Name_____ Date: _____

Current Health Profile

We ask these questions in order to locate potential causes of your current health problems. We are not here to judge you. Your honest answers will give us the ability to better address how to improve your future health. **Please total scores on all pages and write the total at the end *before* bringing it in to your initial exam appointment. Thank you.**

You are What you eat

1. Do you eat more packaged (frozen/canned) fruits and vegetables than fresh? ___Yes (5) ___No (0)
2. Do you eat more cooked vegetables than raw? ___Yes(3) ___No(0)
3. How many meals per day do you include vegetables? ___0(10) ___1-2(5) ___3(0)
4. Do you buy more non-organic vegetables than organic? ___Yes(5) ___No(0)
5. How often do you use a microwave oven?
   ___ never/very rarely (0) ___1-2 times per wk (5) ___3-4 times per wk (10) ___4+ times per wk (15)
6. How often do you consume cereal, whole grain products, pasta, or bread?
   ___ never/very rarely (0) ___1-2 times per wk (5) ___3-4 times per wk (10) ___4+ times per wk (15)
7. Do you eat quick cook grains such as pasta, quick oats, or minute rice more often than slow cooked organic whole grains? ___Yes(10) ___No(0)
8. How often do you consume pasteurized/homogenized milk or cheese?
   ___never/very rarely (0) ___1-2 per wk (3) ___3 per wk (5) ___3+per wk (10)
9. Do you typically eat store bought eggs from cage-raised chickens (as opposed to free-range eggs)?
   ___Yes(10) ___No(0)
10. Do you eat commercially raised meat more than once every four days? ___Yes(10) ___No(0)
11. Do you commonly eat meats (beef, chicken, turkey) from sources other than a free-range and hormone-free source? ___Yes(10) ___No(0)
12. Do you eat canned fish more frequently than fresh fish? ___Yes(5) ___No(0)
13. How often do you use products containing hydrogenated oils?
    ___never/rarely(0) ___once per wk (1)___twice per wk (3) ___2+times per wk (5)
14. Do you eat nuts and /or seeds that are roasted and /or salted? ___Yes(3) ___No(0)
15. How often do you use white table sugar as a sweetener?
    ___never/rarely(0) ___once a wk (3) ___2-3 times per wk (5) ___3+ times per wk (10)
16. How often do you use artificial sweeteners such as Sweet-n-low, Equal, or NutraSweet?
    ___never/rarely(0) ___ once a wk (5) ___2-3 times per wk (10) 3+ times per wk (20)
17. Do you use standard white table salt? ___Yes(5) ___No(0)
18. Do you eat TV dinners or processed foods more than three times a week? ___Yes(10) ___No(0)

19. How often do you eat from fast food restaurants like McDonald's, Wendy's, etc?

___never/rarely(0) ___1-2 times per wk (5) ___3 times per wk (10) ____3+ times per wk (20)

20. How often do you eat snacks from vending machines? ___never/rarely(0)

___1-2 times per wk (5) ___3 times per wk (10) ___3+ times per wk (20)

21. Do you drink city tap water? ___Yes(10) ___No(0)

22. How often do you eat some form of store-bought dessert such as ice cream, cookies, donuts, cakes, or pies?

___never/rarely(0) ___once a wk (5)___2-3 times per wk (10) ___3+times per wk (15)

23. Do you take a probiotic supplement (containing L. plantarum) daily?

___daily(0) ___ once per wk (5) ___only after antibiotics (10) ___never(15)

24. Do you take at least 4,000mg of pharmaceutical grade fish oil supplement?

___daily(0) ___once per wk (5) ___ every few days(10) ___never(15)

25. Do you take at least 1,000 IU (per 40 lbs of body weight) of a Vitamin D supplement?

___daily(0) ___once per wk (5) ___ every few days(10) ___never(15)

26. How much alcohol do you consume? ___none(0) ___once per wk (5) ___several days per wk (10)

___daily(15)

You are What you Eat Total Score _____

You are When you eat

1. Do you frequently skip meals? ___Yes (5) ___No (0)
2. How often do you skip breakfast?

___never/rarely(0) ___2 times per wk (1) ___3 times per wk (5) ___3+times per wk (10)

3. Do you avoid fats when eating? ___Yes(5) ___No(0)
4. Do you frequently eat carbohydrates? (i.e. breads, bagel, pasta, fruit, cereals, muffins, crackers, chocolate, or candy)? ___Yes(10) ___No(0)
5. Do you often get hungry or crave sweets within two hours after eating meals? ___Yes(5) ___No(0)
6. How often do you consume drinks containing caffeine and/or sugar (i.e. coffee, tea, sodas, fruit juices, corn syrup or added sugar)? ___never/rarely(0) ___1 cup a day(5) ___2 cups a day(10) ___> 2 per day (15)
7. Have you tried diets to lose weight?

