WELCOME

PATIENT INFORMATION

Date ____

SS/HIC/Patient ID # ____

Patient Name ____
Last Name

____
First Name Middle Initial

Address ____

City ____

State ____ Zip ____

E-mail ____

Sex ☐ M ☐ F Age ____

Birthdate ____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for ______ years

Occupation ____

Patient Employer/School ____

Employer/School Address ____

____

Employer/School Phone (_____) ____

Spouse's Name ____

Birthdate ____

SS# ____

Spouse's Employer ____

Whom may we thank for referring you? ____

INSURANCE

Who is responsible for this account? ____

Relationship to Patient ____

Insurance Co. ____

Group # ____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____

Birthdate ____ SS# ____

Relationship to Patient ____

Insurance Co. ____

Group # ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____ and assign directly to
Name of Insurance Company(ies)

Dr. ____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____ ____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (______) ____

Cell Phone (______) ____

Best time and place to reach you ____

IN CASE OF EMERGENCY, CONTACT

Name ____

Relationship ____

Home Phone (______) ____

Work Phone (______) ____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date ____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

____

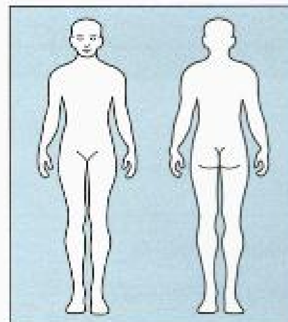
PATIENT CONDITION

Reason for Visit ____

When did your symptoms appear? ____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) ____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? ____

Is it constant or does it come and go? ____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

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HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other ____________________

Name and address of other doctor(s) who have treated you for your condition ____________________

Date of Last: Physical Exam__________ Spinal X-Ray__________ Blood Test__________

Spinal Exam__________ Chest X-Ray__________ Urine Test__________

Dental X-Ray__________ MRI, CT-Scan, Bone Scan__________

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
AIDS/HIV	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Alcoholism	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Measles	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Allergy Shots	☐ Yes	☐ No	Epilepsy	☐ Yes	☐ No	Migraine Headaches	☐ Yes	☐ No	Sexually Transmitted Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fractures	☐ Yes	☐ No	Miscarriage	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Anorexia	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Mononucleosis	☐ Yes	☐ No	Suicide Attempt	☐ Yes	☐ No
Appendicitis	☐ Yes	☐ No	Goiter	☐ Yes	☐ No	Multiple Sclerosis	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Gonorrhea	☐ Yes	☐ No	Mumps	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Gout	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Bleeding Disorders	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No	Tumors, Growths	☐ Yes	☐ No
Breast Lump	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	Parkinson's Disease	☐ Yes	☐ No	Typhoid Fever	☐ Yes	☐ No
Bronchitis	☐ Yes	☐ No	Hernia	☐ Yes	☐ No	Pinched Nerve	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Bulimia	☐ Yes	☐ No	Herniated Disk	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No	Vaginal Infections	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Herpes	☐ Yes	☐ No	Polio	☐ Yes	☐ No	Whooping Cough	☐ Yes	☐ No
Cataracts	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Prostate Problem	☐ Yes	☐ No	Other ____________		
Chemical Dependency	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No	Prosthesis	☐ Yes	☐ No			
Chicken Pox	☐ Yes	☐ No	Kidney Disease	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No			
						Rheumatoid Arthritis	☐ Yes	☐ No			

EXERCISE

☐ None

☐ Moderate

☐ Daily

☐ Heavy

WORK ACTIVITY

☐ Sitting

☐ Standing

☐ Light Labor

☐ Heavy Labor

HABITS

☐ Smoking — Packs/Day __________

☐ Alcohol — Drinks/Week __________

☐ Coffee/Caffeine Drinks — Cups/Day __________

☐ High Stress Level — Reason __________

Are you pregnant? ☐ Yes ☐ No Due Date__________

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS	ALLERGIES	VITAMINS/HERBS/MINERALS
Pharmacy Name__________		
Pharmacy Phone (_____)__________		

OSWESTRY DISABILITY INDEX

Name:______________________________ Age:______ Date:____________ Raw Score:_______

Please complete this questionnaire by circling ***one*** answer in each section. It is designed to give us information as to how your back (or leg) trouble has affected your ability to manage in everyday life.

