MEDICAL HISTORY DISEASES/DIAGNOSIS/CONDITIONS

Check appropriate box and provide date of onset

GASTROINTESTINAL

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

CARDIOVASCULAR

- ☐ Heart Attack _____
- ☐ Other Heart Disease _____
- ☐ Stroke _____
- ☐ Elevated Cholesterol _____
- ☐ Arrhythmia (irregular heart rate) _____
- ☐ Hypertension (high blood pressure) _____
- ☐ Rheumatic Fever _____
- ☐ Mitral Valve Prolapse _____
- ☐ Other _____

METABOLIC/ENDOCRINE

- ☐ Type 1 Diabetes _____
- ☐ Type 2 Diabetes _____
- ☐ Hypoglycemia _____
- ☐ Metabolic Syndrome _____
  (Insulin Resistance or Pre-Diabetes)
- ☐ Hypothyroidism (low thyroid) _____
- ☐ Hyperthyroidism (overactive thyroid)_____
- ☐ Endocrine Problems_____
- ☐ Polycystic Ovarian Syndrome (PCOS) _____
- ☐ Infertility_____
- ☐ Weight Gain_____
- ☐ Weight Loss _____
- ☐ Frequent Weight Fluctuations_____
- ☐ Bulimia _____
- ☐ Anorexia _____
- ☐ Binge Eating Disorder_____
- ☐ Night Eating Syndrome_____
- ☐ Eating Disorder (non-specific _____
- ☐ Other_____

CANCER

- ☐ Lung Cancer _____
- ☐ Breast Cancer _____
- ☐ Colon Cancer _____
- ☐ Ovarian Cancer _____
- ☐ Prostate Cancer _____
- ☐ Skin Cancer _____
- ☐ Other_____

GENITAL AND URINARY SYSTEMS

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

MUSCULOSKELETAL/PAIN

- ☐ Osteoarthritis _____
- ☐ Fibromyalgia _____
- ☐ Headaches _____
- ☐ Chronic Pain _____
- ☐ Other _____

INFLAMMATORY/AUTOIMMUNE

- ☐ Chronic Fatigue Syndrome _____
- ☐ Autoimmune Disease _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus SLE_ _____
- ☐ Immune Deficiency Disease _____
- ☐ Herpes-Genital _____
- ☐ Severe Infectious Disease _____
- ☐ Poor Immune Function _____
  (frequent infections)
- ☐ Food Allergies _____
- ☐ Environmental Allergies _____
- ☐ Multiple Chemical Sensitivities _____
- ☐ Latex Allergy _____
- ☐ Other _____

MEDICAL HISTORY *(CONTINUED)*

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

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 Disorder _____
- ☐ Schizophrenia _____
- ☐ Headaches _____
- ☐ Migraines _____
- ☐ ADD/ADHD_____
- ☐ Autism _____
- ☐ Mild Cognitive Impairment _____
- ☐ Memory Problems _____
- ☐ Parkinson's Disease _____
- ☐ Multiple Sclerosis _____
- ☐ ALS _____
- ☐ Seizures_____
- ☐ Other Neurological Problems _____

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ☐ Full Physical Exam _____
- ☐ Bone Density _____
- ☐ Colonoscopy _____
- ☐ Cardiac Stress Test_____
- ☐ EBT Heart Scan _____
- ☐ EKG _____
- ☐ Hemoccult Test-*stool test for blood* _____
- ☐ MRI _____
- ☐ CT Scan _____
- ☐ Upper Endoscopy _____
- ☐ Upper GI Series _____
- ☐ Ultrasound _____

INJURIES

Check box if yes: ☐ Back Injury ☐ Head Injury ☐ Neck Injury ☐ Broken Bones_____

Other_____

SURGERIES

Check box if yes and provide date of surgery

- ☐ Appendectomy _____
- ☐ Hysterectomy +/- Ovaries _____
- ☐ Gall Bladder _____
- ☐ Hernia _____
- ☐ Tonsillectomy _____
- ☐ Dental Surgery _____
- ☐ Joint Replacement –Knee/Hip _____
- ☐ Heart Surgery–Bypass Valve _____
- ☐ Angioplasty or Stent _____
- ☐ Pacemaker _____
- ☐ Other _____
- ☐ None _____

