Functional Nutrition Intake Form

ALIGN CHIROPRACTIC WELLNESS CENTER, LLC

Date:_____

Account #_____ (office use only)

Personal Information

Name _____
Last First Middle Initial

DOB_____ Age_____

Address_____

City _____ State _____ Zip Code_____

Gender ☐Male ☐ Female

Phone Number_____ ☐Home ☐Mobile ☐Work

Email_____

Would you like to receive appointment reminders via ☐Text message ☐Email

Marital Status ☐ Married ☐ Single ☐Widowed ☐ Divorced/Separated

Occupation _____ Employer_____

Referral Source ☐ Doctor ☐ Friend/Family ☐ Online ☐ Print Ad ☐ Other_____

Emergency Contact Name_____ Phone_____

General Health information

Please rate your current health status: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What health issue(s) or problem(s) would you like to address:

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

Previous Treatments for the above health issues:

1. _____ Did this treatment help? ☐ No ☐ Yes
2. _____ Did this treatment help? ☐ No ☐ Yes
3. _____ Did this treatment help? ☐ No ☐ Yes
4. _____ Did this treatment help? ☐ No ☐ Yes

Are your health issues:

☐ Improving ☐ Staying the same ☐ Worsening ☐ Changing ☐ Other _____

Have you had this health issue or problem in the past ☐ No ☐ Yes

Have you had recent tests or imaging ☐ No ☐ Yes; Where_____

Have you consulted other health care professionals for this health issue? ☐ No ☐ Yes -_____

Past Surgeries, Accidents or Injuries:_____

Have you been diagnosed with the following conditions? Check all that apply:

☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Breast implants
☐ Breathing issue
☐ Cancer _____
☐ Depression
☐ Dementia
☐ Diabetes
☐ Food Sensitivities _____
☐ Fractures _____
☐ Gout
☐ Heart disease
☐ Hernia
☐ Herniated disc
☐ High blood pressure
☐ High cholesterol
☐ Immune disorder
☐ Kidney disease
☐ Migraine headaches
☐ Multiple sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's Disease
☐ Pneumonia
☐ Prostate problem
☐ Prosthesis _____
☐ Psychiatric condition
☐ Rheumatoid arthritis
☐ STDs/STIs _____
☐ Stroke/TIA
☐ TBI/Concussion
☐ Thyroid problem
☐ Tumors/growths
☐ Ulcers
☐ UTIs
☐ Vaginal infection
☐ Other _____

Current Medications and reason for use	Vitamins/Supplements and reason for use

Lifestyle

- Exercise ☐ None ☐ Moderate ☐ Daily
- Dietary Restrictions ☐ None ☐ Gluten ☐ Dairy ☐ Other_____
- Sleep Habits ☐ Back ☐ Side ☐ Stomach ☐ Other_____
  - Hours of sleep ____ Do you feel rested ☐ No ☐ Yes
- Habits ☐ Alcohol ☐ Smoking ☐ Caffeine ☐ High stress ☐ Other_____

Patient name _____ Date _____
Last name First name

Patient HIPAA Consent Form

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment or practice operations will be made only after obtaining your consent. You may request restrictions on your disclosures. In the future, we may contact you for appointment reminders, announcements and to inform you about our practice. I authorize the use of my full name for the purpose of greeting me, announcing me into a room or around the office in the presence of others. This is effective as of April 14, 2003 and remains in effect until further notice. I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan, and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and conduct normal healthcare operations such as quality assessments and physician's certificates. I have read and understand your Notice of Privacy Practices. A more complete description can be requested.

Signature_____ Date_____

Permission & Authorization for Nutritional Consultation & Testing

I authorize Align Chiropractic Wellness Center practitioners to perform a Functional Nutrition Consultation and Testing to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc., to assist me in improving my health, and not for the treatment, or "cure" of any disease.
I understand that Functional Nutrition Consultation & Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems. I understand that Functional Nutrition Consultation & Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Nutritional Consultation & Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Functional Nutrition Consultation & Testing may determine nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

If additional testing is required, lab testing fees will be paid to Align Chiropractic Wellness Center before testing kits are distributed to patients. Upon completion of testing, a team member will contact you to schedule an appointment to review your results. This may take up 2 weeks after the lab has received your samples.

I have read and understand the above information. This permission form applies to subsequent visits and consultations.

