

Metabolic Assessment Form

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

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

1. _____
2. _____
3. _____
4. _____
5. _____

Please circle the appropriate number “0 - 3” 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 relief 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 of “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			
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 fruits and vegetables; undigested foods found in stools	0	1	2 3
Category III			
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2 3
Do you frequently use antacids?	0	1	2 3
Feeling hungry an hour or two after eating	0	1	2 3
Heartburn when lying down or bending forward	0	1	2 3
Temporary relief from antacids, food, milk, 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 IV			
Roughage and fiber cause constipation	0	1	2 3
Indigestion and fullness lasts 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, mucous-like, greasy, or poorly formed	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

Category V			
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
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 VI			
Crave sweets during the day	0	1	2 3
Irritable if meals are missed	0	1	2 3
Depend on coffee to keep yourself going or started .	0	1	2 3
Get lightheaded if meals are missed	0	1	2 3
Eating relieves fatigue	0	1	2 3
Feel shaky, jittery, tremors	0	1	2 3
Agitated, easily upset, nervous	0	1	2 3
Poor memory, forgetful	0	1	2 3
Blurred vision	0	1	2 3
Category VII			
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 & appetite	0	1	2 3
Difficulty losing weight	0	1	2 3
Category VIII			
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 IX				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X				
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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XI				
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
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XII				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3
Category XIII				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
“Splitting” type headaches	0	1	2	3

Category XIV (Males only)				
Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3
Category XV (Males only)				
Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain 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
Decrease in 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 XVI (Menstruating Females Only)				
Are you perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 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 break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XVII (Menopausal Females Only)				
How many years have you been menopausal?				
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

How many alcohol beverages do you consume per week? _____

How many times do you eat out per week? _____

How many times a week do you eat fish? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke? _____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

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

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

Health Questionnaire (NTAF)

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

* Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are **not** enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Medication History

Please circle any of the following medication you have been or are currently taking.

Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

Acetylcholinesterase Reactivators

Pralidoxime

Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSom, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

GABA Antagonist Competitive binder

Flumazenil

Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

Noradrenergic and Specific Serotonergic Antidepressants (NaSSa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Ciprallex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

PARKER WELLNESS CENTERS

Dr. John Parker
4343 West Henderson Blvd.
Tampa, FL 33629
813-254-5200

Dr Alexa Parker
7652 Lockwood Ridge Road
Sarasota, Florida 34243
941-360-8570

Name: _____

Date: _____

Please take several minutes to answer these questions so Dr. Parker can help you get better faster. (Please circle as many that apply)

1. How have you taken care of your health in the past?

- a. Medications
- b. Emergency Room
- c. Routine Medical
- d. Exercise
- e. Nutrition/Diet
- f. Holistic Care
- g. Vitamins
- h. Chiropractic
- i. Other (please specify)

How did these previous methods work for you?

- a.
- b.
- c.
- d.
- e.
- f.
- g.
- h.
- i.

2. How have others been affected by your health condition?

- a. No one is affected
- b. Haven't noticed any problem
- c. They tell me to do something
- d. People avoid me

3. What are you afraid this might be (or beginning) to affect (or will affect)?

- a. Job
- b. Kids
- c. Future ability
- d. Marriage
- e. Self-esteem
- f. Sleep
- g. Time
- h. Finances
- i. Freedom

4. Are there health conditions you are afraid this might turn into?

- a. Family health problems
- b. Heart disease
- c. Cancer
- d. Diabetes
- e. Arthritis
- f. Fibromyalgia
- g. Depression
- h. Chronic fatigue
- i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)

What are you most concerned with regarding your problem? _____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

What would be different/better without this problem? Please be specific.

What do you desire most to get from working with us? _____

What is recovering your health worth ? _____

Confidential Patient Intake Information

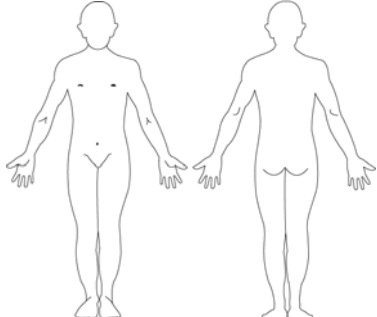
Please fill out the following form in as much detail as possible. All your health information is kept confidential.

Patient Information
Patient Name _____
Today's Date _____ Date of Birth _____
Social Security # _____
Address _____
City _____
State _____ Zip _____
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Height _____ Weight _____
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Engaged
<input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Minor
How many children do you have? _____
Please list any family members being treated here _____
Occupation _____
Employer/School _____
Employer/School Address _____
Employer/School phone #: (____) _____

Contact Information
Home Phone (____) _____
Cell Phone (____) _____
Email address _____
May we contact you via (please check for all applicable):
<input type="checkbox"/> Home phone <input type="checkbox"/> Cell <input type="checkbox"/> Work phone <input type="checkbox"/> Email
<i>In case of emergency please contact:</i>
Name _____
Relationship _____
Home Phone (____) _____
Alternate Phone (____) _____
Spouse's/Partner's name _____
Spouse's/Partner's employer _____
Who referred you? _____