HOSPITALIZATIONS

☐ None

Date:	**Reason:**

GYNECOLOGIC HISTORY *(FOR WOMEN ONLY)*

OBSTETRIC HISTORY (*Check box if yes and provide number)*

☐ Pregnancies_____ ☐ Caesarean_____ ☐ Vaginal deliveries_____
☐ Miscarriage_____ ☐ Abortion_____ ☐ Living Children_____
☐ Post Partum Depression ☐ Toxemia ☐ Gestational Diabetes
☐ Breast Feeding For how long?_____

MENSTRUAL HISTORY

Age at First Period:_____ Menses Frequency:_____ Length:_____ Pain: ☐ Yes ☐ No Clotting: ☐ Yes ☐ No
Has your period ever skipped?_____ For how long?_____
Last Menstrual Period:_____
Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring
How long?_____
Do you use contraception? ☐ Yes ☐ No
☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

☐ Fibrocystic Breasts ☐ Endometriosis ☐ Fibroids ☐ Infertility
☐ Painful Periods ☐ Heavy periods ☐ PMS
Last Mammogram:_____ Breast Biopsy/Date:_____
Last PAP Test:_____ ☐ Normal ☐ Abnormal
Last Bone Density:_____ Results: ☐ High ☐ Low ☐ Within Normal Range
Are you in menopause? ☐ Yes ☐ No
Age at Menopause_____
☐ Hot Flashes ☐ Mood Swings ☐ Concentration/Memory Problems
☐ Vaginal Dryness ☐ Decreased Libido
☐ Heavy Bleeding ☐ Joint Pains ☐ Headaches ☐ Weight Gain
☐ Loss of Control of Urine ☐ Palpitations
☐ Use of hormone replacement therapy? How long?_____

MEN'S HISTORY *(FOR MEN ONLY)*

Have you had a PSA done? ☐ Yes ☐ No
PSA Level: ☐ 0-2 ☐ 2-4 ☐ 4-10 ☐ >10
☐ Prostate Enlargement ☐ Prostate infection ☐ Change in Libido ☐ Impotence
☐ Difficulty Obtaining an Erection ☐ Difficulty Maintaining an Erection
☐ Nocturia (urination at night) How many times at night? _____
☐ Urgency/Hesitancy/Change in Urinary Stream ☐ Loss of Control of Urine

GI HISTORY

Foreign Travel? ☐ Yes ☐ No Where? _____
Wilderness Camping? ☐ Yes ☐ No Where? _____
Have you ever had severe: ☐ Gastroenteritis ☐ Diarrhea ☐ Heartburn ☐ Reflux ☐ Food Poisoning
Do you feel like you digest your food well? ☐ Yes ☐ No
Do you feel bloated after meals? ☐ Yes ☐ No
Do you have frequent gas? ☐ Yes ☐ No If yes, does it have a foul order? ☐ Yes ☐ No
How would you describe your bowel habits: ☐ Daily; ____ times per day ☐ Weekly; ____ times per week
How would you best describe the consistency of your stools: ☐ formed/log like ☐ formed/snake like ☐ pellets ☐ loose
Do your stools frequently have a fowl smell? ☐ Yes ☐ No

PATIENT BIRTH/CHILDHOOD HISTORY

☐ Term ☐ Premature
Pregnancy Complications: _____
Birth Complications: _____
Adopted: ☐ Yes ☐ No
☐ Breast Fed How long?_____ ☐ Bottle Fed
Age at introduction of: Solid Foods:_____ Dairy:_____ Wheat:_____
Did you eat a lot of candy or sugar as a child? ☐ Yes ☐ No
Were you sickly as a child? ☐ Yes ☐No Explain:_____
Were you placed on antibiotics frequently as a child? ☐ Yes ☐ No

DENTAL HISTORY

☐ Silver Mercury Fillings How many? _____
☐ Gold Fillings
☐ Root Canals How many? _____
☐ Implants
☐ Tooth Pain
☐ Bleeding Gums
☐ Gingivitis
☐ Problems with Chewing
Do you floss regularly? ☐ Yes ☐ No

WELLNESS CARE

Have you ever been under the care of Doctor of Chiropractic? □ Yes □ No
Was your care solely for pain or for **nervous system wellness care**? _____
When was your last visit to your Chiropractor?_____
How often do you generally visit your Chiropractor?_____
Are you under the care of any other alternative medicine practitioner? □ Yes □ No If so, specialty_____
Do you have a lifestyle/wellness practitioner or coach? □ Yes □ No Explain_____