SECTION 1 – Pain Intensity
A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care
A. I can look after myself normally without causing extra pain.
B. I can look after myself normally but it is painful.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain
C. Pain prevents me from lifting heavy weights off the floor but I can manage if they are conveniently positioned, e.g., on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift only very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 –Walking
A. Pain does not prevent me walking any distance.
B. Pain prevents me walking more than one mile.
C. Pain prevents me walking more than a quarter of a mile.
D. Pain prevents me from walking more than 100 yards.
E. I can only walk using a stick or crutches.
F. I am in bed most of the time and have to crawl to the toilet.

SECTION 5 –Sitting
A. I can sit in any chair as long as I like.
B. I can sit in my favorite chair as long as I like.
C. Pain prevents me from sitting for more than one hour.
D. Pain prevents me from sitting for more than half an hour.
E. Pain prevents me from sitting for more than ten minutes.
F. Pain prevents me from sitting at all.

SECTION 6 –Standing
A. I can stand as long as I want without extra pain.
B. I can stand as long as I want but it gives me extra pain.
C. Pain prevents me from standing for more than one hour.
D. Pain prevents me from standing for more than half an hour.
E. Pain prevents me from standing for more than ten minutes.
F. Pain prevents me from standing at all.

SECTION 7 – Sleeping
A. My sleep is disturbed by pain.
B. My sleep is occasionally disturbed by pain.
C. Because of pain I have less than 6 hours sleep.
D. Because of pain I have less than 4 hours sleep.
E. Because of pain I have less than 2 hours sleep.
F. Pain prevents me from sleeping at all.

SECTION 8 – Social Life
A. My social life is normal and gives me no extra pain.
B. My social life is normal but increases the degree of pain.
C. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g. dancing, etc.
D. Pain has restricted my social life and I do not go out as often.
E. Pain has restricted social life to my home.
F. I have no social life because of pain.

SECTION 9 – Traveling
A. I can travel anywhere without pain.
B. I can travel anywhere but it gives extra pain.
C. Pain is bad but I manage journeys over two hours.
D. Pain restricts me to journeys of less than one hour.
E. Pain restricts me to journeys of less than 30 minutes.
F. Pain prevents me from traveling except to receive treatment.

SECTION 10 – Changing Degree of Pain
A. My pain is rapidly getting better.
B. My pain fluctuates, but overall is definitely getting better.
C. My pain seems to be getting better, but improvement is slow at present.
D. My pain is neither getting better nor worse.
E. My pain is gradually worsening.
F. My pain is rapidly worsening.

Patient Signature______________________________ Date____________________

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NECK DISABILITY INDEX QUESTIONNAIRE

Please Read: This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each section by circling the **ONE CHOICE** that most applies to you. We realize that you may feel that more than one statement may related to you, but ***PLEASE JUST CIRCLE THE ONE CHOICE THAT MOST CLOSELY DESCRIBES YOUR PROBLEM RIGHT NOW.***

SECTION 1--Pain Intensity
A. I have no pain at the moment
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate.
D. The pain is moderate and does not vary much.
E. The pain is severe but comes and goes.
F. The pain is severe and does not vary much.

SECTION 2--Personal Care (Washing, Dressing, etc.)
A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get dressed; I wash with difficulty and stay in bed.

SECTION 3--Lifting
A. I can lift heavy weights without extra pain.
B. I can lift heavy weights, but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor but I can if they are conveniently positioned, for example on a table.
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 --Reading
A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I cannot read as much as I want because of severe pain in my neck.
F. I cannot read at all.