Signature_____ Date_____

Patient name _____ Date _____
Last name First name

SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ____/____/____ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

**If filling in via computer, use X's and spaces to fill in the circles as best you can, thank you!*

GROUP 1

	1	2	3	
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Gag occasionally
8	○	○	○	Unable to relax; startles easily
9	○	○	○	Extremities cold, clammy
10	○	○	○	Strong light irritates
11	○	○	○	Occasionally weak urine flow
12	○	○	○	Heart pounds after retiring
13	○	○	○	"Nervous" stomach
14	○	○	○	Appetite reduced occasionally
15	○	○	○	Cold sweats often
16	○	○	○	Get heated easily
17	○	○	○	Nerve discomfort
18	○	○	○	Staring, blinks little
19	○	○	○	Sour stomach frequent

GROUP 2

	1	2	3	
20	○	○	○	Joint stiffness on arising
21	○	○	○	Muscle-leg-toe cramps at night
22	○	○	○	"Butterfly" stomach, cramps
23	○	○	○	Eyes or nose watery
24	○	○	○	Eyes blink often
25	○	○	○	Eyelids swollen, puffy
26	○	○	○	Indigestion soon after meals
27	○	○	○	Always seems hungry; feels "lightheaded" often
28	○	○	○	Digestion rapid
29	○	○	○	Vomit occasionally
30	○	○	○	Hoarseness frequent
31	○	○	○	Uneven breathing
32	○	○	○	Pulse slow
33	○	○	○	Gagging reflex slow
34	○	○	○	Difficulty swallowing
35	○	○	○	Temporary constipation or diarrhea
36	○	○	○	"Slow starter"
37	○	○	○	Get "chilled"
38	○	○	○	Perspire easily
39	○	○	○	Sensitive to cold
40	○	○	○	Upper respiratory challenges

GROUP 3

	1	2	3	
41	○	○	○	Eat when nervous
42	○	○	○	Excessive appetite
43	○	○	○	Hungry between meals
44	○	○	○	Irritable before meals
45	○	○	○	Get "shaky" if hungry
46	○	○	○	Fatigue, eating relieves
47	○	○	○	"Lightheaded" if meals delayed
48	○	○	○	Heart palpitates if meals missed or delayed
49	○	○	○	Fatigue in afternoons
50	○	○	○	Overeating sweets upsets
51	○	○	○	Awaken after few hours sleep - hard to get back to sleep
52	○	○	○	Crave candy or coffee in afternoons
53	○	○	○	Moods of “blues” or melancholy
54	○	○	○	Craving for sweets or snacks

GROUP 4

	1	2	3	
55	○	○	○	Hands and feet go to sleep easily, numbness
56	○	○	○	Sigh frequently, "air hunger"
57	○	○	○	Aware of "breathing heavily"
58	○	○	○	High altitude discomfort
59	○	○	○	Opens windows in closed rooms
60	○	○	○	Immune system challenges
61	○	○	○	Afternoon "yawner"
62	○	○	○	Get "drowsy" often
63	○	○	○	Swollen ankles, worse at night
64	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
65	○	○	○	Difficulty catching breath especially during exercise
66	○	○	○	Tightness or pressure in chest, worse on exertion
67	○	○	○	Skin discolors easily after impact
68	○	○	○	Tendency to anemia
69	○	○	○	Noises in head, or "ringing in ears"
70	○	○	○	Fatigue upon exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

1 2 3

71 ○○○ Dizziness
72 ○○○ Dry skin
73 ○○○ Burning feet
74 ○○○ Blurred vision
75 ○○○ Itching skin and feet
76 ○○○ Hair loss
77 ○○○ Occasional skin rashes
78 ○○○ Bitter, metallic taste in mouth in mornings
79 ○○○ Occasional constipation
80 ○○○ Worrier, feels insecure
81 ○○○ Nausea occasionally after eating
82 ○○○ Greasy foods upset
83 ○○○ Stools light colored
84 ○○○ Skin peels on foot soles
85 ○○○ Discomfort between shoulder blades
86 ○○○ Occasional laxative use
87 ○○○ Stools alternate from soft to watery
88 ○○○ Sneezing attacks
89 ○○○ Dreaming, nightmare type bad dreams
90 ○○○ Bad breath (halitosis)
91 ○○○ Milk products cause upset
92 ○○○ Sensitive to hot weather
93 ○○○ Burning or itching anus
94 ○○○ Crave sweets

GROUP 6

1 2 3

95 ○○○ Loss of taste for meat
96 ○○○ Lower bowel gas several hours after eating
97 ○○○ Burning stomach sensations, eating relieves
98 ○○○ Coated tongue
99 ○○○ Pass large amounts of foul-smelling gas
100 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours after
101 ○○○ Watery or loose stool
102 ○○○ Gas shortly after eating
103 ○○○ Stomach "bloating"

GROUP 7

(A)

