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 _____