Alan A Newman D.C.
Integrated Natural Healthcare
Chiropractic + Acupuncture + Nutrition

Dear Patient,

We would like to thank you for choosing Dr. Newman's office for your Nutrition Response Testing. Please fill out the New Patient forms and drop them by the office prior to your appointment, or bring the completed forms the day of your appointment. If your paperwork is not filled out completely before the appointment you may lose your time slot and have to reschedule.

Make sure that there is no lotion on your arms and hands for up to 12 hours prior to your appointment. Please be here 25 minutes before your appointment. If you are unable to make this appointment please call us at least 48 hours in advance.

Please read your packet information, again complete **all** the forms. Drop them off prior to your appointment or bring them with you on the above appointment date. This will save you time and speed up your intake process. If you have any question in regards to your forms, please contact the office at 740-392-7550.

Thank you for your time in this matter and we are looking forward to meeting you as well as helping you with your nutritional needs.

Respectfully,

Office Staff of

Alan Newman, D.C.

1684 Venture Drive, Suite F + Mount Vernon, Ohio 43050 + phone 740 392 7550 + fax 740 392 5335 **alannewmandc.com**

Nutrition Patient Questionnaire

Patient#____________ Classification___________ Date ____________________

Name____ Date of Birth______________ SS#_____________________

Address____City____________________State/Zip_________

Email__________________________________ Phone: Home________________ Cell ________________

Employer__________________________________ Work______________ Occupation _____________________

Married _____ Single _____ Divorced _____ Widow(er) _____ #of Children________

In Case of Emergency, who should we contact?

Name____ Phone_________________ Relationship______________

How did you hear about our office? ____

You are responsible for payment in full at the time of service.

I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.

Patient/Guardian Signature: ____ Date: __________________

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments, treatment(s) and acupuncture.

I have read and understand the above:

Signature _______________________________________ Date _______________________

PERMISSION & AUTHORIZATION FORM

REGARDING THE USE OF NUTRITION RESPONSE TESTING, HEART RATE VARIABLILTY TEST, ZYTO EDS SCREENING, ACUPUNCTURE AND LAB WORK UP

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Alan A. Newman D.C. office to perform Nutrition Response Testing, lab work as needed, Acupuncture, Heart Rate Variability Test, and/or Electro Dermal Screening health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that **Electro Dermal Screening is extremely safe** because it measures only changes in the electrical properties of the skin with sensitive meter. The only discomfort that can be reasonably anticipated is the minimal discomfort of the pressure of the probe pressing against the skin and or clips on the fingers. The use of the computer makes the procedure fast, so any discomfort should be brief.

I understand that **Heart Rate Variability Test is extremely safe** because it is to measure general physical fitness. No discomfort other than a little pressure from the electrodes on the band around the rib cage.

I understand that Nutrition Response Testing, Heart Rate Variability, and/or Electro Dermal Screening are not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing, Electro Dermal Screening, lab work, Acupuncture or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.
This permission form applies to subsequent visits and consultations.

Date: ______________________ Phone: _____________________________
Print Name: ____
Address: ____
City: _______________________ State: ___________ Zip: ____________
Signed: ____
(If minor, signature of parent or guardian required)
Witness: ____

New Patient Introduction Form

Patient Name: ____ Date: ________________________

1. Chief Concerns:

2. Medications and/or Nutritional Supplements currently on:

3. Dietary intake for 2 days before appointment

Breakfast:	Breakfast:
Snacks:	Snacks:
Lunch:	Lunch:
Snacks:	Snacks:
Dinner:	Dinner:
Snacks:	Snacks:

Financial Policy

PATIENTS WITHOUT INSURANCE/NUTRITION PATIENTS:
Payment is expected in full at the time of service. It is the policy of Doctor Newman not to carry an account balance. This includes all non-covered services for chiropractic as well as nutrition.

MEDICAL INSURANCE PATIENTS:
Because all insurance benefits are different, we encourage you to be fully aware of your insurance benefits to avoid any misunderstandings of coverage by verifying your chiropractic benefits with your insurance company. All co-pays are due at the time of service. Deductibles, non-covered services and coinsurances will be billed to the patient as soon as this office has been contacted by the insurance company.

SECONDARY INSURANCE PATIENTS:
Please inform us of any secondary insurance you may have. We will assist you if you need help in filing.

"ON THE JOB" INJURY (Workers' Compensation):
If you are injured on the job, your care should be paid for under your employer's Workers' Compensation insurance. You will need to inform your employer of the accident and obtain the name, phone number, and address of the carrier of their insurance. If your employer does not provide us with this information, if we do not receive payment within 3 months, or if you suspend or terminate care, any fees and services are due immediately.

