VIC Chiropractic Intake Form Nutrition

This is a detailed questionnaire. Do your best to answer each question.

Personal Information

Legal first name

Last name

Preferred first name

Street

Unit

City

State/Province

Postal code

Home phone

Mobile phone

Email address

Date of birth

Relationship status

Gender

- ◯ Male
- ◯ Female

Occupation & Referral

Occupation

Hours per week

Referred by

In case of emergency, who should we contact?

Legal first name

Last name

Relationship

Home phone

Mobile phone

Email address

Have you ever been under Chiropractic care? If so, please share when and describe your experience and the results.

What is your height and weight?

When was the last time you felt really good?

Anything happening before you started to feel bad? (even if it seems unrelated)
Ex: new medications, change in medications, physical trauma, emotional trauma, etc.

What Is your primary complaint/symptom and your reason for scheduling an appointment for treatment?

What caused the onset?

When did It start?

What makes it feel worse?

What makes it feel better?

Anything about your symptoms that don't make sense?

Please list any other health symptoms or health complaints you are experiencing.

Medications (prescription and non prescription)

Please list your current medications, indicate their purpose and whether they are life sustaining by adding an LS beside each description.

Please list your current supplements and purpose.

Please list any surgeries you have had in the past including dates:

Please list any hospitalizations you have had in the past including dates:

Hereditary History

List anything at the bottom of the table that you think is also important for us to know.

	You	Father (Father's Family)	Mother (Mother's Family)	Sibling	Children
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
Neurological (Depression/ADD/Memory/Anxiety)	☐	☐	☐	☐	☐

	You	Father (Father's Family)	Mother (Mother's Family)	Sibling	Children
Digestion (Constipation/Diarrhea/Bloating/Heartburn)	☐	☐	☐	☐	☐
Heart Disease/Stroke/Blood Pressure	☐	☐	☐	☐	☐
Endocrine (Thyroid/Adrenals/Reproductive)	☐	☐	☐	☐	☐
Arthritis (Osteo/Rheumatoid/Gouty)	☐	☐	☐	☐	☐
Sugar (Hypoglycemia/Diabetes)	☐	☐	☐	☐	☐
Insomnia (Hard to get to sleep/stay asleep)	☐	☐	☐	☐	☐
Autoimmune (Lupus/Diabetes/Thyroid/Rheum)	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐
Kidney Issues	☐	☐	☐	☐	☐

Do you have a pacemaker?

- ◯ Yes
- ◯ No

Do you have any metal implants or devices?

- ◯ Yes
- ◯ No

Is there anything else that you would like to share with us regarding your health and/or current condition?

Diet, Habits, and Lifestyle

Diet

How would you rate your diet for health 1-10, 10 being best	
How many meals do you eat per day?	
How many 8 oz. glasses of water do you drink per day?	
How many times per week do you eat fast foods?	
What percentage of foods that you eat are organic?	

Habits

	Yes	No	What?	How much per day?
Do you eat refined foods, trans fats, artificial flavorings?	☐	☐		
Do you eat sugar?	☐	☐		
Do you use caffeine?	☐	☐		
Do you use tobacco?	☐	☐		
Do you use alcohol?	☐	☐		
Do you use cannabis?	☐	☐		

Lifestyle

	Yes	No	What?	How much per week?
Exercise?	☐	☐		
Quiet Time?	☐	☐		
Stretch/Yoga?	☐	☐		

Health History Survey

Check each box if you have ever had or are currently experiencing any of the following.

- ☐ Appendicitis
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Anemia
- ☐ Mumps
- ☐ Goiter
- ☐ Pleurisy
- ☐ Venereal Infection/STI
- ☐ Mental Disorder
- ☐ Pneumonia
- ☐ Polio
- ☐ Whooping Cough
- ☐ Measles
- ☐ Chicken Pox
- ☐ Influenza
- ☐ Alcoholism
- ☐ Epilepsy
- ☐ Vaccinations

Symptom Survey

Though some symptoms are repeated in each section, please mark a symptom that applies to you each time you see it appear in a Group.

Group 1

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Acid foods upset	○	○	○	○
Get chilled, often	○	○	○	○
"Lump" in throat	○	○	○	○
Dry mouth-eyes/nose	○	○	○	○
Pulse speeds after meal	○	○	○	○
Keyed up - fail to calm	○	○	○	○
Cuts heal slowly	○	○	○	○
Gag easily	○	○	○	○
Unable to relax; startles easily	○	○	○	○
Extremities cold, clammy	○	○	○	○
Strong light irritates	○	○	○	○

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Urine amount reduced	○	○	○	○
Heart pounds after retiring	○	○	○	○
"Nervous" stomach	○	○	○	○
Appetite reduced	○	○	○	○
Cold sweats often	○	○	○	○
Fever easily raised	○	○	○	○
Neuralgia-like pains	○	○	○	○
Staring, blinks little	○	○	○	○
Sour stomach frequent	○	○	○	○

