CONFIDENTIAL CLIENT QUESTIONNAIRE

ACHIEVE HEALTH CHIROPRACTIC AND CLINICAL NUTRITION
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GENERAL INFORMATION – PLEASE PRINT DATE ____/____/____

Patient Name _____ Home Address _____

City _____ State _____ Zip Code _____

Birth Date _____/_____/_____ Sex M____ F____ Martial Status M____ S____ D____ W____
Your Employer _____ City _____Occupation_____
Drivers' License No._____ Social Security _____/_____/_____
E-mail _____ Phone___ _____ Work Phone_____
Spouse's Name _____ Birth Date _____/_____/_____ Occupation_____ _____
Spouse's Employer _____ City _____ Phone _____
Your MD _____ Date of Last Physical _____
Dentist _____ Date of Last Visit _____
Date of Last Chiropractic Adjustment _____/_____/_____ Given By Dr. _____
Who May We Contact In Case of Emergency _____ Phone # _____
Who May We Thank For Referring You to Us _____ Phone # _____

PLEASE FILL IN THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS OR THE BACK OF THE PAGE IF NEEDED. OBTAINING THE BEST HEALTH POSSIBLE IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP YOUR DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

HEALTH HISTORY

GIVE THE PRIMARY REASON YOU ARE CONSULTING WITH OUR CLINIC. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND HOW IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD, AND IF THE PROBLEM IS GETTING BETTER, WORSE, OR IS THE SAME.
Primary Health Complaint:

_____
_____
_____
_____

GIVE ANY SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING. LIST THE MOST SEVERE FIRST.

_____

_____

_____

List all nutritional supplement products you are taking. Include the name of the company, amount, why you are taking them and how long you have been taking them. We ask that you bring all bottles to your consultation.

NAME	COMPANY	AMOUNT	WHY TAKING	HOW LONG
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

LIST ALL DRUGS (PRESCRIPTION OR NOT) YOU ARE TAKING. INCLUDE THE REASON TAKEN, AMOUNT, LENGTH OF TIME TAKEN, AND RESULTS.

NAME	AMOUNT	WHY TAKING	HOW LONG	RESULTS
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

List additional drugs on back of this page

List all surgeries you have had. Please include the date, why it was done, and the results.

SURGERY	WHY DONE	DATE
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List additional surgeries on back on this sheet

LIST ALL ALLERGIES YOU HAVE TO FOOD, DRUGS, OR ANY OTHER SUBSTANCES, ALONG WITH THE SYMPTOMS THEY PRODUCE AND INDICATE HOW LONG YOU HAVE SUFFERED FROM EACH ITEM.

ALLERGY	SYMPTOMS
_____	_____
_____	_____
_____	_____

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY. IF YOU DON'T KNOW, SO INDICATE.

O Yes O No My mother was healthy while pregnant with me. If no, describe. _____

O Yes O No Was your birth natural? In no, please check… O Anesthesia O Forceps O C-Section

O Yes O No Were you breast fed for at least the first 6 months? Formula type? _____

O Yes O No Were you fed anything other than milk in the first 6 months? List _____

O Yes O No Were you colicky baby? Until what age? _____

O Yes O No Have you ever been to, or lived, in a foreign country? List _____

O Yes O No Have you ever fainted or had a convulsion? Describe _____

Mark any you have had: O Measles O Chicken Pox O Mumps O German Measles O Roseola
O Scarlet Fever O Rheumatic Fever O Lyme Disease O Mononucleosis

DIET HISTORY

Mark each one using an "O" or none when appropriate.

Give the amount of each you consume:

_____ Ounces of Water	_____ Day	_____ Not Daily
_____ Ounce of Alcohol	_____ Day	_____ Not Daily
_____ Ounce of Coffee/Tea	_____ Day	_____ Not Daily
_____ Ounce of Soda	_____ Day	_____ Not Daily
_____ Ounce of Juice	_____ Day	_____ Not Daily
_____ Other _____	_____ Day	_____ Not Daily

List your ten most frequently eaten foods _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

% of Daily diet prepared at: _____ Home _____ Restaurant _____ Fast Food _____ Vending Machine

% of cooking method: ____ Baked ____ Boiled ____ Broiled ____ Fried ____ Charcoal ____ Steamed

% Prepared from: ____ Fresh Raw ____ Fresh Cooked ____ Canned ____ Frozen ____ Prepackaged

My appetite is: O Normal O Excessive O Poor O None

I crave: O Sweets O Salt O Chocolate O Water O Dirt O Other

Type of water used for drinking/cooking: O Tap Or City O Spring O Well O Rain
O Distilled Bottled O Filtered Bottled O Reverse Osmosis

If purchasing water, is it in… O Soft Plastic O Hard Plastic O Glass

Foods That Disagree With You:
O Raw Vegetables O Raw Fruit O Fats O Fried
O Milk/Dairy O Greasy O Eggs O Onions
O Highly Spiced O Beans O Cabbage O Sugar
O Other _____

DO YOU GET FROM THE FOODS THAT DISAGREE WITH YOU WHAT SYMPTOMS?