MEDICATIONS

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR	REASON FOR USE

PREVIOUS MEDICATIONS: *Last 10 years*

MEDICATION	DOSE	FREQUENCY	START DATE (MONTH/YEAR	REASON FOR USE

NUTRITIONAL SUPPLEMENTS *(VITAMINS/MINERALS/HERBS/HOMEOPATHY)*

SUPPLEMENT AND BRAND	DOSE	FREQUENCY	START DATE (MONTH/YEAR	REASON FOR USE

Have your medications or supplements ever caused you unusual side effects or problems? ☐ Yes ☐ No
Describe: _____
Have you had prolonged or regular use of NSAIDS? (Advil, Aleve, etc.,) Motrin, Aspirin? ☐ Yes ☐ No
Have you had prolonged or regular use of Tylenol? ☐ Yes ☐ No
Have you had prolonged or regular use of Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No
Frequent antibiotics > 3 times/year? ☐ Yes ☐ No
Long term antibiotics ☐ Yes ☐ No
Use of steroids (prednisone, nasal allergy inhalers) in the past? ☐ Yes ☐ No
Use of oral contraceptives? ☐ Yes ☐ No

FAMILY HISTORY

Check family members that apply	MOTHER	FATHER	BROTHER(S)	SISTER(S)	CHILDREN	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	AUNTS	UNCLES	OTHER
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Thyroid Problems/Lupus												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema/Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson's												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												
Miscarrages												
Other												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition 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
Describe:_____

Check all that apply:
☐ Low Fat ☐ Low Carbohydrate ☐ High Protein ☐ Low Sodium ☐ Diabetic ☐ No Dairy
☐ No Wheat ☐ Gluten Restricted ☐ Vegetarian ☐ Vegan
☐ Specific Program for Weight Loss/Maintenance Type: _____
☐ Other _____

Height (feet/inches)_____ Current Weight_____
Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____
Highest adult weight _____ Lowest adult weight _____
Weight Fluctuations (> 10 lbs.) ☐ Yes ☐ No Body Fat % _____

How often do you weigh yourself? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
Do you avoid any particular foods? ☐ Yes ☐ No
If yes, types and reason _____
_____
List your three most favorite foods:
_____
Do you grocery shop? ☐ Yes ☐ No
If no, who does the shopping?_____
Do you read food labels? ☐ Yes ☐ No
Do you cook? ☐ Yes ☐ No If no, who does the cooking?_____
How many meals do you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Erratic eating pattern
☐ Eat too much
☐ Late night eating
☐ Dislike healthy food
☐ Time constraints
☐ Eat more than 50% meals away from home
☐ Travel frequently
☐ Non-availability of healthy foods
☐ Do not plan meals or menus
☐ Reliance on convenience items
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs or food preferences
☐ Love to eat
☐ Eat because I have to
☐ Have a negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely depressed, bored)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Eating in the middle of the night
☐ Confused about nutrition advice

Do you skip meals? □ Yes □ No If so, what meals?_____

The most important thing I should change about my diet to improve my health is:

SMOKING

Currently Smoking? ☐ Yes ☐ No
How many years? _____ Packs per day: _____ Attempts to quit: _____
Previous Smoking: How many years? _____ Packs per day? _____
Second Hand Smoke Exposure? _____

ALCOHOL INTAKE

How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits
☐ None ☐ 1-3 ☐4-6 ☐ 7-10 ☐> 10 If "None," skip to Other Substances
Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None
Have you ever been told you should cut down your alcohol intake? ☐ Yes ☐ No
Do you get annoyed when people ask you about your drinking? ☐ Yes ☐ No
Do you ever feel guilty about your alcohol consumption? ☐ Yes ☐ No
Do you ever take an eye-opener? ☐ Yes ☐ No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ☐ Yes ☐ No
Have you ever been unable to remember what you did during a drinking episode? ☐ Yes ☐ No
Do you get into arguments or physical fights when you have been drinking? ☐ Yes ☐ No
Have you ever been arrested or hospitalized because of drinking? ☐ Yes ☐ No
Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Caffeine Intake: ☐ Yes ☐ No
Coffee cups/day: ☐1 ☐2-4 ☐> 4 | Tea cups/day: ☐1 ☐2-4 ☐> 4
Soda Intake: ☐ Yes ☐ No Caffeinated ☐ Yes ☐ No Diet ☐ Yes ☐ No
12-ounce can/bottle: ☐1 ☐2-4 ☐> 4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.): _____
Are you currently using any recreational drugs? ☐ Yes ☐ No
Type:_____
Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

