

Center for Well Being
7901 Xerxes Ave So
Suite 300
Bloomington, MN 55431

PLEASE FILL OUT COMPLETELY

Today's Date _____ Referred by: _____

Name: _____ Male: ___ Female: ___
First / Middle Initial / Last

Mailing Address: _____ City: _____

State: _____ Zip: _____ Birthdate: _____ Age: _____ Height: _____ Weight: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-Mail: _____

Social Security #: _____ Occupation: _____

Marital Status: ___ S ___ M ___ D ___ W No: of children: _____

Complaints Please rank your current complaints and rate their severity (on a scale of 1-10, 10 is severe)

Other information Please tell us any additional information that the doctor should know

Smoking: Do you currently smoke? _____ If yes, how much? _____ How long have you smoked? _____

Surgeries: What surgeries, operations, traumas, car accidents, etc. Have you had?

- a) Do you have breast implants? _____ Other surgical implants or prostheses? _____
- b) Have you had elective surgery (tummy tuck, face-lift, burned off moes, etc.)? _____
- c) Do you have any metal or plastic inside your body (such as pins, clamps, plates, etc.)? _____
- d) Do you have pierced ears or other body piercings? _____ Tattoos? _____

Current Medications: _____

Current Vitamins/Minerals: _____

Stress Please rate your current stress level (on a scale of 1 to 10, 10 being the highest): _____

What is the main reason(s) for your stress? _____

If over level 5, what step(s) are you taking to reduce your stress level? _____

Dental work Indicate how many of the following you have:

Silver fillings _____ Gold crowns or inlays _____ Posts _____ Bad bite _____

Composites (tooth colored) _____ Stainless steel crowns/inlays _____ Implants _____ New cavities _____

Extractions _____ Porcelain crowns/inlays _____ Braces _____

Bridgework _____ Veneers _____ Bleeding gums _____

Partial or full dentures _____ Root canals _____ Sensitive teeth _____

Do you need further dental work? _____ If so, what? _____

Name of your dentist: _____

Healthcare Recent Chiropractic Physician: name _____ Last seen: _____

Recent Medical Physician: name _____ Last seen: _____

Recent Laboratory tests done: _____

Significant findings: _____

Health Overview For the following questions, circle the phrases that apply to you

Sleep How is your sleep? (*restful, restless, hard to get to sleep, wake up often, get up during night, bad dreams*)

Other symptoms? _____

What time do you usually go to sleep? _____ Number of hours of sleep per night? _____

Type of mattress? (*box spring, water, air, futon*) Type and size of pillow? _____

Type of sheets, covers, bedding? (*100% cotton, polyester, blend*) _____

Digestion How is your digestion? (*adequate, poor, acid reflux or heartburn, burp often, bloated, nausea, vomiting, abdominal pain - high or low*)

Other symptoms? _____

Urination How are your daily urinations? (*every 2-3 hours, too frequent, sense of urgency, too small amount too large amount, burning, dribbling, up at night several times, discolored urine*)

Other symptoms? _____

Bowels How are your bowel eliminations? (*How often? 3/2/1 times daily, skip days Amount: normal, too little, too large Consistency: normal, too hard, very soft, diarrhea Color: brown, black, whitish or green Other: lots of mucus, lots of gas, foul smell, do they sink or float?*) Hemorrhoids? _____

Other symptoms? _____

Women Only: Are you pregnant? _____ Are you breast-feeding? _____ Do you have monthly periods? _____

Date of last menstrual period? _____ In menopause? _____ Have your periods stopped? _____

Had a hysterectomy? _____ If so, when? _____

Are your monthly periods regular (28 day cycle)? _____ Number of days of flow? _____

Circle any of the following symptoms you experience associated with your period: cramping, bloating, feeling weak, mood swings, cravings, heavy bleeding, back pain, headaches, bright red blood, dark clotty blood. Other menstrual symptoms? _____

Have you had a recent pap smear? _____ Mammogram? _____ Pelvic exam? _____

Do you take oral contraceptives? _____ If so, what type? _____

Do you take hormone replacements? _____ If so, what type? _____

Any additional symptoms or relevant information? _____

Pain Do you experience back pain? _____ Circle: Low back/mid back/upper back/rib cage area
Do you experience neck pain? _____ Circle: Stiff, dull, ache, sharp, spasms
Do you experience headaches? _____ Circle: front of head, sides, temples, top, back *How often?* _____
Do you have leg pains? _____ Circle: thigh/knee/calves, feet Numbness? _____
Do you have arm pains? _____ Circle: upper arm, forearm, wrist, hand Numbness? _____
Do you take pain medication? _____ If so, what type and how much? _____
Do you have other pain locations? _____ Where? _____
Have you had any other treatment of anything noted above? _____ If so, what? _____