SECTION 5--Headache
A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 -- Concentration
A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7--Work
A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8--Driving
A. I can drive my car without neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive my car at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9--Sleeping
A. I have no trouble sleeping
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

SECTION 10--Recreation
A. I am able engage in all recreational activities with no pain in my neck at all.
B. I am able engage in all recreational activities with some pain in my neck.
C. I am able engage in most, but not all recreational activities because of pain in my neck.
D. I am able engage in a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities all.

SIGNATURE:____________________________

DATE:____________________________

DISABILITY INDEX SCORE:________________

Reference: © Vernon H, Mior S. The Neck Disability Index: A study of reliability and validity. J Manipulative Physiol Ther 1991;14:409-415.

VEHICLE ACCIDENT INFORMATION

PATIENT INFORMATION

Date_______________

Patient Name_______________

Date of Accident_______________ Time of Accident_______________ ☐ a.m. ☐ p.m.

Please describe the accident in your own words:_______________

Were you the: ☐ Driver ☐ Rear Passenger ☐ Front Passenger ☐ Pedestrian

How many people were in the accident vehicle?_______

ACCIDENT SITE

Road/Street Name_______________

City/State_______________

Nearest intersection with road/street_______________

Driving conditions ☐ Dry ☐ Wet ☐ Icy ☐ Other _______

Which direction were you headed? _______________

Speed you were traveling?_______________

VEHICLE

Make and model of vehicle you were in: _______________

Were you wearing a seatbelt? ☐ Yes ☐ No
If yes, what type? ☐ Lap ☐ Shoulder

Was vehicle equipped with airbags? ☐ Yes ☐ No
If yes, did it/they inflate properly? ☐ Yes ☐ No

Did your seat have a headrest? ☐ Yes ☐ No
If yes, what was the position of the headrest?
☐ Low ☐ Midposition ☐ High

IMPACT

Did your car impact another vehicle? ☐ Yes ☐ No

Did your car impact a structure? ☐ Yes ☐ No
If yes, explain_______________

Did any part of your body strike anything in the vehicle?

☐ Yes ☐ No If yes, explain_______________

Was impact from :

☐ Front ☐ Rear ☐ Left ☐ Right ☐ Other_______

At the time of impact were you:
☐ Looking straight ahead ☐ Looking to the right
☐ Looking to the left ☐ Looking down
☐ Looking up

Were both hands on the steering wheel? ☐ Yes ☐ No
If no, which hand was on the wheel? ☐ Right ☐ Left

Was your foot on the brake? ☐ Yes ☐ No
If yes, which foot was on the brake? ☐ Right ☐ Left

Were you: ☐ Surprised by impact ☐ Braced for impact

OTHER VEHICLE
(if applicable)

Make and model of other vehicle_______________

Which direction was other vehicle headed?_______________

Speed other vehicle was traveling_______________

POLICE

Did the police come to the accident site? ☐ Yes ☐ No

Were there any witnesses? ☐ Yes ☐ No

Was a police report filed? ☐ Yes ☐ No

Was a traffic violation issued? ☐ Yes ☐ No
If yes, to whom?_______________

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PATIENT CONDITION

Were you unconscious immediately after the accident? ☐ Yes ☐ No If yes, for how long?________________

Please describe how you felt immediately after the accident:

____

____

TREATMENT

Did you go to the hospital? ☐ Yes ☐ No

When did you go? ☐ Immediately after accident ☐ Next day ☐ 2 days or more after the accident

How did you get to the hospital? ☐ Ambulance ☐ Private transportation

Name of hospital____________________ Name of doctor____________________

Diagnosis____

____

Treatment received____________________________________

X-rays taken_______________________________________

SYMPTOMS/INJURIES

Have you been able to work since this injury? ☐ Yes ☐ No How many work days have you missed?__________

