# CONFIDENTIAL CLIENT QUESTIONNAIRE

FOR OFFICE USE ONLY
DATE SENT ____/____/____
DATE REC'D ____/____/____
IC TECH SCORE ________

## GENERAL INFORMATION - PLEASE PRINT

DATE ____/____/____

**PATIENT NAME** ________ **HOME ADDRESS** ________

**CITY** ________ **STATE** ____ **ZIP CODE** ____ **HOW LONG?** ____

***E-mail address*** ________@________ *We do not share your address.*

PREVIOUS ADDRESS IF LESS THAN 3 YEARS AT PRESENT

**ADDRESS** ________ **CITY** ____ **STATE** ____ **ZIP CODE** ____

**BIRTH DATE** ____/____/____ **AGE** ____ **SEX** M____ F____ **MARITAL STATUS** M___ S___ D___ W___

**YOUR EMPLOYER** ________ **CITY** ________ **YEARS WITH FIRM** ____

**OCCUPATION** ________ **SOCIAL SECURITY#** ____/____/____

**HOME PHONE** ________ **WORK PHONE** ________ **CELL PHONE** ________

**SPOUSE'S NAME** ________ **BIRTH DATE** ____/____/____ **OCCUPATION** ________

**SPOUSE'S EMPLOYER** ________ **CITY** ________ **PHONE** ________

**YOUR MD** ________ ***DATE OF LAST PHYSICAL*** ________

**DENTIST** ________ **DATE OF LAST VISIT** ________

**DATE OF LAST CHIROPRACTIC ADJUSTMENT** ____/____/____ **GIVEN BY DR** ________

**WHO MAY WE CONTACT IN CASE OF EMERGENCY** ________ **PHONE** ________

**WHO MAY WE THANK FOR REFERRING YOU TO US?** ________ **PHONE** ________

PLEASE FILL OUT THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS. OBTAINING THE BEST HEALTH POSSIBLE IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP YOUR DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

## YOUR HEALTH HISTORY

**GIVE THE PRIMARY REASON YOU ARE CONSULTING WITH OUR DOCTOR. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND WHY IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD AND IF THE PROBLEM IS GETTING BETTER, WORSE OR IS THE SAME.**

**GIVE ANY SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING. LIST THE MOST SEVERE FIRST.**

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LIST ALL NUTRITIONAL SUPPLEMENT PRODUCTS YOU ARE TAKING. INCLUDE THE NAME OF THE COMPANY, AMOUNT, WHY YOU ARE TAKING THEM AND HOW LONG YOU HAVE BEEN TAKING. WE ASK THAT YOU BRING ALL BOTTLES TO YOUR CONSULTATION.

| NAME | COMPANY | AMOUNT | WHY TAKING | HOW LONG |
|---|---|---|---|---|

LIST ALL DRUGS (PRESCRIPTION OR NOT) YOU ARE TAKING. INCLUDE THE REASON TAKEN, AMOUNT, LENGTH OF TIME TAKEN AND RESULTS. LIST ALL OTHER DRUGS YOU HAVE TAKEN IN THE PAST.

| NAME | AMOUNT | WHY TAKING | HOW LONG | RESULTS |
|---|---|---|---|---|

LIST ALL SURGERIES YOU HAVE HAD INCLUDING THE DATE, WHY IT WAS DONE AND THE RESULTS.

| SURGERY | DATE | WHY DONE | RESULTS |
|---|---|---|---|

LIST ANY ALLERGIES YOU HAVE TO FOOD, DRUGS OR OTHER SUBSTANCES ALONG WITH THE SYMPTOMS THEY PRODUCE AND INDICATE HOW LONG YOU HAVE SUFFERED FROM EACH ITEM.

| ALLERGY | SYMPTOMS | HOW LONG |
|---|---|---|

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU DON'T KNOW THE ANSWER, LEAVE BLANK:

()YES ()NO MY MOTHER WAS HEALTHY WHILE PREGNANT WITH ME. IF NO,DESCRIBE____________________

()YES ()NO WAS YOUR BIRTH NATURAL? IF NO, PLEASE CHECK ()ANESTHESIA ()FORCEPS ()C-SECTION

()YES ()NO WERE YOU BREAST FED FOR AT LEAST THE FIRST 6 MOS? ____________________

()YES ()NO WERE YOU FED ANYTHING OTHER THAN BREAST OR COW FORMULA MILK IN THE FIRST 6 MOS? LIST ITEMS ____________________

()YES ()NO WERE YOU A COLICKY BABY? UNTIL WHAT AGE?____________________

()YES ()NO HAVE YOU BEEN TO OR LIVED IN A FOREIGN COUNTRY? LIST____________________

()YES ()NO HAVE YOU EVER FAINTED OR HAD A CONVULSION? DESCRIBE____________________

MARK ANY YOU HAVE HAD: ()MEASLES ()CHICKEN POX ()MUMPS ()GERMAN MEASLES ()HEPATITIS
()SCARLET FEVER ()RHEUMATIC FEVER ()LYMES DISEASE ()MONONUCLEOSIS
()HERPES ()SHINGLES ()VENEREAL DISASE ()HIV/AIDS

## DIET HISTORY MARK EACH ONE USING A "0" OR NONE WHEN APPROPRIATE

GIVE THE AMOUNT OF EACH YOU CONSUME:

_____ OUNCES WATER _____ DAY _____ NOT DAILY
_____ OUNCES ALCOHOL _____ DAY _____ NOT DAILY
_____ OUNCES COFFEE/TEA _____ DAY _____ NOT DAILY
_____ OUNCES SODA _____ DAY _____ NOT DAILY
_____ OUNCES JUICE _____ DAY _____ NOT DAILY
_____ OTHER _____________ _____ DAY _____ NOT DAILY

LIST YOUR 10 MOST FAVORITE FOODS EATEN MOST FREQUENTLY. ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

______________________ ______________________ ______________________

GIVE PERCENTAGE FOR EACH OF THE FOLLOWING. Total for each line to equal 100%

WHERE DAILY DIET PREPARED: _____ HOME _____ RESTAURANT _____ FAST FOOD _____ VENDING MACHINE

HOW FOOD PREPARED: _____ BAKED _____ ROILED _____ BOILED _____ RIED _____ STEAMED _____ MICROWAVE

FOOD PREPARED FROM: _____ FRESH _____ CANNED _____ FROZEN _____ PREPACKAGED

MY APPETITE IS: () NORMAL () EXCESSIVE () POOR () NONE

I CRAVE: () SWEETS () SALT () CHOCOLATE () WATER () DIRT () OTHER __________

TYPE OF WATER USED FOR DRINKING/COOKING: () TAP OR CITY () SPRING () WELL () RAIN () BOTTLED DISTILLED () BOTTLED FILTERED () REVERSE OSMOSIS

IF PURCHASE WATER, IS IT IN: () SOFT PLASTIC () HARD PLASTIC () GLASS

FOODS THAT DISAGREE WITH YOU: () RAW VEGETABLES () RAW FRUIT () FATS () FRIED () MILK/DAIRY () GREASY () EGGS () ONIONS () HIGHLY SPICED () BEANS () CABBAGE () SUGAR

() OTHER ______________________________

WHAT SYMPTOMS DO YOU GET FROM FOODS THAT DISAGREE WITH YOU? ______________________

____________________________________________

DO YOU FAST? () YES () NO IF YES, HOW OFTEN AND HOW LONG? ______________________

HAVE YOU EVER DONE A DETOXIFICATION PROGRAM? () YES () NO EXPLAIN ______________

CHECK ANY OF THE FOLLOWING DIETS YOU HAVE EVER TRIED?

