WELCOME TO HENRY CHIROPRACTIC

DR. JACOB GREEN

DR. MEGAN GREEEN

Grimsley Chiropractic Services, P.C
22780 Three Notch Road, Lexington Park, MD 20653
Phone: 301-737-0662 Fax: 301-737-0675

DR. GRIMSLEY

DR. MEGHAN KEEFE

Full Name:	Date:	Circle: M or F
How did you hear about us?	Date of Birth:	Age:
Address:		
City, State, Zip code:		
Home phone:	Cell:	Work:
Employer:	Occupation:	
Name of Spouse:		
Emergency Contact:	Relationship:	Phone:

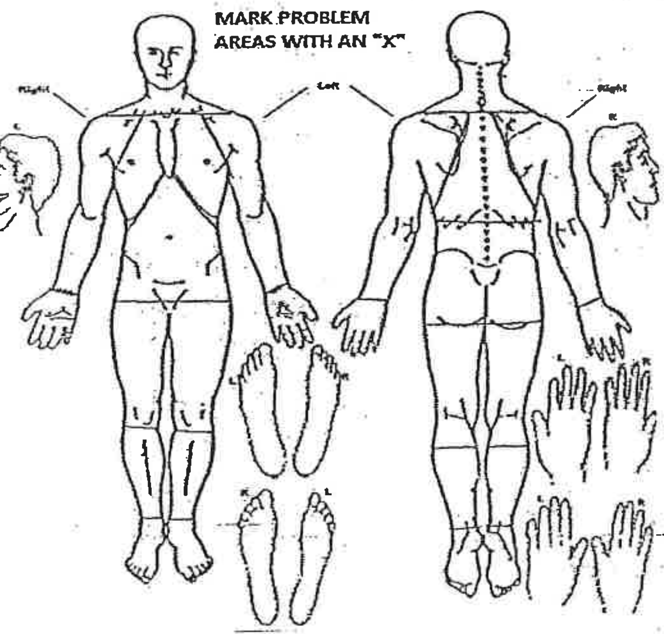
Health Insurance Information

Primary Insurance	Secondary Insurance
Insurance Carrier:	Insurance Carrier:
ID#:	ID#:
Group#:	Group#:
Name of Insured:	Name of Insured:
Relationship: ☐Self ☐Spouse ☐Child ☐Other	Relationship: ☐Self ☐Spouse ☐Child ☐Other
Insured's DOB:	Insured's DOB:
Insured Employer:	Insured Employer:

ertify that I, and/or my dependent(s) have insurance coverage with & assign directly to GCS, P.C. all insurance benefits, if any, otherwise, yable to me for services rendered. I understand that I am financially responsible for all changes whether or not paid by insurance. I thorize the use of my signature on all insurance submissions. GCS, P.C. may use my health care information & may disclose such formation to the above named insurance companies & their agents for the purpose of obtaining payment for services & insurance benefits the benefits payable for related services. A photocopy of the Assignment shall be considered as effective & valid as the original.

gnature________________________ Printed Name:________________________ Date:________

YOUR CONDITION



Reason for visit:

Onset Date:

Condition is getting: ☐Worse ☐Better ☐Same

Rate your pain (1=least, 10=severe):

Frequency of the pain:

Pain interferes with:
☐Work ☐Daily Routine ☐Recreation

Pain to perform:
☐Sitting ☐Standing ☐Walking ☐Bending ☐Lying

Type of Pain: ☐Aching ☐Burning ☐Cramps ☐Dull ☐Numbness ☐Sharp ☐Shooting ☐Stabbing ☐Stiff ☐Swelling ☐Throbbing ☐Tingling ☐Other

Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record:

A record is made each time you visit a hospital, physician, or other health care provider. Your symptoms, examination and test results, diagnosis, treatment, and a plan for future care are recorded. This information is most often referred to as your "health or medical record", and serves as a basis for planning our care and treatment. It also serves as a means of communication among any and all other health professionals who may contribute to your care. Understanding what information is retained in your record and how that information may be used will help you to ensure accuracy and enable you to relate to who, what, when, where, and why others may be allowed to access your health information. This effort is being made to assist you in making informed decisions before authorizing the disclosure of your medical information to others. Use or disclosure of your health information will follow the more stringent of State or Federal laws.

Understanding Your Health Information Rights:

Your health record is the physical property of the health care practitioner or facility that compiled it but the content is about you, and therefore belongs to you. You have the right to request restrictions on certain uses and disclosures of your information, and to request amendments be made to your health record. Your rights include being able to review or obtain a paper copy of your health information, and to be given an account of all disclosures. You may also request communications of your health record be made by alternative means or to alternative locations. Other than activity that has already occurred, you may revoke any further authorizations to use or disclose your health information.