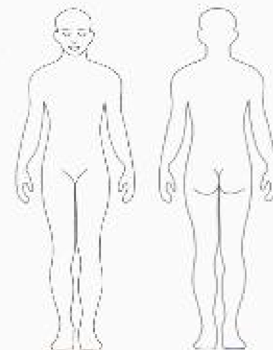
Prior to the injury were you able to work on an equal basis with others your age? ☐ Yes ☐ No

If you have had any of the following symptoms since your injury, please ☑ check:

- ☐ Arm/shoulder pain
- ☐ Back pain
- ☐ Back stiffness
- ☐ Chest pain
- ☐ Dizziness
- ☐ Ear buzzing
- ☐ Ear ringing
- ☐ Fatigue
- ☐ Feet/toe numbness
- ☐ Hand/finger numbness
- ☐ Headaches
- ☐ Irritability
- ☐ Jaw problems
- ☐ Leg pain
- ☐ Memory loss
- ☐ Nausea
- ☐ Neck pain
- ☐ Neck stiff
- ☐ Shortness of breath
- ☐ Sleep difficulty
- ☐ Stomach upset
- ☐ Tension
- ☐ Vision blurred

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain)_____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting ☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other____________

How often do you have this pain?______________________________

Is it constant or does it come and go?____________________________

Does it interfere with your: ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Movements that are painful to perform: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

________________________________ ________________

Signature of Patient, Parent, Guardian or Personal Representative — Date

________________________________ ________________

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

NUTRITIONAL EVALUATION

Date________________________________ Submitted by:____________________________

Name________________________________ Age__________ Sex________________________

Address______________________________ City______________ State/Zip_____________

Phone Number-(home)__________________ (Work)___________________________________

Occupation (Give as much detail as possible)____

____

____

What is your main complaint?____

____

____

Is there anything else that bothers you?____

____

Do you take medication on a regular basis? Yes____ No____ Please list those taken in the last 60 days:

Prescription Non-Prescription

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

Past surgical procedures and dates of those procedures ___________________________________

____

____

Have you been told by a medical doctor that you will need surgery in the future? If so, what and when?__

____

____

Are both your parents still alive? Yes__ No__ Neither__ If yes, what is their state of health? ___________

____

____

If not, please comment to the best of your ability as to the cause of their passing:_____________________

____

What is the state of health of your brothers and sisters?______________________________________

____

What is the state of health of your grandparents?____

____

Additional comments:____

____

____

To properly evaluate your "General Health Status", it is important that you answer all of the following questions. Please check the symptom is you experience the problem noted from a moderate to a severe degree. Do not check it if you do not experience the symptom.

1. Are you troubled by heartburn..............( )
2. Are you troubled by belching or gas.......( )
3. Do you suffer from constipation............( )
4. Do you have loose bowel movements.....( )
5. Do you have bad breath......................( )
6. Does food feel like it lays on your stomach()
7. Do you experience digestive problems when eating fatty or greasy foods...................()
8. Do you suffer from nausea...................( )
9. Have you lost your taste for meat............( )
10. Do you have a poor appetite..................( )
11. Do you catch cold easily......................( )
12. Do you get sore throats often................( )
13. Do you get chest colds easily................( )
14. Do you have a chronic cough................( )
15. Do you sigh or yawn often...................( )
16. Do you suffer with sinus problems.........( )
17. Do you have a stuffy nose even when you do not have a cold...........................( )
18. Do you get ear infections often.............( )
19. Do you have high blood pressure...........( )
20. Do you have low blood pressure............( )
21. Do you get pain or tightness in your chest..()
22. Do you ever get light-headed or dizzy......()
23. Do you get short of breath easily..............( )
24. Do you sleep on more than one pillow....( )
25. Does your heart beat fast for no reason...( )
26. Do you have varicose veins..................( )
27. Are your ankles swollen in the morning....()
28. Do you ankles swell late in the day.........( )
29. Do you get dizzy when changing position...()
30. Do you have trouble breathing.................()
31. Do you get up more than once a night to urinate..()
32. Do you have burning or pain when you urinate..()
33. Do you have trouble starting urine flow......()
34. Do you have or have you had kidney stones..()
35. Do you have or have you had bladder or kidney infections.................................()
36. Are your joints stiff in the AM.................()
37. Are your joints stiff in the PM..................()
38. Do you suffer from swollen joints.............()
39. Do you suffer from muscle cramps............()
40. Do your muscles feel weak......................()
41. Do you ever have numbness in your hands or feet...()
42. Do your hands or feet get cold easily.........( )
43. Do you have tingling sensations in your hands and/or feet..( )
44. Does any part of your body jerk for no reason...()
45. Have you been told you have osteoporosis...()
46. Do you have general aches or pains for no reason...()
47. Do you have reduced physical stamina........( )
48. Do you have spinal pain.........................( )
49. Do you have poor muscle coordination.......( )
50. Does your skin itch..............................( )
51. Is your skin rough or dry........................( )