EXERCISE

Current Exercise Program: *(List type of activity, number of sessions/week, and duration)*

Activity:	**Type:**	**Frequency per Week:**	**Duration in Minutes:**
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, gyrotonics, etc.)			
Sports or Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Medium ☐ High
List problems that limit activity:

_____

_____

Do you feel unusually fatigued after exercise? ☐ Yes ☐ No
If yes, please describe:

_____

_____

Do you usually sweat when exercising? ☐Yes ☐ No

PSYCHOSOCIAL

Are you happy? □ Yes □ No
Do you feel your life has meaning and purpose? □ Yes □ No
Do you believe stress is presently reducing the quality of your life? □ Yes □ No
Do you like the work you do? □ Yes □ No
Have you ever experienced major losses in your life? □ Yes □ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No
Would you describe your experience as a child in your family as happy and secure? □ Yes □ No

STRESS/COPING

Have you ever sought counseling? □ Yes □ No
Are you currently in therapy? □ Yes □ No
Describe: _____
Do you feel you have an excessive amount of stress in your life? □ Yes □ No
Do you feel you can easily handle the stress in your life? □ Yes □ No
Daily Stressors: Rate on scale of 1-10
Work _____ Family _____ Social _____ Finances_____ Health_____ Other_____
Do you practice meditation or relaxation techniques? □ Yes □ No How often? _____
Check all that apply: □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer
□ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No

SLEEP/REST

Average number of hours you sleep per night: □ >10 □ 8-10 □ 6-8 □ < 6
Do you have trouble falling asleep? □ Yes □ No
Do you have trouble staying asleep? □ Yes □ No
Do you wake consistently at the same time during the night? □ Yes □ No Time:_____
Do you feel rested upon awakening? □ Yes □ No
Do you have problems with insomnia? □ Yes □ No
Do you snore? □ Yes □ No
Do you use sleeping aids? □ Yes □ No
Explain: _____

ROLES/RELATIONSHIP

Marital status:
□ Single □ Married □ Divorced □ Gay/Lesbian □ Long Term Partnership □ Widow
List Children:

Child's Name:	**Age:**	**Gender:**

Who is Living in Household? Number: _____
Names:_____
Their employment/Occupations:_____
Resources for emotional support?
Check all that apply:
□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____
Are you satisfied with your sex life? □ Yes □ No

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? □ Yes □ No
If yes, describe symptoms:_____
Do you have any food allergies or sensitivities? □ Yes □ No
If yes, list all:_____
Do you have an adverse reaction to caffeine? □ Yes □ No
When you drink caffeine do you feel: □ Irritable or wired □ Aches & Pains
Do you adversely react to (Check all that apply):
□ Mono-sodium glutamate (MSG) □ Aspartame (Nutrasweet) □ Caffeine □ Bananas
□ Garlic □ Onion □ Cheese □ Citrus Foods □ Chocolate □ Alcohol □ Red Wine
□ Sulfite Containing Foods (wine, dried fruit, salad bars) □ Preservatives (ex. sodium benzoate) □ Dyes
□ Other: _____

Which of these significantly affect you? Check all that apply:
□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____
In your work or home environment, are you exposed to:
□ Chemicals □ Electromagnetic Radiation □ Mold
Have you ever turned yellow (jaundiced)? □ Yes □ No
Have you ever been told you have a liver disorder? □ Yes □ No
Explain: _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides (frequent visits of exterminator) □ Pesticides £ Organic Solvents □ Heavy Metals
□ Other_____
Chemical Name, Date, Length of Exposure: _____
Do you dry clean your clothes frequently? □ Yes □ No
Do you or 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
Do you live on farmland or near farmland? □ Yes □ No

SYMPTOM REVIEW

Please check all current symptoms or those present in during the past the 6 months.

