***Whom may we thank for referring you to this office 🡪 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_?***

**APPLICATION FOR CARE at Sowing Wellness**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT DEMOGRAPHICS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Birth Date: \_\_\_\_-\_\_\_\_-\_\_\_\_ Age: \_\_\_\_\_ 🞏 Male 🞏 Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile Phone:\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: **❑** Single **❑** Married Do you have Insurance: **❑**Yes **❑**No Work Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Spouse’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children and Ages: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name & Number of Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HISTORY of COMPLAINT**

Please identify the condition(s) that brought you to this office: Primarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondarily: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Third: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fourth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On a scale of **1** to **10** with **10** being the worst pain and **zero** being no pain, rate your above complaints by c***ircling the number*:**

**Primary** or chief complaint is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Second** complaints is : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Third** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

**Fourth** complaint: : 0 - 1 - 2 - 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10

When did the problem(s) begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ When is the problem at its worst? 🞏AM 🞏PM 🞏mid-day 🞏late PM

How long does it last? 🞏 It is constant **OR** 🞏 I experience it on and off during the day **OR** 🞏 It comes and goes throughout the week

**How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_**

**C**ondition(s) ever been treated by anyone in the past? 🞏No 🞏 Yes **If yes,** when: \_\_\_\_\_\_ by whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How long were you under care: \_\_\_\_\_\_\_ What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **🞏 N/A**

**\*PLEASE MARK** the areas on the Diagram with the following **letters** to describe your symptoms:

 **R = R**adiating **B** **= B**urning **D =** **D**ull **A =** Aching **N = N**umbness **S =** **S**harp/ **S**tabbing **T= T**ingling

What relieves your symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes them feel worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST RESTRICTED ACTIVITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURREN6T ACTIVITY LEVEL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**USUAL ACTIVITY LEVEL** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your problem the result of ANY type of accident? 🞏 Yes, 🞏 No

Identify any other injury(s) to your spine, minor or major, that the doctor should know about: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PAST HISTORY** Have you suffered with any of this or a similar problem in the past? ❑ No ❑ Yes **If yes** how many times? \_\_\_\_\_\_\_\_ \_ When was the last episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How did the injury happen?\_\_\_\_\_\_\_\_\_\_\_\_ Other forms of treatment tried: 🞏 No 🞏 Yes **If yes,** please state **what** type of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and whoprovided it: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How long ago? \_\_\_\_\_\_\_**What were the results. 🞏 Favorable 🞏 Unfavorable🡪 please explain. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please identify any and all types of jobs you have had in the past that have imposed any physical stress on you or your body: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If you have ever been diagnosed with any of the following conditions, please indicate with a **P** for in the ***Past*, C** for ***Currently*** haveand **N** for *N****ever*** *have had***:**\_**\_\_** Broken Bone \_**\_\_**Dislocations **\_\_\_** Tumors \_**\_\_**Rheumatoid Arthritis \_\_\_Fracture **\_\_\_**Disability \_\_\_Cancer \_\_\_ Heart Attack \_\_\_Osteo Arthritis \_\_\_Diabetes **\_\_\_**Cerebral Vascular **\_\_\_** Other serious conditions:

 **PLEASE identify** **ALL PAST** and any **CURRENT** conditions you feel may be contributing to your present problem:

|  |
| --- |
|  **HOW LONG AGO TYPE OF CARE RECEIVED BY WHOM**  |
| **INJURIES 🡪**  |
| **SURGERIES 🡪** |
| **CHILDHOOD DISEASES🡪**  |
| **ADULT DISEASES 🡪**  |

**SOCIAL HISTORY**

**1. Smoking**: ❑cigars ❑ pipe ❑ cigarettes 🡪 How often? ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**2. Alcoholic** **Beverage**: consumption occurs 🡪 ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**3. Recreational Drug use**: ❑ Daily ❑ Weekends ❑ Occasionally ❑ Never

**4. Hobbies -Recreational Activities- Exercise Regime:** How does your present problem affect the following, See pg 2- Activities of Life

**FAMILY HISTORY**:

**1.** Does anyone in your family suffer with the same condition(s)? ❑ No ❑ Yes

**If yes whom**: ❑ grandmother ❑ grandfather ❑ mother ❑ father ❑ sister’s ❑ brother’s ❑ son(s)

❑ daughter(s)

 Have they ever been treated for their condition? ❑ No ❑ Yes ❑ I don’t know

**2. Any** other hereditary conditions the doctor should be aware of. ❑ No ❑Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize payment to be made directly to Sowing Wellness Business Solutions LLC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to [CLINIC NAME] for any and all services I receive at this office.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Patient or Authorized Person’s Signature Date Completed**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_**

 **Doctor’s Signature Date Form Reviewed**

**Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HR#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_**\_\_/\_\_\_/\_\_\_