52. Do you suffer from skin rashes...............( )
53. Do cuts or scrapes heal slowly...............( )
54. Do you have brown spots on your skin......( )
55. Do you develop bruises for no reason........( )
56. Do you suffer from acne........................( )
57. Do your eyes pain or itch.......................( )
58. Do you have a discharge from your eyes.....( )
59. Do you have difficulty adjusting to light......()
60. Are your eyes bloodshot or sandy.............( )
61. Do your eyes blink often........................( )
62. Do you see poorly in dim light.................( )
63. Are your glasses changed more than once a year...( )
64. Do you have or have you had cataracts.......( )
65. Are your eyes sensitive to light................( )
66. Do you often get "styes"........................( )
67. Do your eyes tire easily.........................( )
68. Do you find it hard to concentrate.............( )
69. Do you get depressed easily....................( )
70. Do you cry easily................................( )
71. Do you find it difficult to relax................( )
72. Do you lose your temper easily................( )
73. Do you suffer from insomnia...................( )
74. Do you gain weight easily......................( )
75. Do you lose weight easily......................( )
76. Do you have excessive thirst...................( )
77. Do you suffer from morning headaches......( )
78. Do you get headaches later in the day.........()
79. Do you get tense if you do not eat on time....()
80. Do you get tired before you eat.................()
81. Do you get tired after you eat...................()
82. Do you exercise on a regular basis............()
83. Do you smoke.....................................()
84. Do you drink alcohol............................( )
85. Would you call yourself a worrier............( )
86. Do you take laxatives............................( )
87. Do you crave sweets.............................( )
88. Do you get tired after sweets...................( )
89. Do you find it difficult to work under pressure()
90. Is your sex drive low.............................( )

For Women

91. Do you have a regular menstrual cycle.........( )
92. Do you have a "normal" menstrual cycle.......( )
93. Do you have pain with your cycle...............( )
94. Do you have pain before or after your cycle....()
95. Are you in "menopause"..........................( )
96. Do you have lumps in your breasts..............( )

Have you ever been diagnosed as having any of the following conditions:

Arthritis..( )
Heart Disease...( )
Diabetes Mellitus.......................................( )
Cholesterol...( )
Hypoglycemia..( )
Allergies..( )
Asthma..( )
Emphysema...( )
Osteoporosis...( )
Multiple Sclerosis.......................................( )
Parkinson's Disease....................................( )
Epilepsy...( )
Triglycerides...( )
Premenstrual...( )

If you are having any problems not listed, please note them in the space below:

____
____
____
____
____
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Current Food Consumption Evaluation

This section of the survey is designed to obtain the information necessary to classify the foods you eat as to their protein, fat, carbohydrate and fiber content. The carbohydrate classification is further broken down to differentiate the amounts of concentrated and complex carbohydrates consumed. All categories are further broken down to average gram per day intake, the number of calories of each and the total fat calories. This nutritional survey will aid your doctor in evaluating the impact your nutritional habits have on your general health. Please be sure you have completed the entire form as accurately as possible.