() LOW CHOLESTEROL () LOW SALT () LOW PURINE () ALL ENERGY
() LOW FAT () DIABETIC () RENAL/KIDNEY () HIGH FIBER
() ULCER () DIVERTICULITIS () COMPLEX CARBOHYDRATE () HIGH PROTEIN
() WEIGHT LOSS (LIST WHICH ONES) ______________________________

HOW MANY DAYS A WEEK DO YOU EXERCISE? ____ HOW LONG EACH TIME? ____ TYPE OF EXRCISE? ________

## BOWEL HEALTH    BM = BOWEL MOVEMENT OR STOOL

HOW MANY TIMES DO YOU HAVE A BM? _____ X A DAY _____ X A WEEK

() YES () NO DO YOU USE LAXATIVES? HOW OFTEN ______________ BRAND ______________

() YES () NO DO YOU GET THE URGE TO HAVE A BM? () YES () NO DO YOU HAVE PAIN WITH BM?

*Answer key for the following tables:* 0 = never 1 = rarely 2 = frequently 3 = always

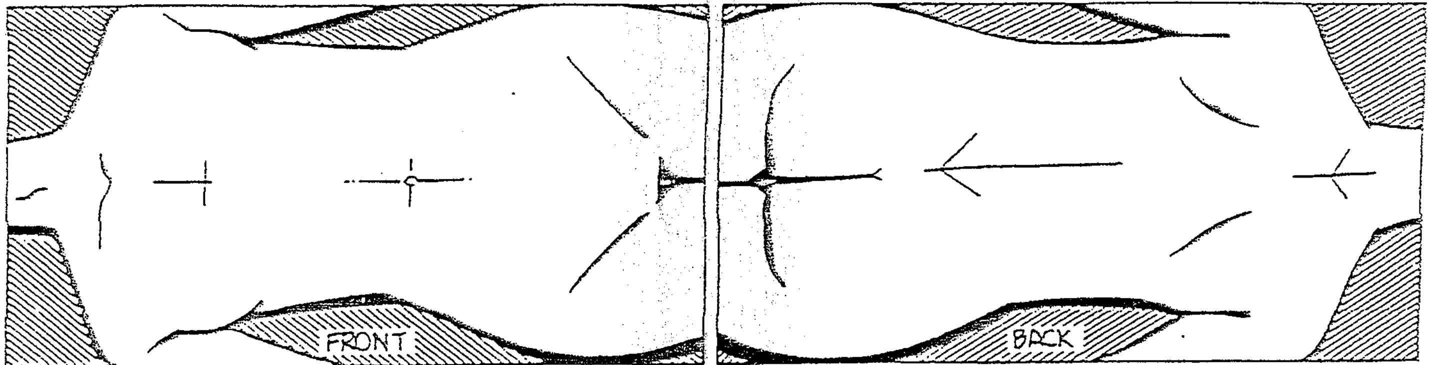
| STOOL SIZE | STOOL CONSISTENCY | STOOL COLOR |
|---|---|---|
| ___2" wide & 6+" length | ___Float like a submarine | ___Med/dark brown |
| ___1" wide & 4+" length | ___Float on top of water | ___Very dark/black |
| ___Thin, long or narrow | ___Sink to bottom | ___Yellow/tan/clay |
| ___Small, hard | ___Loose but not watery | ___Greenish |
| ___Large, hard | ___Diarrhea | ___Blood is visible |
| ___Difficult to pass | ___Alternate hard/diarrhea | ___*Mucus in or around* |

