Natural Care Chiropractic

Nutrition Health History

Name ______________________________ Date ____________

Primary Concerns **Onset** **Interventions Tried**

1. ____
2. ____
3. ____
4. ____
5. ____

Current Supplements ______________________________

Current Medications ______________________________

Vegetarian? Y | N Type ______________ Metal in your body (fillings, staples, pins, etc)? Y | N ____________

Allergies? Y | N Details ______________________ Surgeries? Y | N Details ______________________

Root Canal? Y | N Wisdom Teeth Removal? Y | N Oral Surgery? Y | N

History of Body or Head Trauma/Concussion? Y | N Details ______________________

Hospitalizations (exclude surgeries)? Y | N Details ______________________

Family History of Disease (Diabetes, Heart Disease, Cancer, etc.) ______________________

Height _____ Weight _____ Blood Type _____ Occupation ______________ Industry ____________

If you have any of the following, indicate **C** for a current condition and **P** for a past problem

____ Ulcer
____ Hiatal Hernia
____ Food Intolerance: Type: ______________
____ Chrons | Colitis | IBS
____ Asthma
____ URI Bronchitis ______ times
____ Pneumonia
____ Emphysema
____ Ear Infections ______ times
____ Strep Throat ______ times
____ Staph Infection | MRSA
____ Mononucleosis
____ Measles | Mumps
____ Autoimmune Disease
Type:______________________
____ Diabetes Type: ______________
____ Low Thyroid
____ Neurological Problem(s)
Type: ______________________
____ Cancer Type: ______________
____ Vertigo | Dizziness
____ Learning Disability
____ Addiction Type: ______________
____ Eating Disorder
____ Eye Problems
____ Near-Sighted | Far-Sighted
____ Sleep Apnia | CPAP Use
____ Insomnia
____ Osteoporosis | Osteopenia
____ Arthritis Location: ______________

____ Gout
____ Psoriasis/Eczema
____ Varicose/Spider Veins
____ Heart issues
____ High/Low Blood Pressure
____ High Cholesterol
____ Stroke
____ Incontinence
____ Kidney Stones
____ STD Type: ______________

Male Only

____ Infertility
____ Benign Prostatic Hyperplasia
____ PSA #______________________

Female Only

____ Birth Control Type: ______________
____ Infertility
____ Endometriosis
____ Fibrocystic Breast
____ Uterine Fibroids
____ Ovarian Cysts
____ Yeast Infection
____ PID Pelvic Inflammatory Disease
____ History of Abnormal Pap
____ Menopause
____ PCOS
____ Pregnant? Y | N ________weeks
____ Trying to be Pregnant? Y | N

____ Number of Live Births
____ Pregnancies

Travel History

____ Mexico
____ Central/South America
____ India/Southeast Asia
____ Africa
____ Other ______________

Other Conditions

____
____
____

Please fill out completely

Stress: Scale 1-10 ___
Water: ___ oz/day
Juice: ___ glasses/day
Coffee: ___ cups/day
Soda: ___ times/week
Alcohol: ___ glasses/week
Tobacco: ___ times/day
Soy Use: ___ times/week
Equal (Aspartame): ___ times/week
Splenda (Sucralose): ___ times/week
Cardio Exercise: ___ times/week
Weight Training: ___ times/week
Yoga/Pilates: ___ times/week
Sports: ___ hours/week

Please fill out completely: Rate any symptoms you are currently having: 1=Mild 2=Moderate 3=Severe

EARS
____ Noise (Ring/Hiss/Pound)
____ Plugged
____ Popping
____ Ache | Infection
____ Draining
____ Itchy
____ Hearing Loss
____ Dizziness | Vertigo
____ Excessive Ear Wax
____ Other ________________
____

EYES
____ Burn | Tear | Itchy
____ Ache | Dry | Red
____ Crust in a.m. | Film
____ Bouts of Blurriness
____ Floaters | Spots
____ Tired | Puffy
____ Stye
____ Twitching Around Eye
____ Dark Circles
____ Light Sensitive

SINUS
____ Nosebleeds
____ Dry
____ Drain
____ Stuffy | Plugged
____ Sneeze Frequently
____ Taste | Smell Loss
____ Post Nasal Drip
____ Color

STOMACH
____ Heartburn
____ Indigestion
____ Stomach
____ Ache | Cramps
____ Nausea | Vomiting
____ Bloat After Eat
____ Gas | Flatulence
____ Belching
____ Ulcer

CHEST
____ Tension
____ Tight
____ Pressure
____ Heaviness
____ Congestion
____ Chest | Sternal Pain
____ Palpitations
____ Heart Skip
____ Heart
____ Racing | Slowing

RESPIRATORY
____ Short of Breath Constant
____ Short of Breath Exertion
____ Wheeze
____ Air Hunger | Yawn
____ Frequent sighs
____ Upper Respiratory Infection
____ Asthma

BOWELS
____ Movements ____ per Week
____ Diarrhea
____ Constipation
____ Incomplete
____ Bulky
____ Cramps in Abdomen
____ Pain w/Bowel Movement
____ Laxative | Suppository Use
____ Colonics | Enemas
____ Anal Itching
____ Hemorrhoids
____ Swollen
____ Achy
____ Burning/Itchy
____ Blood

