DR. ROSS WILLIAMS
CHIROPRACTIC
& NUTRITION

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Confidential Nutritional Health History

Today's Date_____

Name_____Birth Date_____ Age____ Height___'____" Weight _____lbs

Address_____ City_____State____Zip_____

Phone: _____ Cell: _____Email: _____

May we thank who referred you? _____

Who is your primary physician? _____

Other healthcare provider? _____

**** Please answer all questions carefully. They are the clues to your problem(s) ****

HEALTH HISTORY

List your Primary Concerns/Reasons for this consult: **When did it begin?** **Rate each**

_____❑mild ❑moderate ❑severe

_____❑mild ❑moderate ❑severe

_____❑mild ❑moderate ❑severe

_____❑mild ❑moderate ❑severe

What has been done so far? (self-treatment, or professional treatment? Use back of page if necessary) **Did it help?**

_____

_____

List any secondary health concerns, or problems you are having:

_____

_____

Surgery? **When?** **Why?** **Result?**

_____

_____

_____

Please check all that apply (C = Current, P = Past)

C	P		C	P		C	P	
❑	❑	AIDS/HIV	❑	❑	Mononucleosis	❑	❑	Polio
❑	❑	Herpes	❑	❑	Multiple Sclerosis	❑	❑	Rheumatic Fever
❑	❑	Chickenpox	❑	❑	Measles	❑	❑	Rosella
❑	❑	Hepatitis	❑	❑	German Measles	❑	❑	Scarlet Fever
❑	❑	Kidney disease	❑	❑	Mumps	❑	❑	Cancer_____
❑	❑	Lyme's Disease	❑	❑	Parkinson's disease	❑	❑	_____

Have you had any recent Diagnostic, Imaging or Laboratory tests? ❑No/❑Yes, ❑Xray/MRI/CT/ECG, ❑Blood test ❑Urine test, ❑Saliva hormone test, ❑Blood Hormone test, ❑Hair analysis for heavy metal &/or mineral survey, ❑GI digestive stool test, ❑Nutrient tests, ❑Food/Air allergy test. ❑Iodine test. ❑Others

**** Please get copies of all your tests to Dr. Ross at least 3 working days before your appointment ****

LIST ALL PRESCRIPTION DRUGS TAKEN:

CURRENT (less than a year)	**Why? / What diagnosis?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

PAST (more than a year)	**Why? / What diagnosis?**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALL NON-PRESCRIPTION OTC DRUGS - CURRENT	**Reason?**	**How long taken? Dose?**
_____		
_____		
_____		

ALL VITAMINS, SUPPLEMENTS, HERBS - CURRENT	**Reason?**	**How long taken? Dose?**
_____		
_____		
_____		

FAMILY MEDICAL HISTORY: List all known Health Conditions. If deceased; Why & When?

Father_____ Mother_____

Brother _____ Sister_____

Brother_____ Sister_____

Grandmother_____ Grandfather_____

SOCIAL HISTORY:

Do you smoke? ❑No ❑Yes, #____years? #____ ❑cigarettes ❑packs per day ❑Quit, What year?_____ #____years smoked?

If Yes, Are You Ready to Quit? ❑Yes ❑No, reason_____

Do You Currently Exercise? ❑No ❑Yes, what do you do? _____

___ times per week for (15 20 30 45 90 minutes or more) per exercise session

If No, what exercise would you consider? ❑Fast Walking ❑Exercise Class ❑Personal trainer ❑Yoga ❑Exercise video's ❑other_____

Do you have any limitations on exercise? ❑No ❑Yes, explain_____

What is your daily Stress Level? circle one (0 1 2 3 4 5 6 7 8 9 10 extreme)

How do you rate your ability to handle stress? circle one (0 1 2 3 4 5 6 7 8 9 10 extreme)

What is your daily Energy Level? circle one (0 1 2 3 4 5 6 7 8 9 10 extreme)

How many Hours at Work/School? #_____hrs/wk ,

My mother was Healthy when pregnant with me. ❑Don't know ❑Yes ❑No, (explain)

I was delivered by: ❑natural birth ❑C-section ❑with forceps ❑mother had anesthesia ❑premature ❑don't know

Were you breastfed at least 6 months? ❑Don't know ❑yes ❑no

Were you a colicky baby? ❑Don't know ❑No ❑yes, until what age?_____

Which foreign countries have you been to, or lived in? _____

Have you ever fainted, or had convulsions? (explain)

HEAD, MOUTH, THROAT:

Teeth: ❑Good, ❑Ok, ❑Not So Good, ❑Some Fillings, ❑Root Canals , ❑Some Missing, ❑All Missing, ❑Dentures, ❑Upper, ❑Lower, ❑Partials, ❑Crowns, ❑Mercury Amalgams, # Fillings ___.