Our Responsibilities:

This office is required to maintain the privacy of your health information and to provide you with notice of our legal commitment and privacy practices with respect to the information we collect and maintain about you. This office is required to abide by the terms of this notice and to notify you if we are unable to grant your requested restrictions or reasonable desires to communicate your health information by alternative means or to alternative locations.

This office reserves the right to changes it practices and effect new provisions that enhance the privacy standards of all patient medical information. In the event that changes are made, this office will notify you at the current address provided on your medical file. If applicable, this office will post changes on our website that provides information about our customer service and/or benefits. Other than the reason described in this notice, this office agrees not to use or disclose your health information without your authorization.

To receive additional information or to report a problem:

For further explanation of this notice you may contact our Privacy Officer at (301) 737-0662. If you believe your privacy rights have been violated, you have the right to file a complaint with this office by contacting the individual above, or by contacting the Secretary of Health and Human Services, with no fear of retaliation by this office.

Your Health Information Will Be Used For Treatment, Payment, and Health Care Operations:

Treatment---Information obtained by your health practitioner in this office will be recorded in your medical record and used to determine the course of treatment that should work best for you. This consists of your physician recording his/her own expectations and those others involved in providing your care such as his/her physician assistant, nurse, or medical assistant. The sharing of your health information may progress to others involved in your care, such as specialty physicians or lab technicians.

Payment---Your health care information will be used in order to receive payment for services rendered by this office. A bill may be sent to you or a third-party payer with accompanying documentation that identifies you, your diagnosis, procedures performed, and supplies used.

Health Care Operations---The medical staff in this office will use your health information to assess the care provided and the outcome of your care compare to others like it. Your information may be reviewed for risk management or quality improvement purposes in our efforts to continually improve the quality and effectiveness of the care and services we provide.

(continued over)

Business Associates---Some or all of your health information may be subject to disclosure through contracts for services to assist this office in providing health care. For example, it may be necessary to obtain specialized assistance to process certain laboratory tests or radiology images. To protect our health information, we require these Business Associates to follow the same standards held by this office through terms detailed in a written agreement.

Notification---Your health care record may be used to notify or assist family members, personal representatives, or other persons responsible for your care to enhance your well-being or whereabouts.

Communications with Family---Using best judgment, a family member, or a close personal friend, identified by you, may be given information relevant to your care and/or recovery.

Upon Your Death--- Your health information may be disclosed consistent with laws governing estate and post-mortem personal matters. Generally, your health information may be disclosed to your personal representative as designated by you and certified by the State and to Funeral Directors with laws governing mortician services.

Organ Procurement Organization---Your health information may be disclosed consistent governing entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation or transplant.

Marketing---This office reserves the right to contact you with information about treatment alternatives and other health related benefits that may be appropriate to you.

Appointment Reminders---This office reserves the right to contact you with appointment reminders through an automated system, by our staff, or via U.S. Postal Service.

Phone Contact---This office reserves the right to contact you via the telephone for such things as test result notification. We may leave a generic message on your answering machine, or with the person answering the phone concerning the nature of the call along with a request that you call us for more specific details.

Research---Your information will be disclosed to researchers upon institutional Review Board approval and upon the assurance that established protocol to ensure the privacy of your health information has been obtained.

Food and Drug Administration (FDA)--- This office is required by law to disclose health information to the FDA related to any adverse effects of food, supplements, products, and product defects for surveillance to enable products recalls, repairs, or replacements.

Workers Compensation---This office will release information to the extent authorized by law in matters of Workers' Compensation.

Public Health---This office is required by law to disclose health information to public health and/or legal authorities charged with tracking reports or birth and morbidity. This office is further required by law to report communicable disease, injury, or disability.

Correction Facilities---This office will release medical information on incarcerated individuals to Correctional Agents or Institutions for the necessary welfare of the individual or for the health and safety of other individuals. The rights outlined in this Notice of Privacy Practices will not be extended to incarcerated individuals.

Law Enforcement--- (1) Your health information will be disclosed for law enforcement purposes as required under State Law or in response to a valid subpoena. (2) Provisions of Federal Law permit the disclosure of your health information to appropriate health oversight agencies, public health authorities, or attorneys in the event that a staff member or business associate of this office believes in good faith that there has been unlawful conduct or violations of professional or clinical standards that may endanger one or more parties, workers, or the general public.