() YES () NO HAVE YOU EVER HAD WORMS OR PARASITES? HOW TREATED? ______________

() YES () NO DO YOU PRESENTLY HAVE RECTAL ITCHING? () DAY () NIGHT () CONTINUOUSLY

## DIGESTION

MARK ANY AREAS OF DISTRESS ASSOCIATED WITH FOOD INTAKE ON THE DIAGRAMS



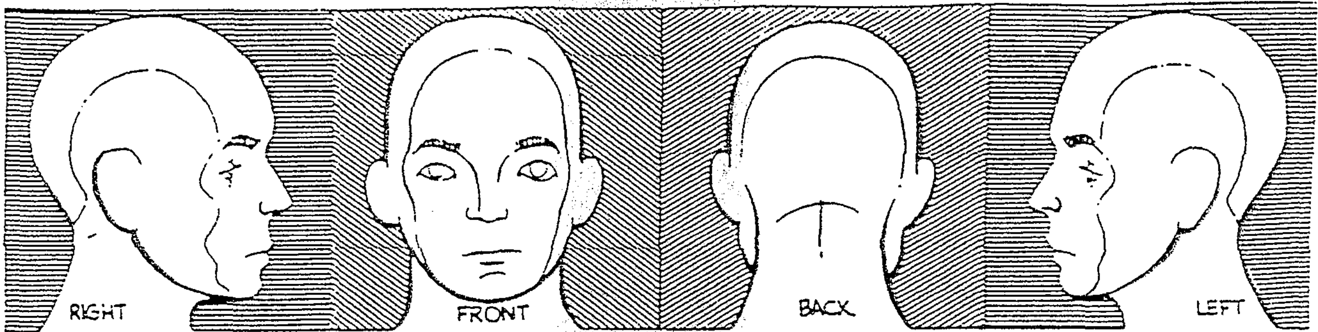

I GET PAIN/HEARTBURN: () BEFORE EATING () AFTER EATING () WHEN LIE DOWN () UPON ARISING

I HAVE: () INDIGESTION () BELCHING () GERD () INTESTINAL GAS () BLOATING
() IMMEDIATELY AFTER EATING () 1 - 2 HOURS () 3 - 5 HOURS () 6 + HOURS
() NO ODOR () SOME ODOR () ODOR USUALLY () FOWL SMELLING
() HIATAL HERNIA () ESOPHAGEAL BURNING/REFLUX () RAISE HEAD OF BED TO SLEEP

LIST ANY DRUGS (PERSCRIPTION OR OTC) OR NATURAL REMEDIES YOU TAKE FOR ANY STOMACH OR BOWEL SYMPTOMS

| PRODUCT | DOSE | HOW FREQUENTLY | RESULTS |
|---|---|---|---|

## HEAD, MOUTH, THROAT MARK ANY AREAS OF HEADACHE OR PAIN MARK ALL THAT APPLY




MY TEETH ARE: () GOOD () SOME FILLINGS ) BAD () SOME MISSING () ALL MISSING () ROOT CANAL
I WEAR DENTURES: () UPPER () LOWER () PARTIALS () CROWNS () MORE THAN 1 METAL TYPE IN MOUTH
MY BREATH IS: () GOOD () SLIGHT ODOR () ODOR OFF/ON () OFFENSIVE ODOR USUALLY
MY TONGUE IS: () COVERED WITH SMALL TASTE BUDS () SORE () FURROWED () COATED _______ COLOR
MY TONGUE COLOR IS: () PINK () RED () RED BLOTCHY () PINK WITH RED TIP
MY TONSILS ARE: () NORMAL () REMOVED AT AGE ____ () ENLARGED () SPOTTED
MY SENSE OF TASTE IS: () NORMAL () POOR () NO TASTE () OVERSALT FOOD () CANKER SORES

MY LIPS ARE: () NORMAL () DRY () PEEL A LOT () FEVER BLISTERS OFTEN () CRACKED IN CORNERS

I GET HEADACHES: () DAILY () WEEKLY () RARELY ) NEVER
() WAKE UP WITH () GET IN AM () GET IN PM
() OF DIFFERENT TYPES () WITH SOME FOODS OR DRINKS
() WITH AURA () WITH NAUSEA/VOMITING

## MUSCLE, LIGAMENT, JOINT, NERVES

I HAVE PAIN IN: () NECK () MID BACK () LOW BACK
() HIP () KNEE () ANKLE () FEET
() SHOULDER () ELBOW () WRIST () HANDS
() OTHER ____________________

I GET: () SWOLLEN JOINTS () SORE JOINTS () JOINTS POP OR CRACK () JAW POPS
() LEG CRAMPS AT REST () LEG CRAMPS WITH ACTIVITY () WORSE AT NIGHT
() FOOT CRAMPS AT REST () FOOT CRAMPS WITH ACTIVITY () FLAT FEET () BURNING FEET

