Nutrition

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Welcome!

Thank you for making this appointment with us. We are excited that you have chosen us to help you in your quest for optimal health and wellness! It is our goal to provide you with the tools you need to reach your specific health goals. This packet is your first step in doing this. Please fill out the following pages and let us know if you have any questions.

Patient Information

Name:_____ Date:_____/_____/_____

Street Address:_____ Apt #:_____

City:_____ State:_____ Zip:_____

Cell#:_____ Home#:_____ Work#:_____

Email:_____ Number of children: _____

Birth Date:_____/_____/_____ Age:_____ Sex:_____ Marital Status:_____

Occupation: _____ Place of employment: _____

Emergency Contact: _____ Relation: _____ Phone #:_____

How did you hear about us?:_____
If you were referred by a friend or family member who is currently a patient of ours, do we have permission to use your first name when thanking them? _____

May we leave messages regarding your personal healthcare information on your answering machine? _____ If yes, which phone number? _____

What are the top health goals you wish to achieve through our office?

_____

Nutritionally, what are some ways you envision that I can help you achieve these goals?

_____

If you need additional writing space, please write on the back or attach separate paper.
List any known allergies you have (eg. environmental, food, herbs etc.).

List any illness(es)/disease(s) you have *previously* been diagnosed with?

List any of the above illness(s)/disease(s) that you *currently* have.

List any surgeries you have had and what year you had them.

List any *prescribed* medications you are currently taking and list their intended purpose.

List any *over-the-counter* medications you are taking and list their intended purpose.

List any *nutritional supplements*/herbs you are currently taking and their intended purpose.

Height: _____ Weight: _____

Do you drink alcohol? _____ If yes, how many drinks per week? _____

Do you smoke or use tobacco? _____ If yes, how many much per day? _____

List any physical activity you are involved in on a regular basis.

List your 3 favorite foods _____

List any foods you couldn't force yourself to like if you tried _____

_____

List your 3 favorite activities to do for fun _____

Women only: Are you pregnant? _____ Are you planning to become pregnant soon? _____
Have you been trying to become pregnant but have been unable to? _____
If menstruating, is your cycle regular? _____ Is your flow normal? _____

Is there anything else you would like us to know about you?

Please review below the listed conditions and indicate health problems of yourself or family members by placing an "X" in the column.

CONDITION	SELF	MOTHER	FATHER	SIBLINGS	CHILDREN
Anemia					
Anxiety/Irritability					
Arthritis					
Asthma					
Cancer					
Constipation					
Depression					
Diabetes					
Diarrhea					
Disc/Back Problem					
Dizziness					
Epilepsy					
Gallbladder trouble					
Gout					
Headaches/Migraines					
Heart Disease					
High Blood Pressure					
High Cholesterol					
Insomnia					
Kidney Trouble					
Liver Trouble					
Menstrual Problems					
Mental Illness					
Obesity					
Pinched Nerve					
Scoliosis					
Sinus Trouble/Allergies					
Skin Problem					
Stomach Trouble					
Thyroid Problems					
Ulcers					
Other:					

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 "Nervous" stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 "Butterfly" stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels "lightheaded" often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels "irregular"
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 "Slow starter"
38 – 1 2 3 Get "chilled" infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get "shaky" if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 "Lightheaded" if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - "blues" or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, "air hunger"
58 – 1 2 3 Aware of "breathing heavily"
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon "yawner"
63 – 1 2 3 Get "drowsy" often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, "black and blue" spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 "Nose bleeds" frequent
71 – 1 2 3 Noises in head, or "ringing in ears"
72 – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP FIVE

73 – 1 2 3 Dizziness
74 – 1 2 3 Dry skin
75 – 1 2 3 Burning feet
76 – 1 2 3 Blurred vision
77 – 1 2 3 Itching skin and feet
78 – 1 2 3 Excessive falling hair
79 – 1 2 3 Frequent skin rashes
80 – 1 2 3 Bitter, metallic taste in mouth in mornings
81 – 1 2 3 Bowel movements painful or difficult
82 – 1 2 3 Worrier, feels insecure
83 – 1 2 3 Feeling queasy; headache over eyes
84 – 1 2 3 Greasy foods upset
85 – 1 2 3 Stools light-colored
86 – 1 2 3 Skin peels on foot soles
87 – 1 2 3 Pain between shoulder blades
88 – 1 2 3 Use laxatives
89 – 1 2 3 Stools alternate from soft to watery
90 – 1 2 3 History of gallbladder attacks or gallstones
91 – 1 2 3 Sneezing attacks
92 – 1 2 3 Dreaming, nightmare type bad dreams
93 – 1 2 3 Bad breath (halitosis)
94 – 1 2 3 Milk products cause distress
95 – 1 2 3 Sensitive to hot weather
96 – 1 2 3 Burning or itching anus
97 – 1 2 3 Crave sweets