Cardiovascular Circle: Fainting episodes, dizziness, blurred vision, rapid heart rate, skipped heart beats, chest constriction/pain, varicose veins, swollen feet/ankles, spider veins, high blood pressure, low blood pressure, shortness of breath, leg pains after exercise or rest. Other: _____
Current medications for any of these? _____

Brain/ Cognition Circle: Confusion, lack of concentration, spaciness, poor memory, "brain-fog", mood changes, agitated/anxiety, depression, Parkinson's, early onset dementia
Any other problems, or diagnosed issues? _____
Current medications for any of these? _____

Respiratory Circle: Frequent colds, flu Sinus infections Sinus drainage or sniffles Sneezing Allergies
Clearing throat Coughs(dry/mucus) Sore throats Bronchitis Asthma Reactive airways
Other: _____
Current medications for any of these? _____

Energy Levels How do you feel your energy level is? _____
Diagnosed with chronic fatigue syndrome? _____ Do you feel refreshed from sleep? _____

Diseases you have had (Circle)
Anemia, Arthritis, Bronchitis, Cancer, Chicken pox, Colitis, Crohn's, Diabetes, Eczema, Heart disease, Influenza, Measles, Pleurisy, Pneumonia, Polio, Rheumatic fever, Thyroid (low/high)
Other: _____

Exercise What kind of exercise do you do? _____
How often? _____ For how long a time? _____

Eyewear Do you wear contact lenses? _____ Glasses? _____ If so, how many hours a day? _____
Do your lenses have tints? _____ An anti-glare coating? _____ A scratch resistant coating? _____

Electromagnetic Exposure How many hours do you spend daily:
Watching TV? _____ Working on a computer? _____ Talking on a phone? _____ Talking on a cellular phone? _____
Wearing a pager? _____ Wearing a headset? _____ Wearing a wrist-watch (with battery)? _____
Riding in a car/truck/vehicle? _____ Near electrical equipment for long periods of time (such as copy machines, high power lines, computers, etc. _____ When you sleep, is your head within 10 feet of a plug-in clock (such as on a night stand)? _____

Clothing How often do you wear 100% natural clothing (cotton, ramie, wool, silk, linen, etc.)? _____
Synthetic clothing (polyester, acrylic, nylon, etc.)? _____ Blends? _____

Personal Care Products List the brand names that you use (*Please take time to complete this list.*)

Shampoo? _____ Shave Cream? _____
Cream rinse? _____ Deodorant? _____
Toothpaste? _____ Soap? _____
Hand body lotion? _____ Facial Cleanser/Moisturizer? _____
Hair spray/gel? _____ Personal (sexual) lubricant? _____
Hair dye? _____ Contraceptive jelly/spermicide? _____
Hair permanent? _____ Fingernail/Toenail polish? remover? _____
Face make-up? _____ Eye make-up? _____
Glass Cleaner? _____ Perfume/Cologne? _____
Dish washing soap? _____ Laundry soap? _____
Tub/Tile Cleaner? _____ Oven Cleaner? _____
All Purpose Cleaner? _____ Roach/ant spray? _____
Toilet Freshener? _____ Carpet Cleaners? _____
Other chemical exposures (*from yard, workplace, art chemicals, etc.*)? _____

Appliances Circle which of the following you use:

Gas stove Electric stove Electric heater Electric blanket Water bed Microwave Juicer VitaMix
Air purifier (*Brand: _____*) Water Purifier (*Brand: _____*)

Cookware What type of cookware do you use? *Circle* Stainless steel, aluminum, iron, teflon-coated,
glass, Corning, non-stick brands Other types: _____

Shower Filter Do you use a chlorine protection filter? _____ Brand: _____
When was your filter last changed? _____

Pets Do you have a pet(s)? _____ If so, what kind/how many? _____
Is it allowed in the house? _____ On your bed? _____ Do you use flea powders on the carpets? _____
What do you feed your pet(s)? _____

Family Health History

Next to the name of disease, denote F (father) M (mother) S (sister) B (brother) G (grandparent)