GENERAL
- □ Cold Hands & Feet
- □ Cold Intolerance
- □ Low Body Temperature
- □ Low Blood Pressure
- □ Daytime Sleepiness
- □ Difficulty Falling Asleep
- □ Early Waking
- □ Fatigue
- □ Fever
- □ Flushing
- □ Heat Intolerance
- □ Night Waking
- □ 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 Degeneration
- □ 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 Spasms
- □ Muscle Stiffness

Muscle Twitches:
- □ Around Eyes
- □ Arms or Legs

- □ Muscle Weakness
- □ Neck Muscle Spasm
- □ Tendonitis
- □ Tension Headache
- □ TMJ Problems

MOOD/NERVES
- □ Agoraphobia
- □ Anxiety
- □ Auditory Hallucinations
- □ Black-out
- □ Depression

Difficulty:
- □ Concentrating
- □ With Balance
- □ With Thinking
- □ With Judgment
- □ With Speech
- □ With Memory

- □ Dizziness (Spinning)
- □ Fainting
- □ Fearfulness
- □ Irritability
- □ Light-headedness
- □ Numbness
- □ Other Phobias
- □ Panic Attacks
- □ Paranoia
- □ Seizures
- □ Suicidal Thoughts
- □ Tingling
- □ Tremor/Trembling
- □ Visual Hallucinations

EATING
- □ Binge Eating
- □ Bulimia
- □ Can't Gain Weight
- □ Can't Lose Weight
- □ Can't Maintain Healthy Weight
- □ Frequent Dieting
- □ Poor Appetite
- □ Salt Cravings
- □ Carbohydrate Craving (breads, pastas)
- □ Sweet Cravings (candy, cookies, cakes)
- □ Chocolate Cravings
- □ Caffeine Dependency

DIGESTION
- □ Anal Spasms
- □ Bad Teeth
- □ Bleeding Gums

Bloating of:
- □ Lower Abdomen
- □ Whole Abdomen
- □ Bloating After Meals

- □ Blood in Stools
- □ Burping
- □ Canker Sores
- □ Cold Sores
- □ Constipation
- □ Cracking at Corner of Lips
- □ Cramps
- □ Dentures w/Poor Chewing
- □ Diarrhea
- □ Alternating Diarrhea and Constipation
- □ Difficulty Swallowing
- □ Dry Mouth
- □ Excess Flatulence/Gas
- □ Fissures
- □ Foods "Repeat" (Reflux)
- □ Gas
- □ Heartburn
- □ Hemorrhoids
- □ Indigestion
- □ Nausea
- □ Upper Abdominal Pain
- □ Vomiting

Intolerance to:
- □ Lactose
- □ All Dairy Products
- □ Wheat
- □ Gluten (Wheat, Rye, Barley)
- □ Corn
- □ Eggs
- □ Fatty Foods
- □ Yeast

- □ Liver Disease/Jaundice (Yellow Eyes or Skin)
- □ Abnormal Liver Function Tests
- □ Lower Abdominal Pain
- □ Mucus in Stools
- □ Periodontal Disease
- □ Sore Tongue
- □ Strong Stool Odor
- □ Undigested Food in Stomach

SYMPTOM REVIEW *(continued)*

SKIN PROBLEMS
- □ Acne on Back
- □ Acne on Chest
- □ Acne on Face
- □ Acne on Shoulders
- □ Athlete's Foot
- □ Bumps on Back of Upper Arms
- □ Cellulite
- □ Dark Circles Under Eyes
- □ Ears Get Red
- □ Easy Bruising
- □ Lack Of Sweating
- □ Eczema
- □ Hives
- □ Jock Itch
- □ Lackluster Skin
- □ Moles w/Color/Size Change
- □ Oily Skin
- □ Pale Skin
- □ Patchy Dullness
- □ Rash
- □ Red Face
- □ Sensitivity to Bites
- □ Sensitivity to Poison Ivy/Oak
- □ Shingles
- □ Skin Darkening
- □ Strong Body Odor
- □ Hair Loss
- □ Vitiligo

ITCHING SKIN
- □ Skin in General
- □ Anus
- □ Arms
- □ Ear Canals
- □ Eyes
- □ Feet
- □ Hands
- □ Legs
- □ Nipples
- □ Nose
- □ Penis
- □ Roof of Mouth
- □ Scalp
- □ Throat

SKIN, DRYNESS OF
- □ Eyes
- □ Feet
  - □ Cracking? □ Peeling?
- □ Hair □ Unmanageable?
- □ Hands
  - □ Cracking? □ Peeling?
- □ Mouth/Throat
- □ Scalp
  - □ Dandruff?
- □ Skin In General