Breath: ❑Good, ❑Slight Odor, ❑Odor Off And On, ❑Usually Offensive Odor.

Tongue: ❑Pink, ❑Red, ❑Blotchy, ❑Pink/ Red Tip, ❑Sore, ❑Furrowed, ❑Coated _____

Tonsils: ❑Normal, ❑Removed at_____ years old, ❑Enlarged, ❑Spotted, ❑Other_____

Eyes: ❑Glaucoma, ❑Cataracts, ❑Other_____

Sense Of Taste Is: ❑Normal, ❑Poor, ❑No Taste, ❑Over Salted Food, ❑Canker Sores.

Lips Are: ❑Normal, ❑Dry, ❑Feel A Lot, ❑Fever Blisters Often, ❑Cracks in the Corners.

Headaches: ❑Never, ❑Rarely, ❑Daily, ❑Weekly **Usually:** ❑First Thing In The Morning, ❑In The Afternoon, ❑At Night

CHEST & HEART:

Have chest pain: ❑Sharp, ❑Dull, ❑Severe, ❑Radiates to my (❑arm ❑neck ❑back), ❑Worst at Rest, ❑Worst at Exertion, ❑Better with exercise, ❑No change with exercise, ❑Other

Pulse/Heartbeat: ❑Too fast, ❑Too Slow, ❑Skips Beats, ❑Other

I have been told I Have: ❑High Blood Pressure, ❑Low Blood Pressure, ❑Heart Disease, ❑ Atherosclerosis/Clogged Arteries, ❑High Cholesterol, ❑High Triglycerides, ❑High Blood Sugar, ❑High CRP (C-Reactive Protein), ❑High Triglycerides, ❑Low Blood Sugar (Hypoglycemia), ❑I had a Glucose Tolerance Test it was (❑Positive, ❑Negative), ❑Insulin Resistance, ❑Diabetes, (❑type 1❑type 2), ❑Metabolic Syndrome, ❑Syndrome X, ❑Central Obesity, ❑Other

Have/ had: ❑Pacemaker, ❑By-Pass Surgery, ❑Stent, ❑Heart Attack, ❑Stroke, (Explain)

RESPIRATORY:

Nasal Congestion: ❑Daily, ❑Several Times a Week, ❑Only on Occasion

Nasal Discharge: ❑Daily, ❑Weekly, ❑Occasionally **It is:** ❑Clear, ❑Yellow, ❑Green, ❑Blood Tinged

Have: ❑Nonproductive Cough [without mucous], ❑Productive Cough [with mucous], ❑Allergies, ❑Hoarseness of Voice, ❑Postnasal Drip, ❑Hay fever, ❑Asthma, ❑Wheezing, ❑Snoring

Have/have had: ❑Frequent Colds, ❑Flu more than once a Year, ❑Pneumonia, ❑Sinus Infections, ❑Antibiotics (3 or more times)

❑Allergies to _____❑Allergy Shots, ❑Allergy Rx, ❑Decongestants, ❑Nasal Sprays, ❑Steroids

Been told I have/had: ❑Pneumonia, ❑Emphysema, ❑Asthma, ❑Bronchitis, ❑Tuberculosis (TB), ❑Other Respiratory/Lung disease, (Explain)

I am/have been exposed to: ❑Toxic Chemicals, ❑Toxic Fumes, ❑Craft Chemicals, ❑Second Hand Smoke (Explain)

MUSCULOSKELTAL, JOINT, NERVE, BLOOD VESSELS:

Often get PAIN: ❑neck, ❑under the shoulder blade, ❑mid back, ❑low back, ❑hip, knee, ❑ankle, ❑feet, ❑sciatica/leg, ❑shoulder, ❑elbow, ❑wrist, ❑hands, ❑_____

I get: ❑swollen joints, ❑sore joints, ❑joints that pop/crack, ❑leg cramp at rest, ❑legs cramp with activity, ❑leg cramp at night ❑foot cramps at rest, ❑foot cramps with activity, ❑burning feet, ❑tingling in feet or hands. ❑_____