1 2 3

104 ○○○ Difficulty sleeping
105 ○○○ On edge
106 ○○○ Can't gain weight
107 ○○○ Intolerance to heat
108 ○○○ Highly emotional
109 ○○○ Flush easily
110 ○○○ Night sweats
111 ○○○ Thin, moist skin
112 ○○○ Inward trembling
113 ○○○ Heart races
114 ○○○ Increased appetite without weight gain
115 ○○○ Pulse fast at rest
116 ○○○ Eyelids and face twitch
117 ○○○ Irritable and restless
118 ○○○ Can't work under pressure

(B)

1 2 3

119 ○○○ Increase in weight
120 ○○○ Decrease in appetite
121 ○○○ Fatigue easily
122 ○○○ Ringing in ears
123 ○○○ Sleepy during day
124 ○○○ Sensitive to cold
125 ○○○ Dry or scaly skin
126 ○○○ Temporary constipation
127 ○○○ Mental sluggishness
128 ○○○ Hair coarse, falls out
129 ○○○ Tension in head upon arising wears off during day
130 ○○○ Slow pulse, below 65
131 ○○○ Changing urinary function
132 ○○○ Sounds appear diminished
133 ○○○ Reduced initiative

(C)

1 2 3

134 ○○○ Failing memory with age
135 ○○○ Increased sex drive
136 ○○○ Episodes of tension in head
137 ○○○ Decreased sugar tolerance

(D)

1 2 3

138 ○○○ Abnormal thirst
139 ○○○ Bloating of abdomen
140 ○○○ Weight gain around hips or waist
141 ○○○ Sex drive reduced or lacking
142 ○○○ Tendency for stomach issues
143 ○○○ Immune system challenges
144 ○○○ Menstrual disorders

(E)

1 2 3

145 ○○○ Dizziness
146 ○○○ Headaches
147 ○○○ Hot flashes
148 ○○○ Hair growth on face or body (female)
149 ○○○ Sugar in urine (not diabetes)
150 ○○○ Masculine tendencies (female)

(F)

1 2 3

151 ○○○ Weakness, dizziness
152 ○○○ Tired throughout day
153 ○○○ Nails weak, ridged
154 ○○○ Sensitive skin
155 ○○○ Stiff joints
156 ○○○ Perspiration increase
157 ○○○ Bowel discomfort
158 ○○○ Poor circulation
159 ○○○ Swollen ankles
160 ○○○ Crave salt
161 ○○○ Areas of skin darkening
162 ○○○ Upper respiratory sensitivity
163 ○○○ Tiredness
164 ○○○ Breathing challenges

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

	1	2	3	
165	○	○	○	Muscle weakness
166	○	○	○	Lack of Stamina
167	○	○	○	Drowsiness after eating
168	○	○	○	Muscular soreness
169	○	○	○	Heart races
170	○	○	○	Hyperirritable
171	○	○	○	Feeling of a band around your head
172	○	○	○	Melancholia (feeling of sadness)
173	○	○	○	Swelling of ankles
174	○	○	○	Change in urinary function
175	○	○	○	Tendency to consume sweets or carbohydrates
176	○	○	○	Muscle spasms
177	○	○	○	Blurred vision
178	○	○	○	Involuntary muscle action
179	○	○	○	Numbness
180	○	○	○	Night sweats
181	○	○	○	Rapid digestion
182	○	○	○	Sensitivity to noise
183	○	○	○	Redness of palms of hands and bottom of feet
184	○	○	○	Visible veins on chest and abdomen
185	○	○	○	Hemorrhoids
186	○	○	○	Apprehension (feeling that something bad will happen)
187	○	○	○	Nervousness causing loss of appetite
188	○	○	○	Nervousness with indigestion
189	○	○	○	Gastritis
190	○	○	○	Forgetfulness
191	○	○	○	Thinning hair

FEMALE ONLY

	1	2	3	
192	○	○	○	Very easily fatigued
193	○	○	○	Premenstrual tension
194	○	○	○	Menses more painful than usual
195	○	○	○	Depressed feelings before menstruation
196	○	○	○	Painful breasts during menses
197	○	○	○	Menstruate too frequently
198			○	Hysterectomy / ovaries removed
199	○	○	○	Menopausal hot flashes
200	○	○	○	Menses scanty or missed
201	○	○	○	Acne, worse at menses

IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

MALE ONLY

	1	2	3	
202	○	○	○	Less involved in exercise/social activities
203	○	○	○	Difficult to postpone urination
204	○	○	○	Weak urinary stream
205	○	○	○	Feeling of “blues” or melancholy
206	○	○	○	Feeling of incomplete bowel evacuation
207	○	○	○	Lack of energy
208	○	○	○	Muscles in arms and legs seem softer/smaller
209	○	○	○	Tire too easily
210	○	○	○	Avoids activity
211	○	○	○	Leg nervousness at night
212	○	○	○	Diminished sex drive

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.