Alzheimer's _____ Arthritis _____ Asthma _____ Cancer _____ Diabetes _____
Depression _____ Epilepsy _____ Heart disease _____ High blood pressure _____
Liver disease _____ Parkinson's _____ Other: _____

Food Choices Circle each type of food you eat often:

1. Pre-made foods: a) canned food b) boxed cereals c) frozen dinners d) bottled/frozen juices e) take-out food
2. Red meat: (beef, pork, lamb) a) commercially grown b) organically raised
3. Chicken: a) commercially grown b) organically raised
4. Turkey: a) commercially grown b) organically raised
5. Fish: a) canned tuna b) fresh fish c) frozen fish d) at restaurants Favorites: _____
6. Fresh vegetables: a) commercially grown (*store-bought*) b) organically grown (*store-bought, self, farmer*)
7. Fresh fruit: a) commercially grown (*store-bought*) b) organically grown (*store-bought, self, farmer direct*)
8. Whole grains: a) commercially grown (*store-bought*) b) organically grown
9. Beans/Peas: a) commercially grown (*store-bought*) b) organically grown
10. Eggs/Butter: a) regular eggs b) organic eggs c) commercial or organic butter? d) Margarine use? _____
11. Milk: a) commercial milk b) organic milk c) goat's milk
12. Cheese: a) commercial cheese b) organic cheese c) Feta or sheep cheese
13. Oils: a) commercial oils type: _____ b) organic oils type: _____
14. Condiments: a) artificial sweeteners (*NutraSweet/Equal, Sweet'N low, Coffeemate, Saccharin, etc.*)
b) commercial salt and pepper c) sea salt d) commercial ketchup or mustard e) commercial vinegar
c) commercial mayonnaise, salad dressings

Food Stressors Circle which of the following you have every week. Indicate how many times per week.

<u>Stimulants</u>	<u>Toxic Oils</u>	<u>Commercial Dairy</u>	<u>Highly heated foods</u>
Coffee (includ. decaff)	Fried Foods	Cow's milk	Bread (store-bought)
Black tea	Fast food	Yogurt	Crackers (store-bought)
Soft drinks/pops	Potato/corn chips	Ice Cream	Bagels (store-bought)
Drinks w/NutraSweet	Roasted nuts	Cottage cheese	Buns (store-bought)
Alcohol	Mayonnaise	Sour cream	Pasta (store-bought)
Chocolate	Margarine	Cheese(regular)	Muffins (store-bought)
Candy, pastries, sweets	Peanut butter (commercial)		Cookies (store-bought)

Food Habits

1) **Eating Out** Do you eat out at restaurants? ____ If yes, how often? ____ Where? ____
 What type of food do you eat there? _____

2) **Home Meals** Do you prepare meals at home? ____ If so, how often? ____
 If yes, what type of food do you prepare? _____

3) **Meal Habits** Do you (circle) a) skip meals often b) have irregular eating times
 c) Eat past 7 PM d) love to eat junk food or snacks in the evening

4) **MSG** Do you avoid food/drinks that list "natural flavors" on the label? _____

5) **Water** Do you drink tap water? ____ Bottled water? ____ If yes, what is the brand? ____
 If you have a home water purifier, when was the cartridge last changed? _____

Typical Diet Please fill out typical diet for the last few weeks. Please be as detailed as possible. For example, instead of writing 'chicken', identify how it was made such as baked, fried, etc. Instead of writing 'salad', identify what was in the salad and type of dressing. *Please be honest.*

BREAKFAST: (Time eaten: _____) _____

LUNCH: (Time eaten: _____) _____

DINNER: (Time eaten: _____) _____

SNACKS (Time eaten: _____) _____

Patient Agreements

I understand that health and accident insurance policies are an agreement between an insurance carrier and myself. I understand that any future insurance problems, situations, etc. that arise with my insurance carrier will have to be addressed by myself.

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment of all services and products.

I understand that I am responsible for payment of any laboratory services that are prescribed for me by the doctor at the time the kit is received. I further understand that if I return a prepaid laboratory test kit for a refund of moneys, there will be a \$50.00 administrative processing fee, and that the return of funds may take up to 30 days from the time of the test kit return. In addition, I understand that there will be no return of funds if I choose to return prepaid laboratory test kits after 90 days.

If I am prescribed nutritional supplementation and elect to purchase these products it is my understanding that I cannot return for refund any refrigerated items at any time or any other product after 90 days. A 15% restocking fee may be charged for returned products.