How Often Do You Consume Any Of The Foods In 7 Days?

AMOUNT	FOOD	TIMES PER WEEK
	DAIRY	
1 cup	Whole Milk	
½ cup	Whole Cottage Cheese	
1 cup	Whole Milk Yogurt	
1 med	Egg	
2-3 oz	Any Hard Cheese	
1 cup	Low-Fat Milk	
½ cup	Low-Fat Cottage Cheese	
1 cup	Low-Fat Yogurt	
2-3 oz	Soft Cheese,Feta,Cream	
	DESSERTS	
1 cup	Ice Cream	
1 Avg	Pastry	
½ cup	Pudding	
½ cup	Sherbet	
	CEREALS	
1 oz.	Bran Flakes	
1 oz.	Granola	
1 cup	Puffed Rice	
1 oz.	Corn Flakes	
	BREADS	
1 Slice	White, Whole Wheat	
1	English Muffin	
1	Bagel	
	Roll	
1 Avg	Pancake, Waffle	
	SANDWICHES	
1 Avg	BLT	
1 Avg	Chicken Salad	
1 Avg	Tuna Salad	
1 Avg	Corned Beef	
1 Avg	Egg Salad	
1 Avg	Ham	

AMOUNT	FOOD	TIMES PER WEEK
	SALAD	
Avg	Mixed Green	
	VEGETABLES	
¼ CUP	Green Peas	
3 ½ oz	Broccoli	
½ cup	Corn	
1 Med	Potato	
1 cup	Green Beans	
½ cup	Spinach	
3 ½ oz	Carrots	
½ cup	Tomatoes	
	SOUPS	
1 cup	Chicken	
1 cup	Minestrone	
1 cup	Clam Chowder	
1 cup	Tomato	
1 cup	Green Pea	
1 cup	Vegetable	
	FATS & OILS	
1 Tbs	Oil	
1 Tbs.	Butter	
	FISH & SHELLFISH	
1 Serving	Baked	
1 Serving	Broiled	
1 Serving	Fried	
1 Serving	Smoked	
	MEATS	
3 ½ oz	Chicken	
3 ½ oz.	Turkey	
3 ½ oz.	Lamb/Veal	
3 ½ oz.	Liver	
1	Frankfurter	
1 oz.	Luncheon Meat	
1 Med.	Steak	

AMOUNT	FOOD	TIMES PER WEEK
	JUICES	
1 cup	Grapefruit, Prune, Orange, Tomato	
1 cup	Apple, Grape, Carrot, Pineapple	
	SODA	
12 oz	All Varieties, Regular	
12 oz	All Varieties, Diet	
	CANDY	
1 oz.	Hard	
1 oz.	Caramel	
1 oz.	Chocolate	
1 oz.	Chocolate Coated Nuts	
	NUTS & SEEDS	
3 ½ oz.	Pumpkin, Sesame,Snflr	
30 nuts	Pistachio	
1 Tbl.	Peanut Butter	
¼ cup	Walnuts, Almonds	
	FAST FOOD LUNCH	
1 Serving	Hamb., Fries, Soda	
1 Serving	Hamb., Fries, Shake	
1 Serving	Fish Fillet	
1 Serving	Cheesebrgr,Fries,Soda	
1 Serving	Cheesebrgr, Fries,Shake	
	FAST FOOD DINNER	
1 Serving	KFC	
3 Slices	Pizza	
1 Serving	Big Mac	
	ALCOHOLIC BEVERAGES	
12 oz.	Beer	
1 Glass	Wine	
1 Jigger	Gin, Vodka	
1 Jigger	Rum, Whiskey	