() TINGLING IN FEET OR HANDS () RESTLESS LEG SYNDROME

I HAVE: () NERVOUS TIC OR TWITCHING - WHERE ____________________ () BELL'S PALSY
() RINGING IN EARS () PARKINSON'S () SCIATIC NEURITIS () MULTIPLE SCLEROSIS
() HAD SPINAL SURGERY - WHERE ____________________ RESULTS ____________________

## HAIR, NAILS, SKIN

HAIR: () COURSE () FINE () FALLS OUT EXCESSIVELY () TURNED GREY AT AGE _____ () OILY () DRY

MALE BEARD: () HEAVY () LIGHT OR SPARSE () NONE ETHNIC BACKGROUND __________________

FEMALE: () FACIAL HAIR ALWAYS () FACIAL HAIR STARTED AT AGE__ () HAIR ON ABDOMEN OR BREASTS

FINGER NAILS: () NORMAL () BRITTLE/BREAK EASILY () SOFT () RIDGED VERTICALLY () WHITE SPOTS
() RIDGED HORIZONTALLY () GROW FAST () GROW SLOW () SHAPED ODDLY () HANGNAILS

SKIN: () NORMAL () OILY () DRY () FLAKY () ACNE () PSORIASIS () BOILS
() SMALL BUMPS ON UPPER ARMS () SKIN CANCER REMOVED ON__________
(DATE)
() ANTIBIOTICS FOR ACNE AT WHAT AGE ______ HOW LONG TAKEN _______

SPOTS ON SKIN: () WARTS () MOLES () SMALL RED () LARGE RED () BROWN () WHITE

HANDS AND FEET: () DRY CRACKED OR BLEEDING AREAS ON () HANDS () HEELS () FEET
() INGROWN TOENAILS () FUNGUS ON FEET OR NAILS () ATHLETE'S FOOT

## CHEST AND HEART MARK ANY AREAS OF PAIN OR DISCOMFORT ON DIAGRAM

I HAVE CHEST PAIN THAT IS: () SHARP () DULL () SEVERE
() RADIATES TO MY ARM, NECK, OR BACK
() WORSE AT REST () WORSE ON EXERTION
() BETTER WITH EXERCISE () NO CHANGE WITH EXERCISE

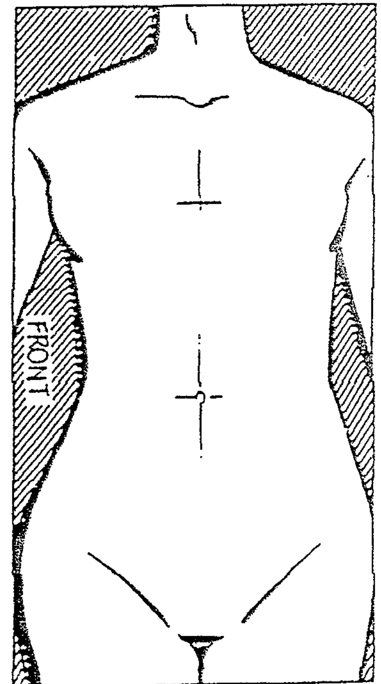
MY PULSE/ HEARTBEAT IS: () TOO FAST () TOO SLOW () SKIPS BEATS

I HAVE: () HIGH BLOOD PRESSURE () LOW BLOOD PRESSURE
I AM: () ON HBP MEDICINE () ON DIURETICS

I HAVE HAD: () HAD A HEART ATTACK () HAD A STROKE
() ANGIOPLASTY () BYPASS SURGERY

I HAVE BEEN TOLD I HAVE: () HEART DISEASE () LUNG DISEASE
() CLOGGED ARTERIES

I HAVE: () VARICOSE VEINS () SPIDER VEINS
() HEMORRHOIDS () HAD VESSEL SURGERY



## RESPIRATORY, LUNGS

I HAVE NASAL CONGESTION: () DAILY () SEVERAL TIMES A WEEK () ONLY ON OCCASION

I HAVE NASAL DISCHARGE: () DAILY () SEVERAL TIMES A WEEK () ONLY ON OCCASION
() CLEAR () YELLOW () GREEN () BLOOD TINGED () OTHER ____________