Patient Condition
What is your major complaint (<i>be as specific as possible</i>) _____
When did you condition/symptoms/pain first appear? (<i>specific date, days ago, weeks, ago, etc.</i>) _____
Is this condition getting progressively worse? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Constant <input type="checkbox"/> Comes and goes
When is it worse? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Changes time of day
Does it interfere with: <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Daily routines <input type="checkbox"/> Recreation <input type="checkbox"/> Other _____
How long has it been since you really felt good? _____
Other doctors seen for this condition: <input type="checkbox"/> MD <input type="checkbox"/> DC <input type="checkbox"/> DO <input type="checkbox"/> DDS <input type="checkbox"/> Other _____
Does the condition/symptom/pain radiate? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, where and how frequently _____
How long/often does the radiation occur/last? _____
Do you have: <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Weakness
Describe _____
List and mark the severity of your condition/symptoms/pain on the scale below:
Body part _____
0 (None) 5 (Severe) 10
Body part _____
0 (None) 5 (Severe) 10
Type of Pain:
<input type="checkbox"/> Sharp <input type="checkbox"/> Dull <input type="checkbox"/> Throbbing <input type="checkbox"/> Tingling <input type="checkbox"/> Other _____
<input type="checkbox"/> Shooting <input type="checkbox"/> Burning <input type="checkbox"/> Aching <input type="checkbox"/> Numbness
What activities or positions aggravate your condition?
<input type="checkbox"/> Bending <input type="checkbox"/> Coughing <input type="checkbox"/> Getting up/down <input type="checkbox"/> Driving <input type="checkbox"/> Lifting <input type="checkbox"/> Lying down
<input type="checkbox"/> Sneezing <input type="checkbox"/> Standing <input type="checkbox"/> Straining at stool <input type="checkbox"/> Turning head <input type="checkbox"/> Twisting <input type="checkbox"/> Walking

Mark all areas on the picture where your condition, symptoms, and/or pain occur.



Patient Condition

What activities or positions relieve your condition:

- | | | | | | |
|-------------------------------|-------------------------------------|----------------------------------|-----------------------------------|-------------------------------------|--------------------------------|
| <input type="checkbox"/> Heat | <input type="checkbox"/> Lying down | <input type="checkbox"/> Sitting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Stretching | <input type="checkbox"/> Other |
| <input type="checkbox"/> Ice | <input type="checkbox"/> Medication | <input type="checkbox"/> Massage | <input type="checkbox"/> Standing | <input type="checkbox"/> Exercise | |

Have you ever had this condition before? Yes No If yes, when? _____

Were you treated for this condition or a similar one before? Yes No If yes, when/by whom? _____

Health History

Do you have any allergies? (food, contact, environmental) _____

List any prescribed medications, over the counter medications, vitamins, herbs and supplements _____

When was your last: Physical examination _____ Blood/lab work _____ X-ray study _____

Injuries/Surgeries you've had and when? _____

Have you had or do you have any of the following conditions or diseases? ***Please check yes or no for each one below***

- | | | |
|--|--|---|
| <input type="checkbox"/> Ankylosing spondulitis | <input type="checkbox"/> Connective tissue issues | <input type="checkbox"/> Knee surgery |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> COPD (bronchitis/emphy) | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Marfan syndrome |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Digestive/bowel problems | <input type="checkbox"/> Osteoporosis/penia |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Dizziness or vertigo | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Bowel/Bladder problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rotator cuff problem |
| <input type="checkbox"/> Buzzing in ear | <input type="checkbox"/> Fusions (spinal, joint) | <input type="checkbox"/> STI/STD |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Gout | <input type="checkbox"/> Shoulder surgery |
| <input type="checkbox"/> Carpal tunnel | <input type="checkbox"/> Hear disease | <input type="checkbox"/> Spinal surgery |
| <input type="checkbox"/> Celiac disease (gluten) | <input type="checkbox"/> Hepatitis (A, B, C, etc.) | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Herpes | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Hip replacement | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Colitis/disceritculitis | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Compression fractures | <input type="checkbox"/> Kidney disease | |

Are there any conditions that run in your family? Yes No If yes, what condition(s) and which family member? _____

Personal and Social Health History

Are you currently pregnant, or do you think you may be pregnant? Yes No If yes, how many weeks? _____

How many hours per week do you typically work/attend school? <20 hrs 20 hrs 30 hrs 40 hrs 40+ hrs

What are your typical duties and postures (sitting, standing, lifting, etc.)? _____

Do you exercise? Yes No If yes, how often and what type? _____

Do you or does anyone else ever "crack" you neck/back/joints? Yes No If yes, how often and what body parts? _____

How would you rate your eating habits? Excellent Pretty good Could be better Needs improvement

How well do you sleep? Excellent Pretty good Restless Can't sleep Wake up often

How many hours of sleep do you get daily? _____ hours ***and*** Do you feel rested in the morning? Yes No

How is your energy overall? Full power OK Low Sporadic/Generally fatigued I depend on caffeine for energy

How do you feel your immune system is working? Strong OK Low

What do you hope to receive from our program? _____

Thank you for completing our health care questionnaire