Have/had: ❑Osteoarthritis, ❑Rheumatoid Arthritis, ❑Gout, ❑Osteoporosis (mild moderate severe), ❑Pinched Nerve, ❑Herniated Disk, ❑Fibromyalgia/Myofasical Pain Syndrome, ❑Nervous Tic or Twitching, ❑Bell's palsy, ❑Ear Ringing, ❑Spinal Surgery(explain)

❑Vascular Surgery (explain)

❑Anemia, ❑Bleeding Disorders, ❑Varicose Veins, ❑Spider Veins, (Explain)

Have you had any LOSS in HEIGHT? ❑No ❑Yes, how much?_____"

Have you had any recent CHANGES in WEIGHT ? ❑No ❑Yes, #____lbs ❑Gain ❑Loss

What is; your **Usual Weight**? _____Lbs, what is your **Ideal Weight**? _____Lbs,

the M**ost you have Weighed**? _____Lbs, at **What age?** _____years old.

your **Lowest (Adult) Weight**? _____Lbs, at **What age?** _____years old.

SKIN, HAIR, NAILS:

SKIN: ❑Normal, ❑Oily, ❑Flaky, ❑Psoriasis, ❑Boils, ❑Small Bumps on Upper Arms, ❑Skin Cancer Removed on _____ (date), ❑Had More Than One Skin Cancer #_____

SPOTS ON SKIN: ❑Warts, ❑Moles, ❑Small Red, ❑Large Red, ❑Brown, ❑White

HANDS & FEET: ❑Dry , ❑cracked or bleeding areas on (❑Hands, ❑Heels, ❑Feet), ❑Ingrown Toenails, ❑Fungus on Feet or Nails, ❑Athletes Foot ❑Other

HAIR: ❑Coarse, ❑Fine, ❑Falls out excessively, ❑Turned grey at age ___, ❑Oily, ❑Dry

MALE BEARD: ❑Heavy, ❑Light or sparse, ❑None,
FEMALE: ❑Facial hair always, ❑Facial hair started at age _____, ❑Hair on abdomen or breasts

FINGER NAILS: ❑Normal, ❑Brittle/break easily, ❑Soft, ❑Ridged vertically, ❑White spots, ❑Ridged horizontally, ❑Grow Fast, ❑Grow Slow, ❑Shaped Oddly, ❑Hangnails ❑Other

DIGESTION:

Do you have any digestive upset after eating?
❑No/❑Yes, ❑Stomach Ache ❑Nausea ❑Constipation ❑Diarrhea ❑Gurgling ❑Flatulence/foul odor ❑Flatulence/mild odor ❑other

What foods disagree with you?
❑None ❑Raw Vegetables ❑Raw Fruit ❑Fats ❑Milk/Dairy ❑Greasy ❑Beans ❑Cabbage ❑Eggs ❑Sugar ❑Onions ❑Highly Spiced

❑_____

I get pain/heartburn: ❑before eating ❑after eating ❑when lying down ❑upon arising

Have: ❑Frequent Heartburn ❑Hiatal Hernia, ❑Esophageal Burning/Reflux, ❑Must Raise Head In Bed To Sleep, ❑Anorexia, ❑Bulimia, ❑IBS (Irritable Bowel Syndrome), ❑Ulcers, ❑Ulcerative Colitis, ❑Crohn's Disease, ❑Diverticulitis

BOWEL & BLADDER:

Bowel Movements? #_____times a day, or #_____times a week.

Average Stool - Size/Shape: ❑2"x6", ❑1'x4" ❑Thin ❑Short ❑long, ❑_____

- Consistency: ❑Constipation, ❑Hard, ❑ClayLike, ❑Soft, ❑Easy, ❑Loose ❑Watery ❑Diarrhea ❑_____

- Stool Color: ❑Med/Dark Brown ❑Dark Brown/Black ❑Yellow/Tan/Clay ❑Greenish ❑Blood Visible ❑Mucus

Laxative use? ❑No ❑yes ❑how often? ❑daily, #___ a week, #___ a month. # a year..

Pain with Bowel Movements? ❑No ❑Yes, (❑Mild ❑Moderate ❑severe).