LYMPH NODES
- □ Enlarged/neck
- □ Tender/neck
- □ Other Enlarged/Tender
- □ Lymph Nodes

NAILS
- □ Bitten
- □ Brittle
- □ Curve Up
- □ Frayed
- □ Fungus-Fingers
- □ Fungus-Toes
- □ Pitting
- □ Ragged Cuticles
- □ Ridges
- □ Soft
- □ White Spots/Lines

Thickening of:
- □ Fingernails
- □ Toenails

RESPIRATORY
- □ Bad Breath
- □ Bad Odor in Nose
- □ Cough-Dry
- □ Cough-Productive
- □ Hoarseness
- □ Sore Throat

Hay Fever:
- □ Spring
- □ Summer
- □ Fall
- □ Change Of Season
- □ Nasal Stuffiness
- □ Nose Bleeds
- □ Post Nasal Drip
- □ Sinus Fullness
- □ Sinus Infection
- □ Snoring
- □ Wheezing
- □ Winter Stuffiness

CARDIOVASCULAR
- □ Angina/chest pain
- □ Breathlessness
- □ Heart Murmur
- □ Irregular Pulse
- □ Palpitations
- □ Phlebitis
- □ Swollen Ankles/Feet
- □ Varicose Veins

URINARY
- □ Bed Wetting
- □ Hesitancy
  (trouble getting started)
- □ Infection
- □ Kidney Disease
- □ Leaking/Incontinence
- □ Pain/Burning
- □ Prostate Infection
- □ Urgency

MALE REPRODUCTIVE
- □ Discharge From Penis
- □ Ejaculation Problem
- □ Genital Pain
- □ Impotence
- □ Prostate or Urinary Infection
- □ Lumps In Testicles
- □ Poor Libido (Sex Drive)

FEMALE REPRODUCTIVE
- □ Breast Cysts
- □ Breast Lumps
- □ Breast Tenderness
- □ Ovarian Cyst
- □ Poor Libido (Sex Drive)
- □ Vaginal Discharge
- □ Vaginal Odor
- □ Vaginal Itch
- □ Vaginal Pain with Sex

Premenstrual:
- □ Bloating Breast Tenderness
- □ Carbohydrate Cravings
- □ Chocolate Cravings
- □ Constipation
- □ Decreased Sleep
- □ Diarrhea
- □ Fatigue
- □ Increased Sleep
- □ Irritability

Menstrual:
- □ Cramps
- □ Heavy Periods
- □ Irregular Periods
- □ No Periods
- □ Scanty Periods
- □ Spotting Between

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 (e.g., work demands, sleep habits) ..... □5 □4 □3 □2 □1
Disengage in negative habits/relationships..... □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
Maintain a chiropractic wellness program to ensure optimum nervous system function..... □5 □4 □3 □2 □1

Comments _____

_____

_____

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 activities? □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?

_____

_____

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

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? □5 □4 □3 □2 □1

Comments: _____

_____

_____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful to you as you implement your personal health program?

□5 □4 □3 □2 □1

Comments: _____

_____

_____

Please list any other concerns that you feel may prohibit you from obtaining optimal health:

_____
_____
_____
_____
_____
_____
_____

3-DAY DIET DIARY INSTRUCTIONS

PLEASE SUBMIT WITH THE ENTIRE INTAKE FORM. DO NOT WAIT AND BRING WITH YOU TO THE APPOINTMENT. WE NEED TO REVIEW PRIOR TO YOUR APPOINTMENT.

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: _____ Date: _____

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____

Stress/Mood/Emotions: _____

Other Comments: _____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color): _____
Stress/Mood/Emotions: _____
Other Comments: _____

MSQ - MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness, and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If you are completing this after your first time, then record your symptoms for *ONLY* the last 48 hours.