NOTICE OF PRIVACY PRACTICES AVAILABILITY: The terms described in this notice will be posed where registration occurs. All individuals receiving care will be given a hard copy

Patient's Comments:

____

____

Signature of Patient or Legal Representative　　　　　　　　Date

____________________ (Description of Legal Representative's Attorney)

HENRY CHIROPRACTIC & WELLNESS CENTER

GREEN CHIROPRACTIC & WELLNESS, LLC

WWW.HENRYCHIROPRACTIC.COM

22780 Three Notch Road
Lexington Park, MD 20653

301-737-0662 Office
301-737-0675 (FAX)

Nutrition Missed Appointment Policy

Effective January 1, 2012, if your scheduled appointment is not cancelled with at least a 24-hour notice or a message left on our voicemail, your account will be charged a $50.00 fee.

Thank you for your consideration to our other patients who can fill in these missed slots.

Product Return Policy

Unopened products/items may be returned within 30 days of purchase with receipt. Any opened products cannot be returned.

Thank you for your understanding.

I have read and accept the above terms and conditions:

Print Name: ______________________________

Signature: ______________________ Date: __________

Fax 301-737-0675

Metabolic Assessment Form™

Name: ______________________ Age: ______ Sex: _____ Date: ______________

PART I

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

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

PART II Please circle the appropriate number 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 relieved 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 or "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				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
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 proteins and meats; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or 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 VI				
Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 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, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?		Yes	No	

Category VIII				
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
Burpy, fishy taste after consuming fish oils	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 IX				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI				
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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

© [illegible] All Rights Reserved
SMG[illegible]

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

- 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

Category XIII

- Cannot fall asleep 0 1 2 3
- Perspire easily 0 1 2 3
- Under a high amount 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 XIV

- Edema and swelling in ankles and wrists 0 1 2 3
- Muscle cramping 0 1 2 3
- Poor muscle endurance 0 1 2 3
- Frequent urination 0 1 2 3
- Frequent thirst 0 1 2 3
- Crave salt 0 1 2 3
- Abnormal sweating from minimal activity 0 1 2 3
- Alteration in bowel regularity 0 1 2 3
- Inability to hold breath for long periods 0 1 2 3
- Shallow, rapid breathing 0 1 2 3

Category XV

- 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 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 hair loss 0 1 2 3
- Dryness of skin and/or scalp 0 1 2 3
- Mental sluggishness 0 1 2 3

Category XVI

- Heart palpitations 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

Category XVI *(Cont.)*

- Night sweats 0 1 2 3
- Difficulty gaining weight 0 1 2 3

Category XVII *(Males Only)*

- Urination difficulty or dribbling 0 1 2 3
- Frequent urination 0 1 2 3
- Pain inside of legs or heels 0 1 2 3
- Feeling of incomplete bowel emptying 0 1 2 3
- Leg twitching at night 0 1 2 3

Category XVIII *(Males Only)*

- Decreased libido 0 1 2 3
- Decreased number of spontaneous morning erections 0 1 2 3
- Decreased fullness of erections 0 1 2 3
- Difficulty maintaining 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
- Decreased 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 XIX *(Menstruating Females Only)*

- Perimenopausal Yes No
- Alternating menstrual cycle lengths Yes No
- Extended menstrual cycle (greater than 32 days) Yes No
- Shortened menstrual cycle (less than 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 0 1 2 3
- Facial hair growth 0 1 2 3
- Hair loss/thinning 0 1 2 3

Category XX *(Menopausal Females Only)*

- How many years have you been menopausal? ________ years
- 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 alcoholic 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 do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ________ ________ ________

List the three healthiest foods you eat during the average week: ________ ________ ________

PART IV

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

____

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

____

© 2015 [illegible] All Rights Reserved
[illegible]

TI Metabolic Effect Questionnaire

1. Which of the following meals would give you sustained and lasting energy if it were the only meal you could eat all day?
   a. Cereal (0)
   b. Eggs and cereal (+1)
   c. Steak and eggs (+2)

2. What best describes your reaction to high-carbohydrate foods such as pasta or potatoes?
   a. They give me a short boost in energy, but I can crash later. (+1)
   b. They make me feel tired and lethargic almost immediately after eating them. (+2)
   c. They give me long lasting energy. (-2)

3. When it comes to desserts, which do you prefer?
   a. I have no preference. (+1)
   b. Creamy, rich sweets like cheesecake or chocolate mousse. (+2)
   c. I like all sweets, but prefer lighter things like cookies and candy bars. (0)