___no(0) ___once(1) ___twice(2)___3-5 times(5) ___more than five times(10)

8. Do you have difficulty burning fat around your belly, hips or thighs even with regular exercise?

___Yes (3) ___No (0)

9. Do you eat your largest meal in the evening? ___Yes(5) ___No(0)

You are When you eat Total Score_____

Digestion

1. How often do you experience lower abdominal bloating?
   ___never/rarely(0) ___ 1-2 times per wk (3) ___3 times per wk (5) ___3+ times per wk (10)
2. Do you frequently have loose stools or diarrhea? ___no(0) ___once a wk (5) ___3or more times per wk (10)
3. How often do you experience constipation or stools that are compact/hard to pass?
   ___never/rarely (0) ____1-2 times per wk (5) ___3 or more times per wk (10)
4. Do you find that you often burp after meals? ___Yes(3) ___No(0)
5. Do you frequently have gas? ___Yes(3) ___No(0)
6. Do you crave certain foods such as bread, chocolate, certain fruit, and dairy products if you have not eaten them in a day or two? ___Yes(5) ___No(0)
7. How often do you have a poor appetite and/or feel worse after eating?
   ___never/rarely (0) ___1-2 times per wk (3) ___3 times per wk (5) ___more than 3 times per wk (10)
8. Do you frequently (more than twice a week) experience abdominal pain, cramps, or general abdominal discomfort? ___Yes(20) ___No(0)
9. How often do you have indigestion, heartburn or an upset stomach?
   ___never/rarely (0) ___1-2 times per wk (3) ___3 times per wk (5) ___more than 3 times per wk (10)
10. How often do you get a headache after eating?
    ___never/rarely (0) ___1-2 times per wk (5) ___3+ times per wk (10)
11. How frequently do you have bowel movements? ___with each meal(0) ___once per day(1)
    ___every few days (3) ___only when taking something to help stay regular (5)

Digestion Total Score_____

Possible Toxicity Indicators

1. Have you ever been given general anesthesia? ___Yes(10) ___No(0)
2. Have you ever taken antibiotics? ___Yes(10) ___No(0)
3. Have you been or are you being treated for any condition requiring that you take medical drugs?
   ___Yes(10) ___No(0)
4. How many bowel movements do you have per day? ___ not every day(10) ___1-2 (5) ___ 3-4 (0)
5. Would you consider your life to be: ___stress free(0) ___mildly stressful(5) ___very stressful(10)
6. Do you have metal fillings in your mouth? ___Yes(10) ___No(0)
7. Do you experience itching in the ears, nose, or rectal area? ___Yes(10) ___No(0)
8. Do you have or have you had dandruff in the past year? ___yes(10) ___No(0)

9. Do you regularly eat or drink products containing sugar, white flour, or processed dairy products?

___Yes(10) ___No(0)

10. Do you crave sugar, fruit, or milk if you don't have either of these items for more than 3 days?

___Yes(10) ___No(0)

11. Do you experience muscle or joint aches on a regular basis? ___Yes(5) ___No(0)
12. Do you experience mood swings? ___Yes(10) ___No(0)
13. Do you suffer from any kind of skin condition? ___Yes (20) ___No (0) What? _____-