POINT SCALE
0 = Never or almost never have the symptom
1 = Occasionally have it, effect is not severe
2 = Occasionally have, effect is severe
3 = Frequently have it, effect is not severe
4 = Frequently have it, effect is severe

KEY TO QUESTIONNAIRE
Add individual scores and total each group. Add each group score and give a grand total.
• Optimal is less than 10 • Mild Toxicity: 10-50 • Moderate Toxicity: 50-100 • Severe Toxicity: over 100

DIGESTIVE TRACT
___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/Stomach pain
Total _____

EARS
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

EMOTIONS
___ Mood swings
___ Anxiety, fear or nervousness
___ Anger, irritability or aggressiveness
___ Depression
Total _____

ENERGY/ACTIVITY
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
Total _____

EYES
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision (does not include near or far-sightedness)
Total _____

HEAD
___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
Total _____

HEART
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

JOINTS/MUSCLES
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
Total _____

LUNGS
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficult breathing
Total _____

MIND
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
Total _____

MOUTH/THROAT
___ Chronic coughing
___ Gagging, frequent need to clear throat
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gum, lips
___ Canker sores
Total _____

NOSE
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
Total _____

SKIN
___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___ Flushing or hot flushes
___ Excessive sweating
Total _____

WEIGHT
___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

OTHER
___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
Total _____

GRAND TOTAL:_____

SPACE FOR ADDITIONAL NOTES

Brain, Body and Mood Survey

Name: Date:

Section 1-S

L

- Anxiety/Worry
- Fatigue
- Insomnia
- Depression
- Pre-menstrual syndrome
- Problems in thinking, concentrating and decision making
- Low self esteem
- Needless feelings of unworthiness and guilt
- Emotionally "numb"
- Loss of interest and pleasure in usual activities
- Obsessive compulsive disorder
- Alcoholism
- Violent temper and poor impulse control
- Panic /agoraphobia syndrome
- Seasonal Affective Disorder (SAD)
- Tics/Tourettes
- Crave sugar, starch, alcohol
- Fibromyalgia/ Chronic Fatigue Syndrome
- Can't shut brain off; can't slow down
- Uncontrolled Appetite (sugars/carbs)
- Headaches
- Unexplained GI Issues

H

- Road Rage
- Hot Flashes
- Irritability

B

- Positive
- Confident
- Flexible
- Easy Going

Section 2-C

L

- Depression and apathy
- Easily bored
- Lack of energy
- Lack of focus
- Lack of drive and low motivation
- Attention Deficit Disorder
- Procrastination and indecisiveness
- Craving carbs, alcohol, caffeine, or drugs for energy

Section 2-C

H

- Sleep trouble
- Anxiety
- Tremors
- Hypertension
- Irritability
- Feeling of "too much caffeine"

B

- Energized
- Upbeat
- Alert

Section 3-G

L

- Anxiety
- Feeling overwhelmed or stressed
- Feeling worried or fearful
- Panic attacks
- Unable to relax or loosen up
- Stiff or tense muscles
- Feeling stressed or burned-out
- Craving carbs, alcohol, or drugs for relaxation and calming
- Poor impulse control
- Poor logic or reasonable thinking
- Seizures

H

- Feeling like you are "sedated" often

B

- Relaxed
- Stress-free

Section 4-E

L

- Heightened sensitivity to emotional pain
- Heightened sensitivity to physical pain
- Crying or tearing up easily
- Eating to soothe your mood, or comfort eating
- Really, really loving certain foods, behaviors, drugs, or alcohol
- Craving a reward or numbing treat

B

- Feelings of pleasure
- Feeling joy
- Feelings of comfort
- Pain-free

Section 5-BS/AF

L

- **Crave sugar, starch or alcohol any time during the day**
- **Irritable, shaky, headaches – especially if too long between meals**
- **Intense cravings for sweets**
- **Lightheaded if meals are missed**
- **Eating relieves fatigue**
- **Agitated, easily upset, nervous**
- **Dizzy when going from bending over to standing**

Section 6-T

L

- **Arrhythmias**
- **Panic Attacks**
- **Cynicism**
- **Pessimism**

H

- **Insomnia**
- **Hyperactivity**

9209 West 110th Building #36
Overland Park, Kansas 66210
(913)322-0251

Consent and Authorization Form

Consent to Professional Treatment: The patient certifies that all information provided to this office is true and correct, to the best of their knowledge. The patient grants their consent to this office and its staff to render treatment as deemed necessary by the attending physician. If the patient is a minor child, under the age of eighteen (18) at the date of treatment, please sign the "Consent to Treatment of Minor" section below.

If this visit and subsequent visits are for chiropractic care, the following applies: I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic x-rays, on me(or the patient for whom I am legally responsible) by the doctors of chiropractic in this clinic, or any others working at this office.