4. What best describes your reaction to eating protein such as chicken, steak, or eggs?
   a. They satisfy my hunger and give me energy for many hours. (+4)
   b. They give me about the same energy as carbohydrate-rich foods such as pasta and potatoes.(+1)
   c. They fill me up and often make me feel sluggish and tired *or* I do not eat meat. (-2)

5. Which do you crave the most?
   a. Protein, salt, and coffee. (+2)
   b. Sugar; coffee; or cocktails, wine, or beer. (-2)
   c. I don't get craving very often, but when I do, I crave a. and b. (+1)

6. What describes your reaction to strong bright lights?
   a. I'm not sensitive to bright lights. (+2)
   b. Light has to be very bright for me to notice. (+2)
   c. I'm sensitive to bright lights and prefer sunglasses when outside. (-2)

7. What best describes your tendency toward anxiety or depression?
   a. I tend to become depressed and moody. (+2)
   b. I'm rarely depressed or anxious. (+1)
   c. I tend to become anxious in many situations. (-2)

8. What best describes you current weight?
   a. I am an average weight. (+2)
   b. I am underweight, but can store fat around my waist. (-8)
   c. I am overweight or obese.(+6)

9. How do you best describe your appetite?
   a. I live to eat and frequently overeat. (+4)
   b. I use food as fuel, but indulge on occasion. (+2)
   c. I eat to live and sometimes I have to remind myself to eat. (-6)

10. What best describes you facial skin?
    a. My skin is very balanced and healthy. (+2)
    b. My skin is sometimes oily and I'm prone to acne or breakouts. (+4)
    c. I have sensitive, often dry skin that sometimes looks red and irritated. (0)

11. If you needed to stay focused for a long period of time, which would help?
    a. Nuts like almonds, walnuts, or peanuts. (+2)
    b. Trail mix with a mix of dried fruit and nuts. (+1)
    c. Dried fruit or candy. (-2)

12. What best describes your digestive system?
    a. I suffer from heartburn or irritable bowel syndrome. (0)
    b. I am frequently constipated or have irregular bowel movements. (+4)
    c. I have regular bowel movements with no problem. (+2)

13. What state best describes you energy levels?
    a. I feel mentally balanced, except on rare occasions when I am stressed or don't get enough sleep. (+2)
    b. I feel mentally alert and wired, yet at the same time, physically tired. (-6)
    c. I feel mentally and physically fatigued most of the time. (+4)

14. What happens when you skip meals?
    a. I become irritable, shaky, and/or light-headed. (+4)
    b. I can skip 1 meal and feel fine, but I become irritable, shaky, and/or light-headed if I miss 2 or more than 4-6 hours without eating. (-4)
    c. Skipping meals does not bother me. I frequently go more than 4 to 6 hours without eating. (-4)

15. What best describes your sleeping habits?
    a. I'm frequently tired, but still have difficulty falling asleep and/or getting up in the morning. (+4)
    b. I have difficulty falling asleep or sleeping soundly, yet still feel wired during the day. (-4)
    c. I fall asleep fine, sleep soundly, and wake feeling refreshed. (+2)

16. How do you best describe how old you look?
    a. I look my age. (+1)
    b. I look older than my age. (0)
    c. I look young for my age. (+2)

17. When do you perspire?
    a. I rarely perspire even when exercising. (+2)
    b. I only perspire when exercising or am very hot. (+1)
    c. I perspire a lot during exercise and even when not exercising. (0)

18. How do you best describe you state of awareness and alertness?
    a. I am acutely aware of my surroundings and the people around me, but can find it difficult to focus on any one task. (-4)
    b. It often takes me a moment to register questions and respond. (+2)
    c. I am aware of my surroundings and responsive to people and their questions. (+1)

Total up the number of answers and record them here: ____________

Higher than 35: *You are a sugar burner.*
Between 20 to 35: *You are a mixed burner.*
Lower than 20: *You are a muscle burner.*

FirstLineTherapy

Diet Diary / Exercise Log

	Day - Date:	Day - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

MET1333 4/08

FirstLine Therapy

Diet Diary / Exercise Log

	Day - Date:	Day - Date:
Wake up:		
Morning Meal Time:		
Snack Time:		
Mid-Day Meal Time:		
Snack Time:		
Evening Meal Time:		
Snack Time:		
Water (ounces)		
Other Drinks (that are not listed with meals or snacks above)		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

Nutritional Health Questionnaire

General Information

Name: ____

Address: ____

City: ____________________ State: __________ Zip: ____________

Home Phone: ____________________ Cell Phone: ____________________

Work Phone: ____________________ Email address: ____________________

Preferred Contact Method: ______________________________________

( ) Male ( ) Female DOB: ______________________

Relationship Status: ( ) S ( ) M ( ) D ( ) W

Occupation: ______________ How Long: __________ Satisfied? (1-10) ______

Passions / Interests: ____

____

What do you hope I can do for you at this time?

