Living Well New Patient Paperwork

1. Please enter your information.

Legal First Name: _____ Middle Initial: _____ Legal Last Name: _____ Preferred Name: _____

Date of Birth: _____

Gender:
○ Female ○ Male

Marital Status:
○ Single ○ Married ○ Domestic Partner
○ Separated ○ Divorced ○ Widowed

Street Address: _____ Apt./Unit #: _____ City: _____ State: _____ Zip Code: _____

Mobile Phone: _____ Home Phone: _____ Email: _____

Employment status _____ Occupation _____

How did you hear about us? _____

Emergency contact name, phone number and relationship _____

Preferred contact method:
○ Mobile Phone ○ Home Phonel

HSA and FSA often cover our services, do you have one?
☐ Yes ☐ No

2. Weight and height information

Your height: _____ Current weight: _____ Lowest adult weight: _____

Highest adult weight: _____ Desired weight: _____ Is your weight stable or up and down? _____

3. (Women only) Are you currently pregnant or nursing?

○ Yes, I'm pregnant ○ Yes, I'm nursing ○ No

4. Have you ever consulted a professional (Nutritionist / Dietician) about your nutrition? If yes, when was that? Please describe what concerns you had in mind then and how effective the consultation was.

_____

_____

_____

_____

5. Are you under consistent chiropractic care?

○ Yes ○ No

6. Would you like to learn which supplements can improve your health?

☐ Yes ☐ No

7. Please list your top major health concerns in order of importance, and indicate date of diagnosis (where relevant):

	Concern	Date
1		
2		
3		

8. Please list 1 to 5 health goals you would like to attain for yourself, in order of priority:

	Goal
1	
2	
3	
4	
5	

9. What problem areas would you like addressed? Please check all that apply.

☐ Love Handles ☐ Wrinkles / Age Spots ☐ Flabby Arms
☐ "Mommy Tummy" ☐ Turkey Neck ☐ Thighs
☐ Back Fat ☐ Cellulite ☐ Scars / Stretch Marks

10. What habits, activities or attitudes do you consider to have contributed to any of your problems?

_____
_____
_____
_____

11. On a scale of 1-10, with 10 meaning "I'm serious and am fully committed," what is your current level of commitment?

_____

12. Who is your biggest supporter when it comes to improving your health?

_____

13. If you have children, please list them and their age.

14. What do you want to achieve during your initial consultation visit?

15. Are you taking any of these medications? (Check all that apply)

- ☐ Chemotherapy Pills (such as Hydroxyurea)
- ☐ Dabigatran (Pradaxa)
- ☐ Prasugrel (Effient)
- ☐ Apixaban (Eliquis)
- ☐ Ticagrelor (Brilinta)
- ☐ Blood Thinners (Including Baby Asprin)
- ☐ Heparin (Any)
- ☐ Anti-Coagulants
- ☐ Warfarin (Coumadin)
- ☐ N/A
- ☐ Anti-Platelet Agents
- ☐ Clopidogrel (Plavix)
- ☐ Rivaroxaban (Xarelto)
- ☐ Dipyridamole

16. Please list any non-prescribed medications you take (laxatives, antihistamines, decongestants, aspirin, tylenol, etc.):

	Type	How Often?
1		
2		
3		

17. Please list any prescribed medications you take:

	Name	Dosage	Purpose?	How long?
1				
2				
3				

18. Supplements now or in the recent past:

	Name of supplement	Dosage	Duration	Benefits	Side effects
1					
2					

19. Do you use recreational drugs? If yes, please specify type and frequency.

	Type	Frequency
1		
2		

20. Allergies or sensitivities (foods, medications, pollen, animals, chemicals):

21. Do you follow a specific diet?

- ○ No
- ○ Vegetarian
- ○ Vegan
- ○ Low Fat
- ○ Low Carb
- ○ High Fiber
- ○ Other

If "other", please specify

22. Eating patterns. Check all that apply:

- ☐ Eat too much
- ☐ Eat too little
- ☐ Forget to eat
- ☐ Emotional eater
- ☐ Eat out of boredom
- ☐ Hungry all the time
- ☐ Late night snacking
- ☐ Fast eater
- ☐ Eat in the car
- ☐ Poor choices
- ☐ Healthy choices
- ☐ No joy in eating
- ☐ Other

If "other", please specify

23. What do you consider healthy food choices?

24. What do you consider poor food choices?

25. Are you pleased with your present diet? What would you like to change?

26. Have you tried to make these changes?

27. Have you tried any popular diets? If yes, which ones and for how long? What could have made them better?

28. How much water do you drink per day?

29. Do you drink coffee? If yes, how much per day?

30. Do you drink sodas? If yes, how much per day?

31. Do you drink alcohol? If yes, please specify:

How much alcohol do you consume per week?

Type of alcohol:

32. Smoking : Answer when applicable:

Do you smoke?
☐ Yes ☐ No ☐ I've quit

How much per day?

For how long?

When did you stop?

Do you work or live closely with a smoker?