SLEEP
____ Hours in Bed
____ Hours Asleep
____ Quality of Sleep
Poor | Fair | Good | Great
____ Difficulty Falling Asleep
____ Difficulty Staying Asleep
____ Interrupted ____per Night
____ Waking at _____ a.m.
____ Crave Sleep During Day
____ Awaken Suddenly (Jolt)
____ Don't Dream
____ Nightmares | Epic dreams
____ Night Sweats
____ Restlessness
____ Restless Leg Syndrome

FECAL CONSISTENCY
____ Normal
____ Light Colored Feces
____ Soft
____ Hard
____ Pebbles
____ Ribbon-like
____ Mucous
____ Contain string-like
____ Black/White Specks
____ Contains Undigested Food

MEMORY
____ Forget Names/Numbers
____ Forget Words
____ Forget Actions
____ Difficulty Concentrating

EMOTIONS
____ Sadness | Depression
____ Moodiness
____ Irritable
____ Frustrated | Angry
____ Nervous | Anxiety
____ Grief
____ Panic | Fear
____ Cry
____ S.A.D.
____ OCD
____ Other ________________
____

APPETITE/DIET
____ Low/Norm/High Appetite
____ Crave Starch | Sweets
____ Crave Chocolate | Ice Cream
____ Eat Lots of Spicy Foods
____ Nighttime Snack
If Meals are Missed:
____ Nausea
____ Extreme Hunger
____ Cold/ Clammy
____ Rapid Heartbeat
____ Moodiness

HEADACHES
____ Base of Skull (Back)
____ Side of Head (Temples)
____ Frontal (Above Eyes)
____ Top of Head
____ Entire Head
____ Migraines

LIBIDO
____ Low | Normal | High

ENERGY
____ Normal/Low/Variable/High
____ Slow to Start in a.m.
____ Low Energy After Meals
____ Energy Crash at
_____ a.m./p.m.

URINATION
____ Times During the Night ____
____ Urgency
____ Burning
____ Pain
____ Odor
____ Dark Color
____ Foamy
____ Incontinence
____ Urinary Tract Infection
____ Kidney Troubles

MALE ONLY
____ Erectile Dysfunction
____ Prostate Problems
____ Burning
____ Achy | Pain
____ Restriction
____ Emission
____ Swelling

FEMALE ONLY
____ Date Last Period_________
____ Cycle - Length (28-30 days):
____ # Days of Flow
____ Heavy Flow
____ Large Clots
____ Cramps
(Mild | Mod | Severe)
____ PMS (Mild | Mod | Severe)
____ Yeast Infection
____ Menopause
____ Hot Flashes
____ Other ________________
____

SKIN/HAIR/NAILS
____ Skin Rash
____ Butt Acne
____ Dry Skin
____ Eczema
____ Psoriasis
____ Nails (White Spots/Ridges)
____ Nails (Weak/Peeling)
____ Hair Loss
____ Limp Hair
____ Varicose/Spider Veins
____ Damp Hands/Feet
____ Dandruff
____ Red Freckles
____ Bruise Easily
____ Missing Outer l/3 of Eyebrow
____ Cold Hands | Cold Feet

OTHER HEALTH EVENTS/ISSUES:
____
____
____
____
____
____
____
____
____
____

OFFICE USE ONLY	Iodine Patch:	Zinc:
pH:	WHR:	BMI:
Eyes:	Ears:	Tongue:
Skin:	Nails:	Weight:
Moist Sense:	BP:	Clinician Initials:

Natural Care Chiropractic

Nutrition Case History

Instructions:

~ Bring all vitamins, minerals and supplements you are currently taking.

~ Please don't take anything, except necessary medication for 24 hours before your appointment.

~ Avoid lotions on your hands and feet the day of testing.

~ Drink water before your appointment as dehydration makes it difficult to obtain accurate readings.

~ Please eat within two hours of your appointment so your blood sugar is level.

~ Avoid caffeine for a minimum of 4 hours before testing. 24 hours is best.

Waiver of Liability Form for Nutrition Services Rendered at Natural Care Chiropractic (NCC)

I, the client, choose to receive a nutrition status screening using either a Nutrition Response Testing (Applied Kinestheology protocol) or EAV (Biomeridian) test equipment which are not FDA approved. The opinions received may include information on stress reduction, nutritional suggestions, including supplements or homeopathics. I agree to communicate with NCC any concerns I have before or after involving the testing.

I understand that NCC does not treat, diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. NCC is not a primary care facility and the treatments are natural and holistic. The nutrition visit at NCC is provided to clients on a cash basis, we do not file or submit insurance claims. NCC will provide a receipt that can be submitted, but the diagnosis codes must be provided by the referring medical doctor.

I acknowledge that any opinions from NCC are not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that service. Any opinions on dietary changes or restrictions including supplementation of any kind are to be done at my own risk. If I have any concerns or ill effects after the nutrition protocols or from the use of any supplements, I will call NCC immediately. All medical information given is strictly confidential.

Patient Name ______________________________ Birthdate ______________

Street Address ______________________________

City, State, Zip ______________________________

Phone ______________________ Email ______________________

Client Signature ______________________________ Date ______________