Group 2

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Joint stiffness after arising	○	○	○	○
Muscle-leg-toe cramps at night	○	○	○	○
"Butterfly" stomach, cramps	○	○	○	○
Eyes or nose watery	○	○	○	○
Eyes blink often	○	○	○	○
Eyelids swollen, puffy	○	○	○	○
Indigestion soon after meals	○	○	○	○
Always seem hungry; feels "lightheaded" often	○	○	○	○
Digestion rapid	○	○	○	○
Vomiting frequent	○	○	○	○
Hoarseness frequent	○	○	○	○
Breathing irregular	○	○	○	○

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Pulse slow; feels "irregular"	◯	◯	◯	◯
Gagging reflex slow	◯	◯	◯	◯
Difficulty swallowing	◯	◯	◯	◯
Constipation, diarrhea alternating	◯	◯	◯	◯
"Slow starter"	◯	◯	◯	◯
Get "chilled" infrequently	◯	◯	◯	◯
Perspire easily	◯	◯	◯	◯
Circulation poor, sensitive to cold	◯	◯	◯	◯
Subject to colds, asthma, bronchitis	◯	◯	◯	◯

Group 3

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Eat when nervous	◯	◯	◯	◯
Excessive appetite	◯	◯	◯	◯
Hungry between meals	◯	◯	◯	◯
Irritable before meals	◯	◯	◯	◯
Get "shaky" if hungry	◯	◯	◯	◯
Fatigue, eating relieves	◯	◯	◯	◯
"Lightheaded" if meals delayed	◯	◯	◯	◯
Heart palpitates if meals missed or delayed	◯	◯	◯	◯
Afternoon headaches	◯	◯	◯	◯
Overeating sweets upsets	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Awaken after few hours sleep - hard to get back to sleep	◯	◯	◯	◯
Crave candy or coffee in the afternoons	◯	◯	◯	◯
Moods of depression - "blues" or melancholy	◯	◯	◯	◯
Abnormal craving for sweets or snacks	◯	◯	◯	◯

Group 4

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Hands and feet go to sleep easily, numbness	◯	◯	◯	◯
Sigh frequently, "air hunger"	◯	◯	◯	◯
Aware of "breathing heavily"	◯	◯	◯	◯
High altitude discomfort	◯	◯	◯	◯
Opens windows in closed room	◯	◯	◯	◯
Susceptible to colds and fevers	◯	◯	◯	◯
Afternoon "yawner"	◯	◯	◯	◯
Get "drowsy" often	◯	◯	◯	◯
Swollen ankles worse at night	◯	◯	◯	◯
Muscle cramps, worse during exercise; get "charley horses"	◯	◯	◯	◯
Shortness of breath on exertion	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Dull pain in chest or radiating into left arm, worse on exertion	○	○	○	○
Bruise easily, "black and blue" spots	○	○	○	○
Tendency to anemia	○	○	○	○
"Nose bleeds" frequent	○	○	○	○
Noises in head, or "ringing in ears"	○	○	○	○
Tension under the breastbone or feeling of "tightness," worse on exertion	○	○	○	○

Group 5

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Dizziness	○	○	○	○
Dry skin	○	○	○	○
Burning feet	○	○	○	○
Blurred vision	○	○	○	○
Itching skin and feet	○	○	○	○
Excessive falling hair	○	○	○	○
Frequent skin rashes	○	○	○	○
Bitter, metallic taste in mouth in mornings	○	○	○	○
Bowel movements painful or difficult	○	○	○	○
Worrier, feels insecure	○	○	○	○
Feeling queasy; headache over eyes	○	○	○	○
Greasy foods upset	○	○	○	○
Stools light-colored	○	○	○	○

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Skin peels on foot soles	○	○	○	○
Pain between shoulder blades	○	○	○	○
Use laxatives	○	○	○	○
Stools alternate from soft to watery	○	○	○	○
History of gallbladder attacks or gallstones	○	○	○	○
Sneezing attacks	○	○	○	○
Dreaming, nightmare type bad dreams	○	○	○	○
Bad breath (halitosis)	○	○	○	○
Milk products cause distress	○	○	○	○
Sensitive to hot weather	○	○	○	○
Burning or itching anus	○	○	○	○
Crave sweets	○	○	○	○

Group 6

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Loss of taste for meat	○	○	○	○
Lower bowel gas several hours after eating	○	○	○	○
Burning stomach sensations, eating relieves	○	○	○	○
Coated tongue	○	○	○	○
Pass large amounts of foul-smelling gas	○	○	○	○

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Indigestion 1/2-1 hour after eating; may be up to 3-4 hrs.	◯	◯	◯	◯
Mucous colitis or "irritable bowel"	◯	◯	◯	◯
Gas shortly after eating	◯	◯	◯	◯
Stomach "bloating" after eating	◯	◯	◯	◯