GROUP SIX

98 – 1 2 3 Loss of taste for meat
99 – 1 2 3 Lower bowel gas several hours after eating
100 – 1 2 3 Burning stomach sensations, eating relieves
101 – 1 2 3 Coated tongue
102 – 1 2 3 Pass large amounts of foul-smelling gas
103 – 1 2 3 Indigestion 1/2 - 1 hour after
104 – 1 2 3 Mucous colitis or "irritable bowel"
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can't gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can't work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
130 – 1 2 3 Mental sluggishness
131 – 1 2 3 Hair coarse, falls out
132 – 1 2 3 Headaches upon arising wear off during day
133 – 1 2 3 Slow pulse, below 65
134 – 1 2 3 Frequency of urination
135 – 1 2 3 Impaired hearing
136 – 1 2 3 Reduced initiative

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, "splitting or rendering" type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Muscle weakness
174 – 1 2 3 Lack of Stamina
175 – 1 2 3 Drowsiness after eating
176 – 1 2 3 Muscular soreness
177 – 1 2 3 Rapid heart beat
178 – 1 2 3 Hyper-irritable
179 – 1 2 3 Feeling of a band around your head
180 – 1 2 3 Melancholia (feeling of sadness)
181 – 1 2 3 Swelling of ankles
182 – 1 2 3 Diminished urination
183 – 1 2 3 Tendency to consume sweets or carbohydrates
184 – 1 2 3 Muscle spasms
185 – 1 2 3 Blurred vision
186 – 1 2 3 Loss of muscular control
187 – 1 2 3 Numbness
188 – 1 2 3 Night sweats
189 – 1 2 3 Rapid digestion
190 – 1 2 3 Sensitivity to noise
191 – 1 2 3 Redness of palms of hands and bottom of feet
192 – 1 2 3 Visible veins on chest and abdomen
193 – 1 2 3 Hemorrhoids
194 – 1 2 3 Apprehension (feeling that something bad is going to happen)
195 – 1 2 3 Nervousness causing loss of appetite
196 – 1 2 3 Nervousness with indigestion
197 – 1 2 3 Gastritis
198 – 1 2 3 Forgetfulness
199 – 1 2 3 Thinning hair

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

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

Please be sure to fill out the "Important" section.

Note: If you are filling out this paperwork at home prior to your appointment, please remember to fill out the Food Diary Form for as many days as you can (up to 7 days) until your scheduled appointment.

If you are currently taking any nutritional supplements, it is beneficial if you are able to bring them with you to your first appointment.

Lawlor Chiropractic - Nutrition
Terms of Acceptance

I hereby attest to the following:

1. I fully understand that the nutritional consultant I am seeing in this office is not a medical physician, and I am not consulting for medical, diagnostic or treatment procedures.
2. The services performed by the nutritional consultant are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease) so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that as a nutritional consultant, the recommendations, discussion, sale of food nutrition, nutritional supplementation, vitamins or minerals, herbs or other nutrients pertains to the whole body concept of nutrition and does not relate in the context of any specific ailment or condition.
4. I understand that the purpose of nutritional supplements is to provide special food concentrates for dietary purposes, and they are not intended to treat or cure any disease.
5. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine.
6. Nutritional counseling, vitamin recommendations and nutritional advice is provided solely to the upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.
7. Regardless of what the disease is called, we do not offer to treat it. Nor do we offer advice regarding treatment prescribed by others. OUR ONLY PRACTICE OBJECTIVE is to support the body's innate wisdom. Our method is specific nutritional counseling (addition of nutrients/elimination of toxins) to correct vertebral subluxation.
8. Nutritional supplements are not refundable or exchangeable due to insurance requirements and the maintenance and quality of our inventory. All special orders must be pre-paid.
9. For repeated (2 or more) missed or rescheduled appointments (less than 24-hours notice is given), there is a $20 fee and prepayment will be required for a future appointment.

I have answered all questions pertaining to my health accurately and to the best of my knowledge, and I have read and fully understand the above statements.

Signature _____ Date _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Lawlor Chiropractic to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

I have read and understand how my Patient Health Information will be used, and I agree to these policies and procedures.

Signature _____ **Date** _____

Consent to Care for Minor (only required if patient is under 18 years of age)

I authorize the practitioner(s) of Lawlor Chiropractic and whomever they may designate as their assistant to administer care deemed necessary for my son/daughter.

Signature _____ Date _____