PERSONAL INJURY OR AUTOMOBILE ACCIDENTS PATIENTS:
Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. In the event that your insurance policy does not include medical payment coverage, you must be represented by an attorney to continue care.
Although you are ultimately responsible for your bill, we will wait for settlement of your claim for up to three (3) months after your care is completed. IF A SETTLEMENT IS NOT REACHEDTHREE (3) MONTHS AFTER THE COMPLETION OF YOUR CARE AT OUR OFFICE YOU WILL BE BILLED FOR THE REMAINDER OF THE FEES. Once the claim is settled or if you suspend or terminate care, any fees for services are due immediately.

MEDICARE PATIENTS:
We do accept assignment from Medicare. Medicare only pays for manual manipulation of the spine. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services including physical therapy, x-rays and exams. Our office completes and files the forms for Medicare.

MEDICAID PATIENTS:
We do accept assignment from Medicaid. Medicaid will pay 100% of allowed charges. You are required to pay the non covered services which include physical therapy. Our office will complete and file all forms.

OTHER COLLECTION POLICY:
1. We charge a 25.00 dollar return check fee even if the check is re-deposited.
2. Any account turned to collections will have a 5% monthly interest fee on the unpaid balance.
3. All missed appointments have a 30.00 dollar fee which will be applied to the patient's account, unless the office is given a 24 hour notice.
4. Dr. Newman's office reserves the right to add a 3% finance charge monthly on any accounts with balances due over 90 days.

I have read and understand the payment policy of Doctor Alan Newman. I agree to the terms of this policy by my signature below.

Patient/Parent/Guardian: ______________________________________ Date: ______________________________

Witness Signature: ____ Date: ______________________________

Alan A Newman D.C.
Integrated Natural Healthcare

Chiropractic + Acupuncture + Nutrition

WELCOME TO DR. ALAN NEWMAN'S OFFICE

Patient Name: ____ **Account #:** __________
Print Please

Patient Name:	Date:	Patient Name:	Date:
1		21	
2		22	
3		23	
4		24	
5		25	
6		26	
7		27	
8		28	
9		29	
10		30	
11		31	
12		32	
13		33	
14		34	
15		35	
16		36	
17		37	
18		38	
19		39	
20		40	

Tell Others About Chiropractic, Acupuncture, and Nutrition

ABN MK ☐ ABN MC ☐ ABN CA ☐
ABN PI ☐ ABN Ins ☐ FP ☐
New CT ☐ Minor ☐ Non-Preg. ☐
P.I.D. ☐ PHI ☐ _______ ☐
X-ray# __________ Date ____________

☐ Ins. Co.: ______________ 2nd:___________
☐ Self Pay
☐ Workers Compensation
☐ Personal Injury
☐ Nutrition

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PATIENT RECORD OF DISCLOSURES

You may request to receive confidential communications of your protected health information (PHI) from Alan A. Newman DC, by alternative means. Alan A. Newman's office cannot ask you the reason for your request, and will accommodate all reasonable requests that you make. If you make a special request, you must give an alternative method of contacting you.

I wish to be contacted in the following manner (check all that apply):

☐ Home telephone (____)_____________
- ☐ Okay to leave message
- ☐ Leave call-back number only

☐ Work telephone (____)_____________
- ☐ Okay to leave message
- ☐ Leave call-back number only

☐ Written Communication
- ☐ Okay to mail to my home
- ☐ Okay to mail to work/office

☐ Cell (____)____________________
- ☐ Okay to leave message
- ☐ Leave call-back number only

☐ E-Mail _______________________

_______________________ Patient/Guardian signature

_______________________ Print Name

_______________________ Date

All disclosures will be made pursuant to the guidelines and requirements as detailed in the "Notice of Privacy Practices". Healthcare entities must keep a record of PHI disclosures, information provided below.

Patient Date of Birth: ________________________________

Date	Disclosed to	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check This Box if the disclosure is authorized
(2) Type Key: T = Treatment Records; P = Payment information; S = Dictated summary O = Healthcare operations
(3) Enter how disclosure was made: F = Fax; P = Phone; M = Mail; O = Other

