Wellness Within
HOLISTIC CHIROPRACTIC

# Health History

Patient name:_____ Date: _____

Address/Zipcode:_____

Date of Birth: _____ Do you have Medicare Part B: □ Yes □ No

Sex: Male □ Female □ Married □ Single □ Divorced □ Widowed □ Separated

Occupation: _____ Employer: _____

Email:_____ Spouses Name: _____

Who may we thank for referring you? _____

Phone number: Cell _____ _____ Home _____

Emergency Contact: _____ Phone # _____

Appointment reminders? □ Yes □ No If yes: □ E-mail (24hr before) □ Text Msg (2hrs before)

Reason for visit: _____

Is this due to an accident? _____□ Auto □ Work related □ Home

If so, has it been reported to: □ Insurance company □ Employer □ Work Comp?

When did the symptoms appear? _____

Is the condition getting worse? _____

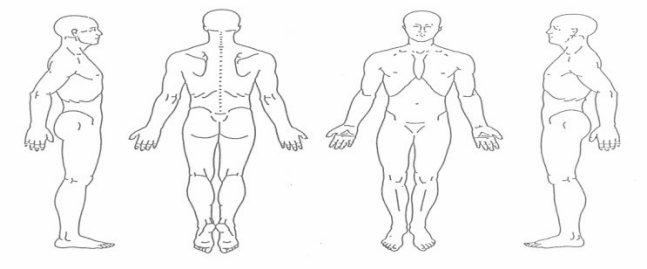
How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your □ Work □ Sleep □ Recreation □ Daily routine □ _____

Are the following painful or difficult? □ Sitting □ Standing □ Walking □ Lying □ Bending

□ Lifting □ Other _____



Where do you feel the pain:

Rate your pain 1-10 _____

Do you feel the following:

□ Numbness □ Tingling □ Weakness

□ Sharp □ Dull □ Ache □ Throbbing

□ Burning □ Swelling □ Stiffness □ Cramps

How does your condition make you feel? _____

What would you be able to do/enjoy that you can't currently if this condition was gone?

_____

Have you been treated for this condition previously? □ Yes □ No

□ Medication □ Surgery □ Chiropractic □ Nutrition □ Acupuncture □ _____

Date of last exam: Physical _____ Blood work _____ Urine _____

X-Rays_____ MRI/CT/Ultrasound _____

Have you had or have any on the following:

| | | | | | |
|---|---|---|---|---|---|
| AIDS | □ Yes □ No | Alcoholism | □ Yes □ No | Allergy shots | □ Yes □ No |
| Anemia | □ Yes □ No | Anorexia | □ Yes □ No | Appendicitis | □ Yes □ No |
| Arthritis | □ Yes □ No | Asthma | □ Yes □ No | Autoimmune | □ Yes □ No |
| Bleeding disorder | □ Yes □ No | Blood pressure | Yes □ No | Breast lump | □ Yes □ No |
| Bronchitis | □ Yes □ No | Bulimia | □ Yes □ No | Cancer | □ Yes □ No |
| Cataracts | □ Yes □ No | Chemical Dependency | □ Yes □ No | Chicken pox | □ Yes □ No |
| Diabetes | □ Yes □ No | | | Emphysema | □ Yes □ No |
| Epilepsy | □ Yes □ No | Glaucoma | □ Yes □ No | Goiter | □ Yes □ No |
| Gout | □ Yes □ No | Heart Disease | □ Yes □ No | Hepatitis | □ Yes □ No |
| Hernia | □ Yes □ No | Herniated Disc | □ Yes □ No | Herpes | □ Yes □ No |
| High Cholesterol | □ Yes □ No | Kidney Disease | □ Yes □ No | Liver Disease | □ Yes □ No |
| Measles | □ Yes □ No | Miscarriage | □ Yes □ No | Mumps | □ Yes □ No |
| Mononucleosis | □ Yes □ No | Multiple Sclerosis | □ Yes □ No | Osteoporosis | □ Yes □ No |
| Pacemaker | □ Yes □ No | Parkinson's | □ Yes □ No | Pinched nerve | □ Yes □ No |
| Pneumonia | □ Yes □ No | Prostate problem | □ Yes □ No | Polio | □ Yes □ No |
| Prosthesis | □ Yes □ No | Psychiatric care | □ Yes □ No | Scarlet fever | □ Yes □ No |
| Rheumatoid Arthritis | □ Yes □ No | Rheumatic fever | □ Yes □ No | Stroke | □ Yes □ No |
| | | Suicide attempt | □ Yes □ No | Tonsillitis | □ Yes □ No |
| Thyroid Problem | □ Yes □ No | Tuberculosis | □ Yes □ No | Tumors | □ Yes □ No |
| Typhoid fever | □ Yes □ No | Ulcers | □ Yes □ No | Vaginal infections | □ Yes □ No |
| Venereal disease | □ Yes □ No | Whooping cough | □ Yes □ No | | |

Other: _____

Do you get headaches? □ Yes □ No How often _____ How would you describe them?:

□ Migraine □ Visual disturbance □ Nausea □ Tension □ Vomiting □ Related to allergies

□ Aura □ Light sensitive □ Related to allergies □ Ocular migraine

Are you pregnant? □ Yes □ No If so, due date?_____

Have you ever taken antibiotics? □ Yes □ No When_____

Are you on birth control? □ Yes □ No Have you used hormone replacement therapy □ Yes □ No

Are you Vegetarian □ Yes □ No Do you skip meals □ Yes □ No

How much sugar do you eat? □ Little □ Moderate □ High Do you crave sugar □ Yes □ No

| Injuries/Surgeries you have had: | Description | Date |
|---|---|---|
| Falls | | |
| Head injuries | | |
| Broken Bones | | |
| Auto Accidents | | |
| Surgeries | | |

# Metabolic Assessment Form™

**Name:** _____ **Age:** _____ **Sex:** _____ **Date:** _____

**PART I**

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

**1.** _____ **4.** _____

**2.** _____ **5.** _____

**3.** _____

**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 |



*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:**