Possible Toxicity Indicators Total Score_____

Stress

1. On average, over the past 30 days, I would rate my overall level of PSYCHOLOGICAL/EMOTIONAL STRESS as: ___ High (20) ___ Medium (10) ___ Low (5) ___ None (0)
2. Do you eat more when stressed than when not stressed? ___More (10) ___Same/less (0)
3. Do you worry over job, income or money problems? ___Yes(10) ____No(0)
4. Are any of your relationships causing you stress? ___Yes(10) ___No(0)
5. Do you often feel anxious? ___Yes(5) ___No(0)
6. Do you sometimes lash out at others? ___Yes (5) ___No (0)
7. Do you feel your sex drive is lower than normal for someone your age? ___Yes (5) ___No (0)
8. Do you feel isolated or lonely? ___Yes (5) ___No (0)
9. Do you take any form of medication prescribed by a physician directly or indirectly related to stress in your life or for a psychological disorder? ___Yes (15) ___No (0)

Stress Total Score_____

Sleep Wake Cycles

1. How often do you wake up feeling un-rested and in need of more sleep?

___Never/rarely (0) ___once a wk (1) ___3 times a wk (5) ___3+ times per wk (10)

2. Do you commonly go to bed after 10:00PM? ___Yes (10) ___No (0)
3. Do you sleep on your stomach or in the fetal position? ___Yes (10) __No (0)
4. How often do you wake up at night between 1 and 4 and have a hard time falling back to sleep?

___Never/rarely (0) ___once a week (1) ___3 times per week (5) ___3+ times per week (10)

Sleep Wake Cycle Total Score_____

Exercise – Answer these questions based the <u>On Average, over the Past 30 Days</u>:

1. I perform at least 30 minutes of exercise the following number of DAYS per WEEK:

___7 (0) ___6 (0) ___5 (2) ___4 (5) ___3 (7) ___2 (10) ___1 (13) ___0 (15)

2. I perform exercise with weights or resistance bands? ___Yes (0) ___No (5)

3. I perform stretches as often as I exercise? ___Yes (0) ___No (5)
4. I typically SIT at work/school, commuting, and during my leisure time for the following number of combined HOURS per DAY (only count the hour if you do not get up and take a spinal mobility break in that hour)? ___Never/rarely (0) ___1-2 hours (1) ___2-4 hours (3) ___More than 6 hours (10)
5. I perform SPINAL CONDITIONING exercises (exercises to strengthen spinal postural muscles) and SPINAL HYGIENE exercises (exercises to improve range of motion and posture) the following number of DAYS per WEEK: ___7 (0) ___6 (0) ___5 (2) ___4 (5) ___3 (7) ___2 (10) ___1 (13) ___0 (15)
6. I would rate my current overall FUNCTIONAL ABILITY (mobility, balance, strength) to perform physical activities of daily life as: ___Very Low (20) ___ Fair (10) ___ Good (5) ___ Excellent (0)

Please describe the type and duration of daily exercises you currently do:

_____

_____

_____

Exercise Total Score_____

Misc.

1. I understand my current health issues are affected by or a result of my past/current life styles.
___Yes (0) ___No (10)
2. Is there anything that you know you could do to improve your health but you are not currently doing?
___Yes (5) ___No (0)
3. Do you smoke? ___Yes (20) ___No (0)
4. Are you within a reasonable range of the recommended weight for your body type? ___Yes (0) ___No (10)
5. Do you have your nervous system evaluated by a chiropractor for subluxation at least every 2-4 weeks?
___Yes (0) ___No (10)
6. During my lifetime, I have suffered the following number of SIGNIFICANT SPINAL TRAUMAS or INJURIES (from falls, accidents, work or sport activities, etc.) that have resulted in neck or back pain, and/or the need to limit activities for more than one week and for which I did not receive at least 12 visits of acute chiropractic care in the first 6 weeks following the injury/trauma:
__0(0) __1(3) __2(5) __3(10) __4+(15)

Misc Total Score_____

(Overall Total Score_____)

****<u>During your new patient appointment you will be doing a few functional fitness exercises: squats, push-ups, plank, & balance – please be sure to wear something comfortable that you can move freely in.</u>**
<u>Also please make sure to bring all your paperwork filled out completely.</u>

What 3 behaviors/activities that if you chose to eliminate would create a benefit to your current and future health?

1. _____

2. _____

3. _____

What do you feel is a limiting factor(s) to accomplishing these 3 changes in the next 12 months?

_____

_____

_____

What 3 behaviors/activities that if you chose to add would create a benefit to your current and future health?

1. _____

2. _____

3. _____

What do you feel is a limiting factor(s) in accomplishing this in the next 12 months?

_____

_____

_____