PATIENT SYMPTOM SURVEY

DATE**_________________**

PATIENT'S NAME**____ *AGE*_______**

WEIGHT**_________ *HEIGHT*_________ *BLOOD PRESSURE*___________ *PULSE*___________ *O*$_2$__________**

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

- 090 ☐ General Good Health
- 091 ☐ Desires Nutritional & Metabolic Analysis
- 001 ☐ Skin Disorder L25.9
- 002 ☐ Acne L70.8
- 003 ☐ Psoriasis L40.8
- 004 ☐ Urticaria (Hives) L50.9
- 005 ☐ ADD/ADHD F90.1/F90.9
- 006 ☐ Allergies, Unspecified J30.9
- 007 ☐ Allergic Rhinitis from food J30.5
- 008 ☐ Sinusitis J01.90
- 009 ☐ Alzheimer's G30.9
- 010 ☐ Poor Concentration/Memory F07.8
- 011 ☐ Parkinson's Disease G20
- 012 ☐ Anemia D64.9
- 013 ☐ Arthritic Disorder M12.9
- 014 ☐ Osteoporosis M81.0
- 015 ☐ Asthma J45.909
- 016 ☐ Emphysema J43.9
- 017 ☐ Cancer
  - 018 ☐ Breast C50.919female C50.929male
  - 019 ☐ Prostate C61
  - 020 ☐ Lung C34.90
  - 021 ☐ Colon and Rectal C18.9
  - 022 ☐ Skin C44.90
  - 023 ☐ Leukemia w/o remission C95.90
    Leukemia w/ remission C95.91
  - 024 ☐ Lymphoma, malignant C85.89
  - 025 ☐ Brain Tumor, malignant C71.9
- 027 ☐ Anxiety Disorder F41.9
- 028 ☐ Autism F84.0
- 033 ☐ Edema R60.9
- 034 ☐ Eczema L25.9
- 035 ☐ Chronic Fatigue R53.82
- 036 ☐ Circulatory Disorder I99.9
- 037 ☐ Heart Disease I51.9
- 038 ☐ High Cholesterol E78.0
- 039 ☐ High Blood Pressure I10
- 040 ☐ Low Blood Pressure I95.9
- 041 ☐ Tachycardia (High Heart Rate) R00.0
- 042 ☐ Numbness R20.9
- 043 ☐ Constipation K59.00
- 044 ☐ Indigestion K30
- 045 ☐ Ulcerative Colitis K51.90
- 046 ☐ Depression F32.9
- 047 ☐ Diabetes Mellitus E11.9
- 030 ☐ Diabetes Type I E10.9
- 031 ☐ Diabetes Type II E11.65
- 029 ☐ Hyperglycemia [high blood sugar] R73.09
- 048 ☐ Hypoglycemia [low blood sugar] E16.2
- 049 ☐ Dizziness/Balance Problem R42
- 050 ☐ Ear Infection H65.90
- 051 ☐ Epstein Barr B27.90
- 052 ☐ Eye Problems H57.13
- 053 ☐ Cataracts H26.9
- 054 ☐ Glaucoma H40.9
- 055 ☐ Macular Degeneration H35.30
- 056 ☐ Fever R50.9
- 057 ☐ Fibromyalgia M79.7
- 058 ☐ Gallbladder Disorder K82.9
- 059 ☐ Gout M10.9
- 060 ☐ Headaches R51
- 061 ☐ Hearing Loss H91.90
- 062 ☐ Infertility, male N46.9
- 064 ☐ Liver Disease K76.9
  - 065 ☐ Hepatitis K71.6
  - 066 ☐ Hepatitis B B16.9
  - 067 ☐ Hepatitis C B17.10
- 068 ☐ Kidney Disorder N28.9 or Bladder Disorder N32.9
- 063 ☐ Prostate Disorder N42.9
- 069 ☐ Hyperthyroidism E05.90
- 070 ☐ Hypothyroidism E03.9
- 071 ☐ Systemic Lupus M32.10
- 072 ☐ Infertility, female M97.9
- 073 ☐ Interstitial Cystitis N30.11
- 074 ☐ Irregular Menstrual Cycle N92.6
- 075 ☐ Menopausal Symptoms N95.1
- 076 ☐ Hot Flashes N95.1
- 077 ☐ Mental Disorder F99
- 078 ☐ Insomnia G47.00
- 079 ☐ Mouth/Throat/Tongue
- 080 ☐ Canker Sores K12.0
- 081 ☐ Overweight E66.3
- 082 ☐ Underweight R63.6
- 083 ☐ Sexual Disorder F66
- 084 ☐ Spinal Problems M53.9
- 085 ☐ Obesity E66.9
- 086 ☐ GERD K21.9
- 087 ☐ HIV B20
- 088 ☐ Crohn's Disease K50.90
- 089 ☐ Irritable Bowel Syndrome K58.9
- 092 ☐ Normal Pregnancy Z33.1
  **only applicable if *currently* pregnant
- 093 ☐ Shingles B02.9
- 140 ☐ Migraines G43.909
- 141 ☐ Rheumatoid Arthritis M06.9
- 142 ☐ Non-Systemic Lupus L93.0
- 143 ☐ Multiple Sclerosis G35
- 144 ☐ ALS (Lou Gehrig's) G12.21
- 145 ☐ Polymyalgia Rheumatica M35.3
- 146 ☐ Scleroderma M34.9
- 171 ☐ Goiter E04.9
- 178 ☐ Raynaud's Syndrome I73.00
- 179 ☐ Hemochromatosis E83.119
- 180 ☐ Thalassemia D56.8
- 181 ☐ Brain aneurysm I61.9