33. Your activity level

Do you exercise regularly?
☐ Yes ☐ No

Type of exercise:

How often?

Length of sessions:

Do you sweat?
☐ Yes ☐ No

34. What level of stress do you consider yourself to be under?

○ Low ○ Moderate ○ High

35. How would you describe your bowel movement?

☐ Strained ☐ Loose ☐ Soft
☐ Hard ☐ Very thin ☐ Diarrhea
☐ Explosive ☐ Constipated ☐ Undigested food
☐ Blood in stool ☐ Mucus in stoll ☐ Regular
☐ Other

If "other", please specify

36. Please list all surgeries you have had:

	Surgery	When?
1		
2		
3		

37. Health history - Musculo-skeletal

☐ Headaches ☐ Joint stiffness/swelling ☐ Broken/fractured bones
☐ Back pain ☐ Hip pain ☐ Leg pain
☐ Problems walking ☐ Chest, ribs, abdominal pain ☐ Arthritis
☐ Osteoporosis ☐ Bone or joint disease ☐ Other

If "other", please specify

38. Health history - Skin

- ☐ Acne
- ☐ Allergies
- ☐ Hives
- ☐ Cosmetic surgery
- ☐ Athlete's foot
- ☐ Other
- ☐ Rashes
- ☐ Warts

If "other", please specify

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39. Health history - Reproductive system

- ☐ Hysterectomy
- ☐ PMS
- ☐ Prostrate concerns
- ☐ Endometriosis
- ☐ Menopause
- ☐ Other
- ☐ Pelvic inflammatory disease
- ☐ Fertility concerns

If "other", please specify

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40. Health history - Circulatory and respiratory

- ☐ Dizziness
- ☐ Cold feet or hands
- ☐ Blood clots
- ☐ Allergies
- ☐ High blood pressure
- ☐ Shortness of breath
- ☐ Night sweats
- ☐ Stroke
- ☐ Sinus problems
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Swollen ankles
- ☐ Heart condition
- ☐ Asthma
- ☐ Other

If "other", please specify

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41. Health history - Nervous system

- ☐ Spinal cord injury
- ☐ Twitching of face
- ☐ Sleep disorders
- ☐ Herpes/shingles
- ☐ Multiple sclerosis
- ☐ Other
- ☐ Chronic fatigue syndrome
- ☐ Fatigue
- ☐ Ulcers
- ☐ Cerebral palsy
- ☐ Muscular dystrophy
- ☐ Numbness/tingling
- ☐ Chronic pain
- ☐ Paralysis
- ☐ Epilepsy
- ☐ Parkinson's disease

If "other", please specify

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42. Health history - Digestive

- ☐ Nervous stomach
- ☐ Intestinal gas
- ☐ Diverticulitis
- ☐ Irritable bowel
- ☐ Indigestion
- ☐ Bloating
- ☐ Crohn's disease
- ☐ Food allergies
- ☐ Constipation
- ☐ Diarrhea
- ☐ Colitis
- ☐ Other

If "other", please specify

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43. Health history - Other

- ☐ Migraine
- ☐ Forgetfulness
- ☐ Hearing impaired
- ☐ Eating disorder
- ☐ Infectious disease
- ☐ Other
- ☐ Cancer
- ☐ Confusion
- ☐ Visually impaired
- ☐ Diabetes
- ☐ Anxiety
- ☐ Loss of appetite
- ☐ Depression
- ☐ Bladder infection
- ☐ Fibromyalgia
- ☐ Thyroid Disease

If "other", please specify

_____

44. How would your life change if you did not have the problems listed on this form?

_____

_____

_____

_____

45. Feel free to use the space below to inform us of any extra information pertinent to your health:

_____

_____

_____

_____

Metabolic Assessment

46. Category I Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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 amounts of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Do you use laxatives frequently	0	1	2	3

47. Category II Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

48. Category III Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

49. Category IV Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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, bloated	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

50. Category V Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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	No	Yes		

51. Category VI Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep your self going or awake	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

52. Category VII Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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 to 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

53. Category VIII Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

54. Category IX Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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
Excessively perspiration or perspiration with little or no activity	0	1	2	3

55. Category X Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

56. Category XI Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
Heart palpatations	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

57. Category XII Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

58. Category XIII Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

59. To be directed to the next appropriate set of questions, please select one:

○ Male ○ Menstruating Female ○ Menopausal Female

60. Category XIV (Males Only) Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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

61. Category XV (Males Only) Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
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 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
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

62. Category XVI (Menstruating Females Only) Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
Are you perimenopausal	No	Maybe	Probably	Yes
Alternating menstrual cycle lengths	0	1	2	3
Extended menses, greater than 32 days	0	1	2	3
Shortened menses, less than every 24 days	0	1	2	3
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
Irritably 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

63. Category XVII (Menopausal Females Only) Please check the appropriate number "0-3" on the questions below. 0 as the least/never to 3 as the most/always

	Least/Never	Occasionally	Frequently	Most/Always
How many years have you been menopausal?	0-3	3-6	6-10	10+
Do you ever have uterine bleeding since menopause	0	1	2	3
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 breast(s)	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