O Yes O No Are you on a special diet? Explain _____

O Yes O No Do you fast? If yes, how often and how long? _____

O Yes O No Have you ever done a detoxification program? Explain _____

BOWEL HEALTH BM = Bowel Movement or Stool

How many times do you have a BM? _____ X a Day _____ X a Week

O Yes O No Do you use laxatives? How often _____ Brand _____
O Yes O No Do you get the urge to have a BM?
O Yes O No Respond promptly when get the urge?
O Yes O No Do you have pain with BM?

Answer key for the following tables: 0 = Never 1 = Rarely 2 = Frequently 3 = Always

Stool Size	Stool Consistency	Stool Color
____ 2" wide & 6"+ length	____ Float like a submarine	____ Med. / Dark brown
____ 1" wide & 4"+ length	____ Float on top of water	____ Very Dark/ Black
____ Thin, long or narrow	____ Sink to Bottom	____ Yellow/ Tan/ Clay
____ Small, hard	____ Loose but not watery	____ Greenish
____ Large, hard	____ Diarrhea	____ Blood is Visible
____ Difficult to pass	____ Alternate hard /diarrhea	____ Mucus in or around

O Yes O No Have you ever had worms of parasites? How Treated? _____
O Yes O No Do you presently have rectal itching? O Day O Night O Continuously

DIGESTION

I get pain/heartburn: O Before Eating O After Eating O When I lie down O Upon Arising
I have: O Indigestion O Intestinal Gas O Bloating O Belching
O Immediately after eating O 1-2 hours O 3-5 hours O 6 + hours
O No odor O Some odor O Odor Usually O Foul Smelling

I have: O Hemorrhoids How Long _____
O Varicose Veins How Long _____ O Hiatal Hernia
O Esophageal Burning/Reflux O Raise head of bed to sleep

HEAD, MOUTH, THROAT

My teeth are: O Good O Some fillings O Bad O Some Missing O All Missing O Root Canal

I wear dentures: O Upper O Lower O Partials O Crowns O 1+ Metal Type in Mouth

My breath is: O Good O Slight Odor O Odor Off/On O Offensive Odor Usually

My tongue is: O Covered with small taste buds O Sore O Furrowed O Coated _____ Color My

tongue Color is: O Pink O Red O Red Blotchy O Pink with red tip

My tonsils are: O Normal O Removed at age _____ O Enlarged O Spotted

My lips are: O Normal O Dry O Peel a lot O Fever Blisters Often O Cracked in Corners

My sense of taste is: O Normal O Poor O None O Oversalt Food O Canker Sores

I get headaches: O Daily O Weekly O Rarely O Never O Wake up with

O Get in A.M. O Get in P.M. O With some foods or drinks O With aura O With Nausea

MUSCLE, LIGAMENT, JOINT, NERVES, AND BLOOD VESSELS

Mark all the apply

I have pain in: O Neck O Mid Back O Low Back O Hip O Knee O Ankle

O Feet O Sciatic/ Leg O Shoulder O Elbow O Wrist O Hands O Other

_____

I get: O Swollen Joints O Sore Joints O Joints that Pop or Crack O Jaw Pops

O Leg Cramps at Rest O Leg Cramps with Activity O Flat Feet O Foot Cramps at rest

O Worse at night O Foot cramps with Activity O Burning Feet O Tingling in feet or hands

I: O Fall asleep easily O Can't fall asleep O Wake up and can't get back to sleep

I have: O Nervous Tic - Where? _____ O Bell's Palsy O Parkinson's

O Had spinal surgery - Where? _____ O Hemorrhoids O Varicose Veins

O Had vessel surgery O Spider Veins

HAIR, NAILS, SKIN

Mark all that apply.

Hair: O Course O Fine O Falls out excessively O Turned Grey at age ____

O Oily O Dry

Male Beard: O Heavy O Light or sparse O None

Female: O Facial hair always O Facial hair started at age___ O Hair on abdomen or breasts

Finger Nails: O Normal O Brittle/Break easily O Soft O Ridged Vertically O Hangnails

O Grow Fast O Shaped Oddly O Grow Slow O Ridged Horizontally

Skin: O Normal O Oily O Dry O Flaky O Psoriasis O Acne

O Small bumps on upper arms O Skin cancer removed on ___/___/___ O Had more than One

Spots on Skin: O Warts O Moles O Small Red O Large Red O Brown O White Hands and Feet:

O Dry, Cracked, or bleeding areas on… O Hands O Heels O Feet

O Ingrown Toenails O Fungus on feet or nails O Athlete's foot

CHEST AND HEART

Mark all that apply.