I HAVE: () NON-PRODUCTIVE COUGH {W/O MUCUS} () PRODUCTIVE COUGH {WITH MUCUS}
() ALLERGIES TO ______________________ () HOARSENESS OF VOICE () POST-NASAL DRIP
() HAYFEVER () ASTHMA () WHEEZING () SNORING

I HAVE/HAVE HAD: () FREQUENT COLDS () FLU ONCE OR MORE A YEAR
() PNEUMONIA () SINUS INFECTIONS
() ANTIBIOTICS 3 OR MORE TIMES IN MY LIFE
() ALLERGIC TO ____________________

I TAKE: () ALLERGY SHOTS () ALLERGY MEDICINE () DECONGESTANTS () NASAL SPRAYS () STEROIDS

I USE: () CIGARETTES ___PACK/DAY () SNUFF/CHEW () CIGARS () EXPOSED TO 2ND HAND SMOKE

I HAVE BEEN TOLD I HAVE: () LUNG DISEASE ____________________ () EMPHYSEMA () COPD

## EMOTIONAL, NERVOUS AND METABOLISM MARK ALL THAT APPLY

I AM/HAVE: () NERVOUS () ANXIOUS () DEPRESSED () SENSITIVE TO NOISE
() CONFUSED EASILY () SLEEPY DURING DAY () EXHAUSTED A LOT () FATIGUE EASILY

() LOSS OF APPETITE () RAGE () FEARFUL () HEAR VOICES
() WEAKNESS () POOR MEMORY () IRRITABILITY () MORBID THOUGHTS

I AM/HAVE: () SUSPICIONS OF OTHERS () THOUGHTS OF SUICIDE () QUICK MOOD CHANGES
() FEAR OF INSANITY () FEAR SERIOUS DISEASE LIKE________________________________
() AVOID CROWDS () FRIENDS AVOID ME () HAVE HYPOGLYCEMIA OR LOW BLOOD SUGAR
() HAD GLUCOSE TOLERANCE TEST AND IT WAS () POSITIVE () NEGATIVE

I: () TAKE DAYTIME NAPS () DREAM TOO MUCH () HAVE NO DREAMS AT ALL () HAVE NIGHTMARES

I: () WAKE UP TIRED () AM COLD WHEN OTHER ARE COMFORTABLE () FEEL TOO HOT
() HAVE COLD HANDS () HAVE COLD FEET
() PERSPIRE TOO MUCH () HAVE INADEQUATE PERSPIRATION WHEN EXERCISE