If necessary, please state your most significant concern…

____

____

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight

124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:
184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? ____________________

What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other ____________

What year was your home built? __________ Any renovations in the past year? ____________________

Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No

Explain: ____

Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No

Explain: ____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda

379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:
172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day

126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss
Type: ________________

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

- 245 ☐ Coarse hair
- 246 ☐ Coarse skin
- 247 ☐ Diabetic
- 248 ☐ Excessive thirst
- 249 ☐ Frequently feels cold
- 250 ☐ Frequently feels hot
- 251 ☐ Gets lightheaded when standing quickly
- 252 ☐ Heals slowly
- 253 ☐ Unusually jumpy or nervous
- 254 ☐ Unusually tired most of the time

Cardiovascular

- 190 ☐ Cold feet
- 191 ☐ Cold hands
- 192 ☐ Experiences shortness of breath while sitting still
- 193 ☐ Heart skips beats
- 194 ☐ Tendency of High blood pressure
- 195 ☐ Leg cramps during bedtime
- 196 ☐ Leg cramps during daytime
- 197 ☐ Low blood pressure at times
- 198 ☐ Pain in leg/hips when walking
- 199 ☐ Frequent swollen ankles
- 200 ☐ Pains in the heart or chest
- 201 ☐ Spells of rapid heart rate
- 202 ☐ Troubled with blood clots
- 203 ☐ Unusually slow pulse rate
- 204 ☐ Varicose veins
- 205 ☐ Heart palpitations

Skin

- 520 ☐ Bruises easily
- 521 ☐ Excessive perspiration
- 522 ☐ Frequent goose bumps
- 523 ☐ Has acne
- 524 ☐ Has Psoriasis
- 525 ☐ Hives
- 526 ☐ Itchy skin
- 527 ☐ Problems with Eczema
- 528 ☐ Has moles which are changing in size and/or color
- 530 ☐ Skin is rough, especially on the back of the arms
- 529 ☐ Skin eruptions
- 531 ☐ Skin is tender
- 532 ☐ Sores that heal slowly
- 533 ☐ Troubled with boils
- 534 ☐ Dry skin

Ears

- 220 ☐ Discharge from ears
- 221 ☐ Hard of hearing
- 222 ☐ Punctured ear drum
- 223 ☐ Recurrent ear infection
- 224 ☐ Ringing or noises in the ears
- 225 ☐ Tinnitus

Eyes

- 320 ☐ Bloodshot eyes
- 321 ☐ Blurred vision
- 322 ☐ Cross eyes
- 323 ☐ Eye pain
- 324 ☐ Eyes feel gritty
- 325 ☐ Eyes watery
- 326 ☐ Mild Glaucoma
- 327 ☐ Far sighted
- 328 ☐ Developing cataracts
- 329 ☐ Mild Macular degeneration
- 330 ☐ Itchy eyes
- 331 ☐ Near sighted
- 332 ☐ Dry Eyes

Feet

- 350 ☐ Corns
- 351 ☐ Frequent foot cramps
- 352 ☐ Heel spurs
- 353 ☐ Painful feet
- 354 ☐ Plantar warts
- 355 ☐ Swelling in the feet and/or ankles
- 356 ☐ Plantar fasciitis
- 357 ☐ Fungal Infection

Neuromuscular

- 440 ☐ Bites nails
- 441 ☐ Frequent muscle soreness
- 442 ☐ Muscle spasms
- 443 ☐ Muscle weakness
- 444 ☐ Tremors
- 445 ☐ Frequent headaches
- 446 ☐ Often dizzy
- 447 ☐ Frequently feels faint
- 448 ☐ Has Epilepsy
- 449 ☐ Has motion sickness
- 450 ☐ Has Osteoarthritis
- 451 ☐ Has Rheumatism
- 452 ☐ Rheumatoid Arthritis
- 453 ☐ Joint stiffness in the morning
- 454 ☐ Swollen joints
- 455 ☐ Leg pain at rest
- 456 ☐ Spinal curvature
- 457 ☐ Low back pain
- 458 ☐ Neck pain
- 459 ☐ Pain between the shoulders
- 460 ☐ Shoulder/arm pain
- 461 ☐ Numbness/tingling in the body
- 462 ☐ Sleep walks
- 463 ☐ Stutters or stammers
- 464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

- ☐ Dairy
- ☐ Eggs
- ☐ Garlic
- ☐ Gluten
- ☐ Mold
- ☐ Peanut
- ☐ Ragweed
- ☐ Shellfish
- ☐ Soy
- ☐ Sulfa drugs
- ☐ Tree nuts
- ☐ Wheat

☐ Other ____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***