I have chest pain that is: O Sharp O Dull O Severe

O Worse at rest O Worse on Exertion

O Radiates to my arm, neck, or back O Better with Exercise O No change with exercise

My pulse/heartbeat is: O Too fast O Too slow O Skips beats

I have: O High blood Pressure O Low Blood Pressure

O Had a heart attack O Had a stroke

I am: O On HBP Medicine O On Diuretics O On Low Salt diet

O On high fiber diet O On low cholesterol diet O On cholesterol medication

I have been told I have: O Heart disease O Clogged arteries

RESPIRATORY

Mark all that apply

I have nasal congestion: O Daily O Several times a week O Only on occasion

I have nasal discharge: O Daily O Several times a week O Only on occasion

O Clear O Yellow O Green O Blood Tinged O Other _____

I have: O Non-Productive Cough (w/out mucus) O Productive cough (with mucus) O Allergies

O Hoarseness of voice O Post-nasal drip O Hay fever

O Asthma O Wheezing O Snoring

I have/have had: O Pneumonia O Frequent colds O Flu once or more a year

O Sinus Infections O Antibiotics 3 or more times in my life

O Allergies to _____

I take: O Nasal spray O Allergy Shots O Allergy medicine

O Steroids O Decongestants

I use: O Snuff or Chew O Cigars O Exposed to secondhand smoke O Cigarettes _____ Packs/Day

I have been told I have: O Emphysema O Lung disease _____

I am/have been exposed to: O Toxic Chemicals O Toxic Fumes O Craft Chemicals

EMOTIONAL, NERVOUS, AND METABOLISM
Mark all that apply.

I am/have: O Nervous O Anxious O Depressed O Irritability O Morbid thoughts
O Sensitive to noise O Sleepy during the day O Exhausted a lot
O Confused Easily O Fatigue easily O Loss of appetite
O Rage O Fearful O Hear voices O Weakness O Poor Memory

I am/have: O Suspicions of others O Thoughts of suicide O Quick mood changes
O Fear of insanity O Fear of serious disease like _____
O Avoid Crowds O Friends avoid me O Have hypoglycemia or low blood sugar
O Had glucose tolerance test and it was O Positive O Negative
O Take daytime naps O Dream too much O Have no dreams at all O Have nightmares
O Wake up tired O Feel too hot O Am cold when others are comfortable
O Have cold hands O Have cold feet O Have inadequate perspiration when exercising
O Perspire too much

O Yes O No Do you feel well rested when you wake up in the morning?

_____ Rate the quality of your sleep. 1 being awful and 10 being great)

FEMALE SPECIFIC

Mark all that apply.
Age of first period _____

I am on: O Birth control O Hormone Replacement : O Estrogen O Progestin
O Oral O Wild Yam Cream O Patch

My menstrual Periods are/have: O Normal O Painful before and during
O Painful first day O Excessive flow O Scanty flow O Clots
O hemorrhaging O Regular every _____ days O Irregular
O No period in _____ months O Two or more per month O Abnormal since _____ years of age

I had: O Menstrual problems before first child O Menstrual problems after first child
O Menopause at age _____ O Hysterectomy at age _____

My: O Uterus is in position O Uterus is out of position O Bladder is Prolapsed

My menstrual blood color is: O Pink O Red O Brown O Black O Other _____

I have/have had: O Endometriosis O Constipation w/ periods O Diarrhea w/ periods

I have breast soreness: O Before period O During period O After period O All month long

I have: O Fibrocystic breasts O Had breast cancer O Produce milk but not pregnant or nursing

My breasts are: O Firm O Soft and saggy O Have implants O Had reduction

O Have ____ children O Been pregnant ____ times O Fear of pregnancy O Like children O Dislike children
O Am sterile O Don't want more O Want more

I get: O Bladder infections O Yeast infections O Yeast infections after antibiotics
O Vaginal Dryness O Painful intercourse
O Vaginal burning/itching on O Inside O Outside

I urinate: O ____ times per day O ____ times at night O More frequently than normal

O With pain O With itching/burning O With difficulty starting/stopping

My urine color is: O Pale Yellow O Bright Yellow O Dark Yellow

O Clear O Cloudy O With mucus in it

O Varies a lot O Other _____

I have/had: O Venereal disease O Genital herpes O Herpes O HIV/AIDS

My libido is: O Normal O Excessive O Increased O Diminished O Absent

(Libido means desire for sexual relations).

MALE SPECIFIC

Do you experience: O diminished sex drive O loss of erections O lethargy O muscle loss or weakness

O "spare tire syndrome" O insomnia O anxiety O mood swings O loss of self-confidence

O loss of motivation O less stamina O declining memory

OTHER CONCERNS NOT LISTED

Please list any other health concerns you have here.

_____

_____

_____

_____

_____