DO YOU FEEL WELL RESTED WHEN YOU WAKE UP IN THE MORNING () YES () NO

________ RATE THE QUALITY OF YOUR SLEEP (1 BEING AWFUL AND 10 BEING GREAT)

## FEMALE SPECIFIC

MY MENSTRUAL PERIODS ARE: AGE OF FIRST PERIOD____

()NORMAL ()PAINFUL FIRST DAY ()PAINFUL BEFORE AND DURING

()FLOW IS EXCESSIVE ()HAVE CLOTS OR HEMORRHAGE ()FLOW IS SCANTY

()REGULAR EVERY ____DAYS ()IRREGULAR

()NO PERIOD IN ____MONTHS ()TWO OR MORE PER MONTH

()ABNORMAL SINCE ____YEARS OF AGE

()MENSTRUAL PROBLEMS BEFORE FIRST CHILD ()MENSTRUAL PROBLEMS AFTER FIRST CHILD

MENSTRUAL BLOOD COLOR IS: ()PINK ()RED ()BROWN ()BLACK ()OTHER________________

I HAVE/HAVE HAD: ()ENDOMETRIOSIS ()CONSTIPATION WITH PERIODS ()DIARRHEA WITH PERIODS

ORGAN DROP: ()UTERUS IN POSITION ()UTERUS OUT OF POSITION ()BLADDER PROLAPSED

I AM/HAVE BEEN: ()ON BIRTH CONTROL PILL __________ ()TOTAL YEARS ON BCP_____

Name

()MENOPAUSE AT AGE ____ ()HYSTERECTOMY AT AGE____

I AM ON HORMONE REPLACEMENT: ()ESTROGEN ()PROGESTIN ()ORAL ()PATCH

()WILD YAM CREAM ()BIO-IDENTICAL FORMULATION

I HAVE BREAST SORENESS: ()BEFORE PERIOD ()DURING PERIOD ()AFTER PERIOD ()ALL MONTH LONG

I HAVE: ()FIBROCYSTIC BREASTS ()HAD BREAST CANCER

()PRODUCE MILK BUT NOT PREGNANT OR NURSING

MY BREASTS ARE: ()FIRM ()SOFT AND SAGGY ()HAVE IMPLANTS ()HAD REDUCTION SURGERY

I: ()HAVE_____CHILDREN ()BEEN PREGNANT ____ TIMES ()LIKE CHILDREN ()DISLIKE CHILDREN

()WANT MORE ()DON'T WANT MORE ()AM STERILE ()HAVE FEAR OF PREGNANCY

I GET: ()BLADDER INFECTIONS ()YEAST INFECTIONS ()YEAST INFECTIONS AFTER ANTIBIOTICS

()VAGINAL BURNING/ITCHING ON ()INSIDE ()OUTSIDE

()VAGINAL DRYNESS ()PAINFUL INTERCOURSE

I URINATE: ()____TIMES PER DAY ()____TIMES AT NIGHT ()MORE FREQUENTLY THAN NORMAL

()WITH PAIN ()WITH DIFFICULTY STARTING/STOPPING ()WITH ITCHING OR BURNING

MY URINE COLOR IS: ()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER___________

()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

MY URINE HAS: ()ODOR DESCRIBE________________________________________

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS: ()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT

LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS.

continue at diagram on next page

## MALE SPECIFIC

I AM: ()OVERLY TIRED ()EXHAUSTED ()GETTING TOO OLD FOR ANYTHING ()IMPOTENT

MY PROSTATE: ()NORMAL ()ENLARGED ()HAD CANCER ()REMOVED

I HAVE: ()PAIN ON URINATION ()DIFFICULTY STARTING URINE FLOW ()DIFFICULTY STOPPING FLOW
()DRIBBLING OF URINE ()DECREASED STREAM SIZE ()PAIN OR PRESSURE AFTER SEX
()GET UP TO URINATE ____TIMES PER NIGHT ()BURNING DISCHARGE

MY URINE COLOR IS: ()PALE YELLOW ()BRIGHT YELLOW ()DARK YELLOW ()OTHER____________
()CLEAR ()CLOUDY ()WITH MUCUS IN IT ()VARIES A LOT

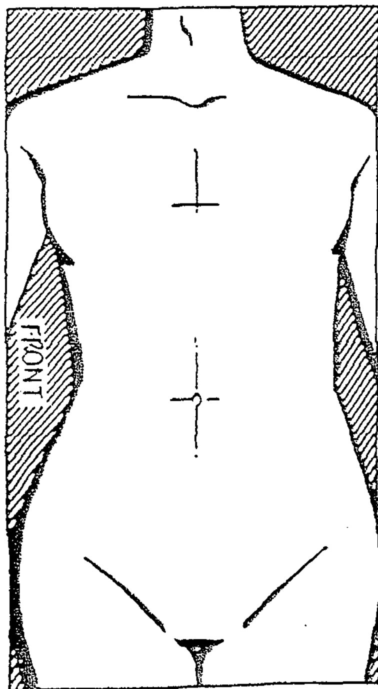
MY URINE HAS ()ODOR DESCRIBE ______________________________