____

____

____

What are your health concerns?

____

____

____

For how long have you experienced these conditions?

____

____

____

Medical Information

Primary Physician's Name: ______________________ Phone #: ____________

Please list any Allergies you may have to:

1) Foods: ____

____

2) Medications: ____

____

3) Chemicals: ____

____

4) Environmental: ____

____

5) Others: ____

List Major Traumas, Surgeries and Hospitalizations you have had:

____

____

____

____

Have you had prolonged use of any medication in the past? (Antibiotic, Acid Blockers...)

____

____

Medications and Supplements:

- Please list ALL prescription medication, nutritional supplements and herbs that you are currently taking.

	Name	Dosage	Frequency	How Long	Reason
Medications					

	Name	Dosage	Frequency	How Long	Reason
Supplements					

FOR WOMEN ONLY:

1) # Of pregnancies: ________Year:____________Trying to Conceive? ______________
2). Are you currently pregnant? ______________ Are you breastfeeding? __________

Family History

Relationship	Alive/Deceased	Present Health or Cause of Death
Paternal Grandmother		
Paternal Grandfather		
Maternal Grandmother		
Maternal Grandfather		
Father		
Mother		
Brothers		
Sisters		

Physical Activity / Life Style

What kind of physical activities do you do? ______________________
Are you satisfied with your energy level? ______________________
Do you have any problems/limitations that limit your physical activity? ____________
____

Activity	Type(s)	Days per Week	Duration
Cardio / Aerobic			
Strength training			
Yoga / Stretching			
Others			

What do you do for Relaxation? ______________________
____
How many hours of sleep do you get a night / day? ______________________
Do you sleep well? ______________________
On a scale of 1 – 10, with 1 being low and 10 being high, how stressful is your:

- Work: ______ - Social/Family Situation: ________
- Current Health Status: _______ - Life in General: _________

What do you believe you can do to make a difference in your current health status?
____
____

Nutrition Information

Have you ever had nutritional counseling? ______________________
Please list any special dietary restrictions / habits you have: ______________________
____
____
What foods do you crave if anything? ______________________
____
Please describe any changes you have made to your diet to improve your health: ___
____
____
How would you describe your relationship to food? ______________________
____
____
Height: ______________ Current Weight: ________________ Ideal Weight: ________
Highest Adult Weight: ______________________
Lowest Adult Weight: ______________________

Food Frequency: How often do you eat, drink or do the following? Please insert a number and circle <u>day</u> (d) or <u>week</u> (wk.)

Meals per day: _______.
Snacks per day: ______.
Red Meat: ______ d / wk.
Chicken / Turkey: ______ d / wk.

Water (ounces per day): ______.
Prepare meals: ______ d / wk.
Nuts / Seeds: ______ d / wk.
Lentils/Beans: ______ d / wk.
Yogurt/Kefir: ______ d / wk.
Fats and oils: ______ d / wk. What Kinds? ________________________________
Eggs: ______ d / wk.
ALL VEGGIES: ______ d / wk.
Bread: ______ d / wk.
Whole grains: ______ d / wk.
Pasta: ______ d / wk.
Soft Drinks: ______ d /wk., diet OR Regular
Chips/crackers etc.: ______ d / wk.
Fast Food: ______ d / wk.

Deli Meat: ______ d / wk.
Fish: ______ d / wk.
Shellfish: ______ d / wk.
Organ Meat: ______ d / wk.
Soy products: ______ d / wk.
Dairy Milk / Cheese: ______ d / wk.
ALL FRUITS: ______ d / wk.
Coffee: ______ d / wk. Decaf? __________
Herb or other Tea: _______ d / wk.
Frozen Dinners: ______ d / wk.
Candy: ______ d / wk.
Alcoholic Drinks: ______ d / wk.
Eat fast or on the run: ______ d / wk.

Environmental Information

How often do you consume or are exposed to any of the following? Please insert a number and circle day (d) or week (wk.).

Cigarette smoke: _______ d / wk.
Perfumes/hair dyes: _______ d / wk.
Recreational drugs: _______ d / wk.
Mold: ______ d / wk.
Bottled water: ______ d / wk.

Wood Stove: _______ d / wk.
Pesticides: _______ d / wk.
Pet dander: _______ d / wk.
Cleaning Products: ______ d / wk.
Teflon or aluminum pans: ______ d / wk.