Name _____ Date ____/____/_____

PATIENT#: _____ Kings Canyonc Chir

DATE: _____/_____/_____ 4842 E Kings Canyo

AGE: _____ 559-255-7121

BIRTH DATE: _____/_____/_____ MALE or FEMALE

NAME: _____

ADDRESS: _____

CITY / STATE / ZIP: _____

HOME PHONE #: _____ WORK PHONE#: _____

CELL#: _____ BEST TIME & NO. TO CONTACT: _____

E-MAIL ADDRESS: _____

OCCUPATION _____

EMPLOYER'S NAME AND ADDRESS: _____

CITY / STATE / ZIP: _____

SINGLE: MARRIED: DIVORCED: WIDOWED:

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

Your Health and Weight Loss Profile

Why This Form Is Important

We focus on your ability to be well. Our goals are to first address the issues that brought you to this office and Second, to offer you the opportunity of improved health, wellness and quality of life in the future

On a daily basis we all experience physical, biochemical and psychological/emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual and may not even be felt until they become serious. Answering the following questions will give us a profile of the specific stresses past and present that you face and allow us to better assess the challenges to your health potential.

How many inches of fat do you want to lose? And where?

_____

_____

1. Have you tried to lose weight before?

Since the Problem Started is it . . About the Same ☐ Getting Worse ☐ Getting Better ☐

What makes it worse? _____

What makes it better? _____

2. What have you done to change your mindset and reset your weight-o-stat _____

Signature: _____ Date ____/____/_____

Name _____ Date ____/____/_____

What have you all done that was of no help to lose the fat?

Is this or other conditions interfering with your: ☐ Work ☐ Leisure ☐ Sleep ☐

☐ Positive Mental Attitude ☐ Sports ☐ Exercise ☐ Walking ☐ Energy ☐

☐ Other:

4. Have you had to, or feel you may need to make any positive changes in your life due to your condition? (i.e. eat better, less alchohol or drugs, skipping meals, eating less, actiity, exercise, refined carbs, etc.) if so, what?

Other Doctors seen for this condition: ☐ Chiropractor ☐ Medical Dr. ☐ Other

Name/Address

Date: ____/____/_____ What was the diagnosis?

What was done?

Other Health Concerns (If any): List health concerns or leave blank	Rate of Severity 1 = mild 10 = worst imaginable	When did this episode start	If you had the condition before, when	Did problem begin with an injury
1				
2				
3				
4				

Possible Contraindications

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

Current/Past	y Pregnant? ☐ yes ☐ No	
☐ Thyroid Problems		
☐ Cancer	☐ Photo Sensitive	☐ Epilepsy
☐ Pacemaker	☐ Liver Problems	
☐ Minor	☐ Kindey Problems	

General History

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem:

Current/Past	ent/Past	Current/Past	ent/Past
☐ Headaches	☐ Pins and needles in legs	☐ Fainting	☐ Neck pain
☐ Pins and needles in arms	☐ Loss of smell	☐ Back Pain	☐ Loss of balance
☐ Dizziness	☐ Buzzing in ears	☐ Ringing in ears	☐ Nervousness

Signature: _____ Date ____/____/_____

Name _____ Date ____/____/_____

☐ Numbness in fingers	☐ Numbness in toes		☐ Loss of taste	☐ Stomach Upset
☐ Fatigue	☐ Depression		☐ Irritability	☐ Tension
☐ Sleeping problems	☐ Stiff Neck		☐ Cold Hands	☐ Cold Feet
☐ Diarrhea	☐ Constipation		☐ Fever	☐ Hot Flashes
☐ Cold Sweats	☐ Lights bother eyes		☐ Urinary Problem	☐ Heartburn

5. Pain

List any drugs you are taking and why: (prescription and non-prescription) _____

Have you had any surgery? (Please include all surgery)

1 Type _____ Date ____/____/_____ Dr. _____

2 Type _____ Date ____/____/_____ Dr. _____

3 Type _____ Date ____/____/_____ Dr. _____

6. Please list your top three (or more) stresses in each category:

1 Physical stress (falls, accidents, work postures, etc.)

a _____

b _____

c _____

2 Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs, etc.)

a _____

b _____

c _____

3 Psychological stress (work, relationships, finances, self-esteem, etc.)

a _____

b _____

c _____

Comments: _____

On a scale of 1-10 describe your psychological/emotional stress levels: (1= none/ 10=extreme)

Personal Level: _____ Occupational Level _____ Other: _____

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating Habits _____ Exercise Habits _____ Sleep: _____

General health _____ Mind-set: _____ Mental Exercise: _____

Have you ever:	Yes	No
7. Consume Caffien?	☐	☐

Signature: _____ Date ____/____/_____

Name _____Date ____/____/_____

	8. Poor Sleep Habits - problems falling asleep, waking up, waking up tired?		☐		☐
	9. Ever checked your nerves for proper nerve function?		☐		☐
	10. Ever exposed to some of the 60,000 toxins in todays world?		☐		☐
	I consent to a professional and complete examination if needed & to any examination that the doctor deems				
	necessary. I understand that any fee for service rendered is due at the time of service and cannot be payed later.				

Signature: _____Date ____/____/_____

Name _____ Date ____/____/_____

Signature: _____ Date ____/____/_____

Name _____ Date ____/____/_____

Hobbies

Family

Are your symptoms constant or intermitent

Signature: _____ Date ____/____/_____

Name _____Date ____/____/_____

Signature: _____Date ____/____/_____

Name _____Date ____/____/_____

Signature: _____Date ____/____/_____