I hereby authorize the doctor to treat my conditions(s). The doctor will not be held responsible for any pre-existing medically diagnosed condition (by another doctor), or any previous medical diagnosis.

*****Attention Blue Cross Blue Shield insurance patients:**

The doctors of this clinic are providers with Blue Cross Blue Shield of Minnesota for chiropractic services only. Specialized laboratory test procedures, acupuncture, laser and nutritional consultations are considered a non covered service through this office and I fully understand that I am responsible for the payment of these services in full at the time services are received. I understand completely that these services will not be submitted to Blue Cross Blue Shield or any of their affiliate companies. I understand that there may be treatment and fee schedule limitations that I will have to abide by for chiropractic services.

If I have an insurance deductible with Blue Cross Blue Shield for covered services, I understand and agree to pay in full for all services until I have met the deductible amount.

The applied kinesiology testing procedure portion of the initial chiropractic exam is a non-covered service. I understand and agree to personally pay that portion in full.

The insurance company does not pay for all reexaminations under chiropractic. I will be personally responsible for them.

Nutritional supplements, pillows, orthotics or other miscellaneous supplies are non-covered items.

I have read and fully understand the above information regarding laboratory tests, insurance and payments and I am clear on the policy of this clinic. The above policy applies to all future testing and treatment as well.

X_____

Patient/Parents Signature

Date

X_____

Printed Name

Medical Symptoms Questionnaire

Name _____

Date _____

Rate each of the following symptoms based upon your typical health profile for:
Past 30 days

Point Scale

- 0 - *Never or almost never* have the symptom
- 1 - *Occasionally* have it, effect is *not severe*
- 2 - *Occasionally* have it, effect is *severe*
- 3 - *Frequently* have it, effect is *not severe*
- 4 - *Frequently* have it, effect is *severe*

HEAD

Headaches
Faintness
Dizziness
Insomnia

Total

EYES

Watery or itchy eyes
Swollen, reddened or sticky eyelids
Bags or dark circles under eyes
Blurred or tunnel vision

(does not include near or far-sightedness) Total

EARS

Itchy ears
Earaches, ear infections
Drainage from ear
Ringing in ears, hearing loss

Total

NOSE

Stuffy nose
Sinus problems
Hay fever
Sneezing attacks
Excessive mucus formation

Total

MOUTH/THROAT

Chronic coughing
Gagging, frequent need to clear throat
Sore throat, hoarseness, loss of voice
Swollen or discolored tongue, gums, lips
Canker sores

Total

SKIN

Acne
Hives, rashes, dry skin
Hair loss
Flushing, hot flashes
Excessive sweating

Total

HEART

Irregular or skipped heartbeat
Rapid or pounding heartbeat
Chest pain

Total

LUNGS

Chest congestion

	_____	Asthma, bronchitis	
	_____	Shortness of breath	
	_____	Difficulty breathing	Total _____
DIGESTIVE TRACT	_____	Nausea, vomiting	
	_____	Diarrhea	
	_____	Constipation	
	_____	Bloated feeling	
	_____	Belching, passing gas	
	_____	Heartburn	
	_____	Intestinal/stomach pain	Total _____
JOINTS/MUSCLE	_____	Pain or aches in joints	
	_____	Arthritis	
	_____	Stiffness or limitation of movement	
	_____	Pain or aches in muscles	
	_____	Feeling of weakness or tiredness	Total _____
WEIGHT	_____	Binge eating/drinking	
	_____	Craving certain foods	
	_____	Excessive weight	
	_____	Compulsive eating	
	_____	Water retention	
	_____	Underweight	Total _____
ENERGY/ACTIVITY	_____	Fatigue, sluggishness	
	_____	Apathy, lethargy	
	_____	Hyperactivity	
	_____	Restlessness	Total _____
MIND	_____	Poor memory	
	_____	Confusion, poor comprehension	
	_____	Poor concentration	
	_____	Poor physical coordination	
	_____	Difficulty in making decisions	
	_____	Stuttering or stammering	
	_____	Slurred speech	
	_____	Learning disabilities	Total _____
EMOTIONS	_____	Mood swings	
	_____	Anxiety, fear, nervousness	
	_____	Anger, irritability, aggressiveness	
	_____	Depression	Total _____
OTHER	_____	Frequent illness	
	_____	Frequent or urgent urination	
	_____	Genital itch or discharge	Total _____
GRAND TOTAL			TOTAL _____