 **Activities of Daily Living/Symptoms/Medications**

**Patient Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ File#\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

 **Daily Activities: Effects of Current conditions On Performance**

 Please identify how your current condition is affecting your ability to carry out activities that are routinely part of your life:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Bending  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Concentrating  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Doing computer Work  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Gardening  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Playing Sports  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Recreation Activities  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Shoveling  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sleeping  | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Watching TV | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Carrying | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Dancing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Dressing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Lifting | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Pushing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Rolling Over | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sitting | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Standing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Working | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Climbing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Doing Chores | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Driving | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Performing Sexual Activity | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Reading | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Running | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Sitting to Standing | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |
| Walking | [ ]  No Effect | [ ]  Painful (can do) | [ ] Painful (Limits) | [ ]  Unable to Perform |

**Please mark P** for in the **Past, C** for **Currently** haveand **N** for **Never**

\_\_\_ Headache

\_\_\_ Pregnant (Now)

\_\_\_ Dizziness

\_\_\_ Prostate Problems

\_\_\_ Ulcers

\_\_\_ Neck Pain

\_\_\_ Frequent Colds/Flu

 \_\_\_ Loss of Balance

\_\_\_ Impotence/Sexual Dysfun.

\_\_\_ Heartburn

\_\_\_ Jaw Pain, TMJ

\_\_\_ Convulsions/Epilepsy

\_\_\_ Fainting

\_\_\_ Digestive Problems

\_\_\_ Heart Problem

\_\_\_ Shoulder Pain

\_\_\_ Tremors

\_\_\_ Double Vision

\_\_\_ Colon Trouble

\_\_\_ High Blood Pressure

\_\_\_ Upper Back Pain

\_\_\_ Chest Pain

\_\_\_ Blurred Vision

\_\_\_ Diarrhea/Constipation

\_\_\_ Low Blood Pressure

\_\_\_ Mid Back Pain

\_\_\_ Pain w/Cough/Sneeze

\_\_\_ Ringing in Ears

\_\_\_ Menopausal Problems

\_\_\_ Asthma

\_\_\_ Low Back Pain

\_\_\_ Foot or Knee Problems

\_\_\_ Hearing Loss

\_\_\_ Menstrual Problem

\_\_\_ Difficulty Breathing

\_\_\_ Hip Pain

\_\_\_ Sinus/Drainage Problem

\_\_\_ Depression

\_\_\_ PMS

\_\_\_ Lung Problems

\_\_\_ Back Curvature

\_\_\_ Swollen/Painful Joints

\_\_\_ Irritable

\_\_\_ Bed Wetting

\_\_\_ Kidney Trouble

\_\_\_ Scoliosis

\_\_\_ Skin Problems

\_\_\_ Mood Changes

\_\_\_ Learning Disability

\_\_\_ Gall Bladder Trouble

\_\_\_ Numb/Tingling arms, hands, fingers

\_\_\_ ADD/ADHD

\_\_\_ Eating Disorder

\_\_\_ Liver Trouble

\_\_\_ Numb/Tingling legs, feet, toes

\_\_\_ Allergies

\_\_\_ Trouble Sleeping

\_\_\_ Hepatitis (A,B,C)

**List Prescription & Non-Prescription drugs you take**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** File#/HRN \_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_

**INITIAL NERVE SYSTEM PROFILE**

When was your most recent auto accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What speed was the collision? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your most recent strain / stress at work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe the manner of the injury \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was treatment received? Please describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your job require you remain in long term stressful postures?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(*i.e. all day seating, repeated lifting, long term computer use)*

Spinal traumas in the past? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma as a child! i.e. fall on your head, impact to your head, concussion,

 fall onto your back or tailbone, biking accident\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Work around the house – lifting, bending, woke up with stiff neck, “back went out”

**INITIAL NUTRITIONAL PROFILE**

Have you tested with high triglycerides or high cholesterol? (Y / N) Values?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) \_\_\_\_\_\_\_

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

 Diet Soda Coffee Juice Milk Soda Alcohol

Please list any supplements you take regularly: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INITIAL FITNESS PROFILE**

How many times per week do you exercise?

Cardiovascular \_\_\_Hours \_\_\_Days/Wk Weight Training \_\_\_Hours \_\_\_Days/Wk

Low Impact (Yoga, etc.) \_\_\_Hours \_\_\_Days/Wk

What is your target weight? \_\_\_\_\_\_\_\_\_\_\_\_\_What is your current weight? \_\_\_\_\_\_\_\_\_\_\_

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10) \_\_\_\_\_\_\_\_***

**INITIAL TOXICITY PROFILE**

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? \_\_\_\_\_ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

 **INITIAL STRESS PROFILE**

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

 **Doctor Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_