I understand and I am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise such judgement during the course of the procedure, which the doctor feels at the time, based on the fact then known, is in my best interest.

I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content and I agree to the above named procedures. I intend this consent to cover the entire course of treatment of my present condition and for my future condition(s) for which I seek treatment.

Name(Print):_____ Name(Signature):_____ Date:_____

Consent to Treatment of a Minor (If applicable): I hereby request and authorize _____, and whomever he/she may designate as his/her assistant or authorized representative, to administer chiropractic care as he/she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory, and other testing at the doctor's discretion.

Child's name_____ Relationship to child:_____

As of today's date, I have the legal right to select and authorize health care service for the minor child names above. If applicable, under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse, former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Name(Print):_____ Name(Signature):_____ Date:_____

Consent to Perform and Interpret X-rays: The patient consents to the performance of x-rays as deemed necessary by the attending physician of this office. The patient acknowledges that certain risks are associated with x-rays. The patient, hereby states that they have no known limitations that would forbid the taking of x-rays.

The patient further agrees that this office may seek outside interpretation of patient x-rays by a qualified professional not employed by this office. The patient agrees to any additional fees associated with this service and assigns benefits to be paid directly to that professional by your third-party payor.

Name(Print):_____ Name(Signature):_____ Date:_____

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Consent and Authorization Form (cont.)

Assignment of Benefits and Release of Records: The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. This assignment is irrevocable. Failure to fulfill this obligation will be considered a breach of contract between the patient and this office.

The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred.

Name(Print):_____ Name(Signature):_____ Date:_____

Financial Obligation and Appointment Policy: The patient accepts full financial responsibility for services rendered by this practice. This office reserves the right to charge fair market value for missed appointments or appointments canceled without any advanced notification required by this office. Payment in full is required for all services rendered at the time of visit, unless alternative arrangements have been agreed to in advance. Patient accepts full responsibility for any fees incurred, including but not limited to legal fees, collection agency fees, and any and all other expenses incurred in the collection of past due accounts. Patient should direct any questions regarding this financial obligation and appointment policy to the clinic manager or physician.

The patient further authorizes the practice to retain credit card, debit card, checking account or other payment source(s) supplied by patient to the practice for current and future charges, when incurred.

This clinic reserves the right to charge interest on any accounts 90 days past due.

Name(Print):_____ Name(Signature):_____ Date:_____

Patient Health Information(PHI) and Privacy Policy: The patient consents to the use or disclosure of my protected health information by this office for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of this office. I understand that analysis, diagnosis or treatment of me by this office may be conditioned upon my consent as evidenced by my signature below. Our Privacy Policy is not limited to, but includes the following:

1. The patient understands and agrees to allow this office to use their PHI for the purpose of treatment, payment, health care operations and coordination of care. The patient agrees to allow this office to submit requested PHI to the payor(s) named by the patient for the purpose of payment. This office will limit the release of all PHI to the minimum necessary to receive payment.
2. The patient has the right to examine and obtain a copy of their 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. This office is not obligated to agree to those restrictions.
3. The patient's written consent shall remain in effect for as long as the patient receives care at this office, regardless of the passage of time, unless the patient provides written notice to revoke their consent. A revocation of consent will not apply to any prior care or services.
4. This office is committed to protecting your PHI and meeting its HIPAA obligations: Staff have been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures.
5. Patients have the right to file a formal complaint with our privacy official about any suspected violations.

This office has the right to refuse treatment if the patient does not accept the terms of this policy.

Name(Print):_____ Name(Signature):_____ Date:_____

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Consent and Authorization Form (cont.)

Patient Photo Release: I hereby give permission to Align, LLC to use photographs taken of myself and/or the undersigned minor children. Photos may be used for print, web or digital reproduction and for commercial and/or editorial use, including (but not limited to) advertising/promotion via social media, e-news letters, and/or printed material relevant to Align, LLC. I seek no compensation for the use of these photographs.

I release Align, LLC from any expectation of confidentiality for myself and/or the undersigned minor children and attest that I am the parent or legal guardian of the children listed below and I have the authority to authorize Align, LLC to use their photographs and names.

Street Address: _____

City, State, and Zip: _____

Names and Ages of Minor Children:

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name:_____ Age:_____ Name:_____ Age:_____

Name(Print):_____ Name(Signature):_____ Date:_____