Group 7A

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Insomnia	◯	◯	◯	◯
Nervousness	◯	◯	◯	◯
Can't gain weight	◯	◯	◯	◯
Intolerance to heat	◯	◯	◯	◯
Highly emotional	◯	◯	◯	◯
Flush easily	◯	◯	◯	◯
Night sweats	◯	◯	◯	◯
Thin, moist skin	◯	◯	◯	◯
Inward trembling	◯	◯	◯	◯
Heart palpitates	◯	◯	◯	◯
Increased appetite without weight gain	◯	◯	◯	◯
Pulse fast at rest	◯	◯	◯	◯
Eyelids and face twitch	◯	◯	◯	◯
Irritable and restless	◯	◯	◯	◯
Can't work under pressure	◯	◯	◯	◯

Group 7B

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Increase in weight	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Decrease in appetite	◯	◯	◯	◯
Fatigue easily	◯	◯	◯	◯
Ringing in ears	◯	◯	◯	◯
Sleepy during day	◯	◯	◯	◯
Sensitive to cold	◯	◯	◯	◯
Dry or scaly skin	◯	◯	◯	◯
Constipation	◯	◯	◯	◯
Mental sluggishness	◯	◯	◯	◯
Hair coarse, falls out	◯	◯	◯	◯
Headaches upon arising wear off during day	◯	◯	◯	◯
Slow pulse, below 65	◯	◯	◯	◯
Frequency of urination	◯	◯	◯	◯
Impaired hearing	◯	◯	◯	◯
Reduced initiative	◯	◯	◯	◯

Group 7C

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Failing memory	◯	◯	◯	◯
Low blood pressure	◯	◯	◯	◯
Increased sex drive	◯	◯	◯	◯
Headaches, "splitting" or "rending" type	◯	◯	◯	◯
Decreased sugar tolerance	◯	◯	◯	◯

Group 7D

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Abnormal thirst	◯	◯	◯	◯
Bloating of abdomen	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Weight gain around hips or waist	◯	◯	◯	◯
Sex drive reduced or lacking	◯	◯	◯	◯
Tendency to ulcers, colitis	◯	◯	◯	◯
Increased sugar tolerance	◯	◯	◯	◯
Women: menstrual disorders	◯	◯	◯	◯
Young girls: lack of menstrual function	◯	◯	◯	◯

Group 7E

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Dizziness	◯	◯	◯	◯
Headaches	◯	◯	◯	◯
Hot flashes	◯	◯	◯	◯
Increased blood pressure	◯	◯	◯	◯
Hair growth on face or body (unusual for female)	◯	◯	◯	◯
Sugar in urine (not diabetes)	◯	◯	◯	◯
Unusual masculine tendencies (female)	◯	◯	◯	◯

Group 7F

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Weakness, dizziness	◯	◯	◯	◯
Chronic fatigue	◯	◯	◯	◯
Low blood pressure	◯	◯	◯	◯
Nails weak, ridged	◯	◯	◯	◯
Tendency to hives	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Arthritic tendencies	◯	◯	◯	◯
Perspiration increase	◯	◯	◯	◯
Bowel disorders	◯	◯	◯	◯
Poor circulation	◯	◯	◯	◯
Swollen ankles	◯	◯	◯	◯
Crave salt	◯	◯	◯	◯
Brown spots or bronzing of skin	◯	◯	◯	◯
Allergies - tendency to asthma	◯	◯	◯	◯
Weakness after colds, influenza	◯	◯	◯	◯
Exhaustion - muscular, nervous	◯	◯	◯	◯
Respiratory disorders	◯	◯	◯	◯

FEMALES

For Female Only

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Very easily fatigued	◯	◯	◯	◯
Premenstrual tension	◯	◯	◯	◯
Painful menses	◯	◯	◯	◯
Depressed feelings before menstruation	◯	◯	◯	◯
Menstruation excessive and prolonged	◯	◯	◯	◯
Painful breasts	◯	◯	◯	◯
Menstruate too frequently	◯	◯	◯	◯
Vaginal discharge	◯	◯	◯	◯

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Hysterectomy/ovaries removed	○	○	○	○
Menopausal hot flashes	○	○	○	○
Menses scanty or missed	○	○	○	○
Acne, worse at menses	○	○	○	○
Depression of long standing	○	○	○	○

For Women Only Symptoms
Last Cycle?

For Women Only Symptoms
Last Pap?

For Women Only Symptoms
Number of Miscarriages?

MALES

For Male Only

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Prostate Trouble	○	○	○	○
Urination difficult or dribbling	○	○	○	○
Night urination frequent	○	○	○	○
Depression	○	○	○	○
Pain on inside of legs or heels	○	○	○	○

	MILD (1-2x's/yr)	MODERATE (several x's/yr)	SEVERE (almost constant)	NEVER
Feeling of incomplete bowel evacuation	◯	◯	◯	◯
Lack of energy	◯	◯	◯	◯
Migrating aches and pains	◯	◯	◯	◯
Tire too easily	◯	◯	◯	◯
Avoids activity	◯	◯	◯	◯
Leg nervousness at night	◯	◯	◯	◯
Diminished sex drive	◯	◯	◯	◯

For Men Only Symptoms

Vasectomy?

Important for All!

Please list below the (up to) five main complaints you have in order of their importance (1 most important)

1.	
2.	
3.	
4.	
5.	