DIABLO CHIROPRACTIC
NUTRITION + WELLNESS CONSULTATION
CONFIDENTIAL HEALTH HISTORY

Name_____ Date of Birth _____ Date _____
Address _____ City _____ State _____ Zip _____
Phone _____ Email _____
Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____
Marital Status: Single ___ Partner ___ Married ___ Separated ___ Divorced ___ Widow ___

LIST GOALS FOR THIS VISIT: _____
_____
_____
_____
_____

Date of last physical exam: _____ Practitioner name and phone number _____

What types of therapy have you tried for this problem/s:
Diet Modification _____ Fasting_____ Vitamins/Minerals_____ Herbs_____ Homeopathy _____ Chiropractic_____
Acupuncture_____ Conventional Drugs _____ Massage_____ Other_____

Current medications (prescription or over the counter): _____
_____
_____
Major Hospitalizations, Surgeries, Injuries. Please list all procedures and dates: _____
_____
_____
_____

Circle the level of stress you are experiencing on a scale of 1-10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10
Identify the major causes of stress (eg., changes in job, work, residence, financial, relationship, legal, other):
_____
_____
_____

Do you consider yourself: underweight_____ overweight_____ just right_____
Your weight today_____ Weight 6 months ago_____ Weight 1 year ago_____
Do you sleep well_____ How many hours/night_____ Do you wake up throughout the night_____
If so, what time_____

Do you cook?_____ What % of your food is home cooked _____
Where does the rest of your food come from _____

MEDICAL HISTORY

Allergies/hay fever_____
Arthritis_____
Asthma_____
Alcoholism_____
Alzheimer's Disease_____
Autoimmune Disease_____
Blood pressure issues_____
Bronchitis_____
Cancer_____
Chronic Fatigue_____
Carpal Tunnel Syn._____
Cholesterol, elevated_____
Circulatory problems_____
Colitis_____
Constipation _____
Dental problems_____
Depression_____
Diabetes_____
Diarrhea_____
Diverticular Disease_____
Drug addiction_____
Fatigue_____
Eating Disorder_____
Epilepsy_____
Eyes, ears, nose, throat problems_____
Environmental Sensitivities_____
Fibromyalgia_____
Food intolerance_____
Gastroesophageal reflux _____
Genetic disorder_____
Glaucoma_____
Gout_____
Heart Disease_____
Infection, chronic_____
Inflammatory bowel disease_____
Insomnia_____
Kidney or bladder disease_____
Learning disabilities_____
Liver/Gallbladder disease_____
Mental illness_____
Migraine headaches_____
Neurological problems (Parkinson's, paralysis)____
Sinus problems_____
Stroke_____
Thyroid trouble_____
Obesity_____
Osteoporosis_____
Pneumonia_____
STD_____
Seasonal Affective Disorder_____
Skin Problems_____
Tuberculosis_____
Ulcers_____
Urinary Tract Infections____
Varicose veins_____

MEDICAL (MEN)

Prostrate cancer_____
Decreased sex drive____
Infertility_____
Urinating at night_____
STD_____
Other: _____

MEDICAL (WOMEN)

Menstrual irregularities_____
Endometriosis_____
Infertility_____
Fibrocystic breasts_____
Fibroids/ovarian cysts_____
PMS_____
Breast Cancer_____
Pelvic Inflammatory Disease_____
Vaginal infections/Discharge_____
Decreased sex drive_____
STD_____
Age of first period_____
Date of last gynecological exam_____
Mammogram_____
Pap_____
Number of children_____
Number of pregnancies____
C-section_____
Menopause_____
Date of last period_____
Length of cycle_____days
Interval of time between cycles_____
Any recent changes in normal menstrual flow (eg., heavier, large clots, spotting)_____

FAMILY HEALTH HISTORY (PARENTS + SIBLINGS)

Arthritis_____
Asthma_____
Alcoholism_____
Alzheimer's disease____
Cancer_____
Depression_____
Diabetes_____
Drug addiction_____
Eating disorder_____
Genetic disorder_____
Glaucoma_____
Heart disease_____
Infertility_____
Learning Disabilities_____
Mental illness_____
Migraine Headaches_____
Neurological disorders_____
Obesity_____
Osteoporosis_____
Stroke_____
Suicide_____
Other_____

HEALTH HABITS

Tobacco:
Cigarettes: #/day_____
Cigars: #/day_____
Alcohol
Wine: #glasses/d or wk____
Liquor: #glasses/d or wk____
Beer: #glasses/d or wk____
Recreational Drugs_____
Caffeine:
Coffee: #cups/day_____
Tea: #cups/day_____
Soda: #cans/day_____
Water: #glasses/d_____

EXERCISE

5-7 days/wk_____
3-4 days/wk_____
1-2 days/wk_____
What form do you prefer?_____

NUTRITION + DIET

Mixed food diet (animal + vegetable sources)____
Vegetarian_____
Vegan_____
Salt restriction_____
Fat restriction_____
Starch restriction_____
Food Allergies_____

EATING HABITS

Skip breakfast_____
Two meals/day_____
One meal/day_____
Graze_____
Food rotation_____
Constantly hungry_____
Eat on the run_____

CURRENT SUPPLEMENTS

Multivitamin/Mineral___
Vit C_____
Vit E_____
EPA/DHA____
Evening Primrose/GLA____
Calcium, source_____
Magnesium_____
Zinc_____
Minerals, describe_____
Probiotics_____
Digestive Enzymes_____
Amino Acids_____
CoQ10_____
Antioxidants_____
Herbs, teas_____
Herbs, extracts_____
Chinese herbs_____
Ayurvedic herbs_____
Bach flowers_____
Protein shakes_____
Superfoods (eg., maca, cacao, bee pollen)_____
Liquid meals_____
Other_____

GOALS:

Have more energy_____
Be stronger_____
Have more endurance____
Increase exercise_____
Live pain-free_____
Have better mobility____
Decrease stress_____
Manage stress better____
Reduce food cravings_____
Increase sex drive_____
Lose weight_____
Be more muscular_____
Improve complexion____
Have healthier hair_____
Have healthier nails_____
Be less moody_____
Be less depressed_____
De less indecisive_____
Do better on tests in school_____
Feel more motivated____
Be more organized_____
Increase mental clarity_____
Improve memory_____
Not be dependent on over the counter medications_____
Sleep better_____
Get rid of allergies_____
Improve immunity_____
Get less colds + flu_____
Have stronger teeth_____
Reduce your risk of inherited disease tendencies (e.g., cancer, heart disease, etc)_____