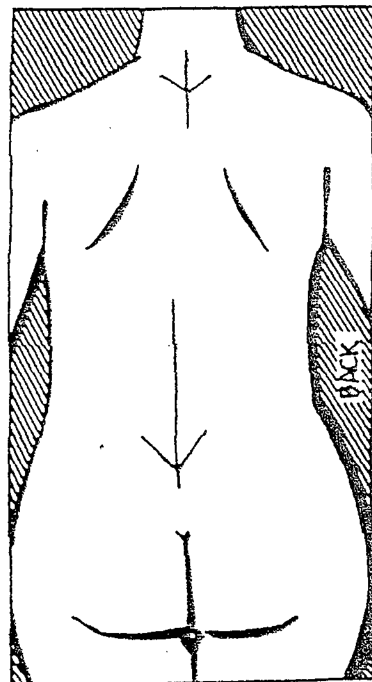
I HAVE: ()HERNIA____________ ()PAIN IN TESTICLES OR SCROTUM

I HAVE / HAD: ()VENEREAL DISEASE ()GENITAL HERPES ()HERPES I ()HIV/AIDS

MY LIBIDO IS: ()NORMAL ()EXCESSIVE ()INCREASED ()DIMINISHED ()ABSENT
LIBIDO MEANS DESIRE FOR SEXUAL RELATIONS

**USE THE DIAGRAMS BELOW TO MARK ALL AREAS OF PAIN OR DISCOMFORT YOU HAVE EXPERIENCED IN THE PAST 90 DAYS.** DESCRIBE YOUR PAIN/DISCOMFORT IN THE MARGINS AND CONNECT WITH ARROW TO EACH AREA THE DESCRIPTION APPLIES TO.



ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PROFESSIONAL SUCH AS DENTIST, MASSAGE THERAPIST, ACUPUNCTURIST, PSYCHOLOGIST, ETC? PLEASE EXPLAIN.

PLEASE FILL OUT YOUR FAMILY HEALTH HISTORY ON THE CHART BELOW
PUT AN "N" IN THE BOX IF HAVE IT NOW OR A "P" IF HAD IN THE PAST

| | ALCOHOLISM | ALLERGIES | ALZEHIMER'S DISEASE | ARTHRITIS | ASHTMA | ATHEROSCLEROSIS | CANCER | DIABETES | EPILEPSY | GLAUCOMA | HEADACHES | HIGH BLOOD PRESSURE | KIDNEY DISEASE | OBESITY | OSTEOPOROSIS | SINUS PROBLEMS | STROKE | THYROID PROBLEM | TUBERCULOSIS | ULCERS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| YOU | | | | | | | | | | | | | | | | | | | | |
| SPOUSE | | | | | | | | | | | | | | | | | | | | |
| CHILDREN | | | | | | | | | | | | | | | | | | | | |
| MOTHER | | | | | | | | | | | | | | | | | | | | |
| FATHER | | | | | | | | | | | | | | | | | | | | |
| MATERNAL GRANDPARENTS | | | | | | | | | | | | | | | | | | | | |
| PATERNAL GRANDPARENTS | | | | | | | | | | | | | | | | | | | | |
| SISTERS | | | | | | | | | | | | | | | | | | | | |
| BROTHERS | | | | | | | | | | | | | | | | | | | | |

USE THIS SPACE TO ADD ANYTHING ELSE YOU WOULD LIKE TO SHARE ABOUT YOUR HEALTH CONCERNS OR THAT YOU THINK THE DOCTOR SHOULD KNOW

Please review this form to be sure your answers are accurate and sign below. Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature______________________________ Date________________

Healing Choices®
Natural Healthcare
Improving the health of the community . . . one person at a time!

# Tracking Your Symptoms & Improvement

Patient Name: ______________________________ Date: ____________

Important: Only complete this after you have answered all the questionnaires. Please take a few minutes to look back at each page of the questionnaires. In the middle column write those symptoms or health concerns that are of moderate concern, and the ones that are the strongest concern. In the first column write "M" for moderate, and "S" for a strong level of concern. This information will help us track the success of your therapeutic nutrition program.

| M or S | Sign / Symptom or Desired Result for Health Improvement | Date of Success |
|---|---|---|
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