Hemorrhoids? ❑No ❑Yes, (❑Mild ❑Moderate ❑severe). **Do they bleed?** ❑No ❑Yes, (❑Rarely, ❑Often)

Ever had worms or parasites? ❑No ❑Yes, how were they treated? _____

Rectal Itching? ❑No ❑Yes, how often?_____

Urination: #___ x per day, and #____ X at Night, ❑"too often", ❑Painful, ❑Difficult Starting or Stopping, ❑ Itching, ❑Burning

Urine color: ❑Clear, ❑Pale Yellow, ❑Bright Yellow, ❑Dark Yellow, ❑Cloudy, ❑Mucus, ❑Blood, ❑It Varies
❑Other

EMOTION, PSYCH, METABOLISM, SLEEP:

I am/have: ❑Nervousness, ❑Anxiety (mild moderate severe), ❑Depression (mild moderate severe),, ❑Sensitivity to Noise,
❑Ease Confusion, ❑Sleepy During Days, ❑Exhausted a lot, ❑Fatigue Easily, ❑Loss of Appetite, ❑Rage, ❑Fearful,
❑Hear Voices, ❑Weakness, ❑Poor Memory, ❑Irritability, ❑Morbid Thoughts, ❑Suspicions of Others,
❑Thoughts of Suicide, ❑Quick Mood Changes, ❑Fear of Insanity, ❑Avoid Crowds, ❑People Avoid Me,
❑Fear of Serious Disease Like _____ ❑Other

I Have: ❑Adrenal Fatigue, ❑Hypothyroid; ❑Hashimoto's, ❑Grave's disease (hyperthyroid), ❑Goiter,

❑I am cold when others are comfortable, ❑Feet Too Hot, ❑Have Cold Hands, ❑Have Cold Feet,
❑I Perspire Too Much, ❑I Perspire Too Little with Exercise

Do you get Adequate Sleep? ❑Yes, how much?_____ hrs ❑No, why?_____

I ❑fall asleep easily, ❑hard time falling asleep, ❑often wake up & can't back to sleep, ❑often wake up 2am to 4am.

I ❑Take Daytime Naps, ❑Dream Too Much, ❑Have No Dreams at all, ❑Have Nightmares

❑I have (mild moderate severe) Insomnia), ❑I usually wake up tired,

What time to you normally go to bed? _____ pm am

Rate the quality of your sleep (1 being awful & 10 being great): (_____)

My libido (sex drive) is: ❑Normal, ❑Excessive, ❑Increased, ❑Diminished, ❑Absent

MEN ONLY:

I have/had: ❑BPH (Benign Prostatic Hypertrophy), ❑ED (Erectile Dysfunction),_____

I am on: ❑Hormone Replacement Therapy (❑Bio-Identical, ❑Synthetic) what?_____

FEMALE ONLY:

Are you pregnant, or think you could be? ❑No ❑Yes, when are you due?_____ Date of last menstrual period_____

❑Have a Normal cycle, ❑Regular cycle every _____days, ❑Irregular cycle, ❑No Period in ____Months/Years, ❑Painful on First Day, ❑Cramps, ❑Heavy Flow, ❑Scanty Flow, ❑PMS, ❑Hot Flashes, ❑Sweats, ❑Painful Before & During, ❑2 or more cycles a Month, ❑Clots, (Explain)

❑First Period age?_____, ❑Abnormal Since age _____, ❑Menstrual Problems Before First Child, ❑Menstrual Problems After first Child, ❑Menopause, at what age?_____, ❑Hysterectomy, at what age? _____,

I am on: ❑Hormone Replacement Therapy (❑Bio-Identical, ❑Synthetic),what?_____

❑Birth Control Pills, ❑was on Birth Control, but Stopped on _____ (Date),

Menstrual Blood Color is: ❑Pink, ❑Red, ❑Brown, ❑Black, ❑Other _____

I have/had: ❑PCOS, ❑Endometriosis, ❑Constipation with Periods, ❑Diarrhea with Periods, ❑Uterus is in Position,

❑Uterus is out of Position, ❑Prolapsed Uterus, ❑Prolapsed Bladder,

Breast soreness: ❑Before Periods, ❑During Periods, ❑After Periods, ❑All Month Long

Breasts: ❑Firm, ❑Soft, ❑Implants, ❑Reduction Surgery(date)_____, ❑Breast Lumps, ❑Fibrocystic Breasts,

❑Have/Had Breast Cancer (explain)

Have: ❑No Children, # ____ Children, Have Been Pregnant #_____ Times,

I get: ❑Bladder/Urinary Tract Infections (UTI), ❑Candida (Yeast Infections), ❑Yeast Infections After Antibiotics,

❑Vaginal Burning/Itching (❑Inside, ❑Outside), ❑Vaginal Dryness, ❑Painful Intercourse

DIETARY HISTORY: – (Be Brutally Honest - The More Real Your Answers the More Help You Will Receive)

Would it be difficult for you If a change in your current eating habits are recommended,? ❑No ❑Yes, explain?

