completing this questionnaire.