Are you on a Special Diet? ❑No, ❑Low Sodium, ❑Low Fat, ❑Atkins, ❑South Beach, ❑other _____

Have You Ever Done Any Forms Of Detoxification? Explain

Diet Preference: ❑Vegetarian, ❑Vegan, ❑Mostly Vegi / Some Meat ❑Mostly Meat / Some Vegi ❑Fish ❑Chicken ❑Beef ❑Soy ❑Other

In your opinion, is your current diet mostly healthy? ❑Yes ❑No, explain?

My appetite is: ❑normal ❑excessive ❑Sporadic ❑poor ❑no appetite. **I Eat:** ❑fast ❑medium ❑slow ❑Other

List Your 10 Favorite Foods Eaten Most Frequently?

1 _____ 6 _____

2 _____ 7 _____

3 _____ 8 _____

4 _____ 9 _____

5 _____ 10_____

List Your Least Favorite Foods?

_____

_____

Any Known Allergy/Sensitivity to Foods, or Environmental Agents? **Describe your Reaction(s)**

_____

_____

_____

Do you react to? ❑Gluten (wheat, rye, barley) ❑Lactose ❑Eggs ❑Soy ❑Dairy ❑Other_____ ❑None ❑Don't know

List Any Food Cravings.

_____

_____

How Many Meals Do You Normally Eat on Work Days? #_____meals a day. **On Weekends?** #_____meals a day.

What % of your meals are: Fresh Home___%, Packaged/Frozen___%, Restaurant ___%, Fast Food ___%, Vending Machine ___%

Baked___%, broiled___%, boiled___%, fried___%, charcoal___%, steamed___%, raw___%,

Rank in Order of Preference: (1 2 3 4 5 Etc) Sweet___, Sour___, Salt___, Chocolate___, Water___, Dirt ___, Other_____

If you snack what Do You Normally Snack On?_____

How many times a week do you eat the following? ❑None

❑ice cream/frozen desserts #___per week, ❑cookies #___per week, ❑sweet roll/pastries #___per week,
❑candy, candy bars #___per week, ❑desserts pie, cake #___per week, ❑other sweets_____ #___per week

Do You Eat Before Bedtime? ❑No ❑Yes, What? _____

Do you regularly eat Fermented Foods? ❑No ❑Yes, which ones; ❑Sauerkraut, ❑Keefer , ❑Yogurt (❑lowfat, ❑flavored, ❑plain),

❑miso, ❑Natto, ❑(other) _____

Do you try to eat Low Fat &/or No Fat Foods? ❑No ❑Yes, What? _____

Why? _____

Your Liquid Consumption: (0 for None)

Water:	#___ 12oz glasses a ❑day ❑week	Milk:	#___ 12oz glasses a ❑day ❑week
Coffee:	#___ 6 oz glasses a ❑day ❑week	Beer:	#___ 12oz glasses a ❑day ❑week
Tea:	#___ 6 oz glasses a ❑day ❑week	Wine:	#___ 12oz glasses a ❑day ❑week
Soda:	#___ 12oz glasses a ❑day ❑week	Liquor:	#___ 6 oz glasses a ❑day ❑week
Diet Soda:	#___ 12oz glasses a ❑day ❑week		
Energy drinks:	#___ 46oz glasses a ❑day ❑week	_____:	#___ 12oz glasses a ❑day ❑week

Are you an Alcoholic ❑No, ❑Yes, How long?__years. ❑Still Drinking. ❑In recovery, How long?_____ ❑months, ❑ years.

7 Day Food Diary

List all foods and beverages consumed for one full week. Include the food eaten and the amount.

Time	Meal Eaten	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	Breakfast							
	Snack							
	Lunch							
	Snack							
	Dinner							
	Snack							
	Other							

Do you have any other past or present health issues, or concerns, not covered in this questionnaire that you would like the doctor to know about? ❑No ❑Yes, Please explain;

What are your Goals for this Nutritional Evaluation?

1. -
2. -
3. -
4. -

What are your Barriers to Success, **if any**? (e.g. time, money, motivation, etc).

1. -
2. -
3. -
4. -

OUR FINANCIAL POLICY

To keep our costs and prices low we operate on a cash basis. We do not bill insurance. On request we will provide you with a statement you can mail to your insurance company for direct reimbursement according to the terms of your contract with them.

Patient/Parent/Guardian **Signature** _____ **Date** _____