Alaska Health Improvement Center

PLEASE PRINT CLEARLY:

Name _____ Date _____

Street _____ Apt # _____

City _____ State_____ZIP_____

Social Security Number _____ - ___ - _____ Date of Birth_____ Age ____ Gender: M / F

Occupation _____ Employer / # hours per week _____/ _____

Home Phone (____) ____-_____ Cell (____) ____-_____Work (____) ____-_____

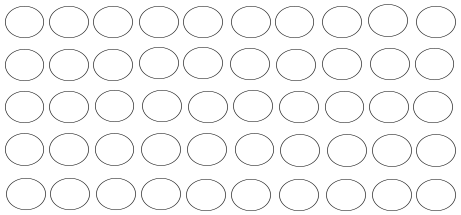
e-mail address: _____

REFERRED BY: _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other:_____

Please list your top symptoms in order of importance: How bad? **Really bad** **Perfect**

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



Previous treatment(s) for symptom(s):_____

_____

How would fixing these symptoms help you in life?

1. _____

What long term health problem is effecting your desire to do what?

1. _____

List any Life Threatening Allergies:_____

Are you currently under the care of a physician or other health care professionals? Yes / No

Provider's name:_____ Date of last visit: _____

Provider's name:_____ Date of last visit:_____

Provider's name:_____ Date of last visit:_____

Current medications/drugs and dose: (use separate sheet if needed)

Name / dose:	Name / dose:
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Nutritional supplements you are taking: _____

_____

Name: _____ Date_____

HEALTH HISTORY, FAMILY, LIFESTYLE:

List other major illnesses (with approx. dates): _____

_____

List any surgery or operations with approx. date:_____

_____

Past accidents or injuries: _____

_____

Do you smoke, drink coffee or alcohol? (if yes indicate how much per day):

Cigarettes _____ Coffee _____ Alcohol _____

What role do sports and exercise play in your life?_____

_____

Marital Status: S M D W Spouse's name: _____

Please describe your spouse's health:_____

Name(s) of Children	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle any that apply or describe):

Cancer / Diabetes / Heart / Other:_____

Do you or family members come in close contact with household pets or other animals? (List)

_____

WHAT ARE YOUR EXPECTATIONS?

How long do you expect it to take to fully resolve your health?_____

The most important things I should do to improve my health are:

1. _____
2. _____

Will your family and/or friends be supportive of your desire to make food and/or lifestyle changes? ___

On a scale of 1-10, how important is it for you to improve this situation?

Unimportant **1 2 3 4 5 6 7 8 9 10** I'd do anything to fix this!

Are there specific services you are seeking from this office? (check all that apply)

r Chiropractic
r Nutrition Response Testing℠
r Designed Clinical Nutrition℠
r Allergy Clearing
r Physical Rehabilitation & Clinical Massage
r Education regarding my health situation
r Comprehensive testing and treatment plan

SIGNED:_____ **DATE** _____

Name: _____ Date_____

DIETARY INFORMATION

What foods did you eat often as a child?

Breakfast	Lunch	Dinner	Snacks	Liquids

Please write down what you have eaten over the last two days:

Breakfast	Lunch	Dinner	Snacks	Liquids

Breakfast	Lunch	Dinner	Snacks	Liquids

Do you cook? _____ What percentage of your food is home-cooked?

Where do you get the rest from?_____

Do you crave sugar, coffee, cigarettes, or have any major addictions? _____

Please explain: _____

_____

BODY CARE INFORMATION

Please list the body care products you typically used as a child/teenager (lotions, deoderant, perfume, makeup)

_____

_____

Please list the body care products you currently use or used recently (lotions, deoderant, perfume, makeup)

_____

_____

_____

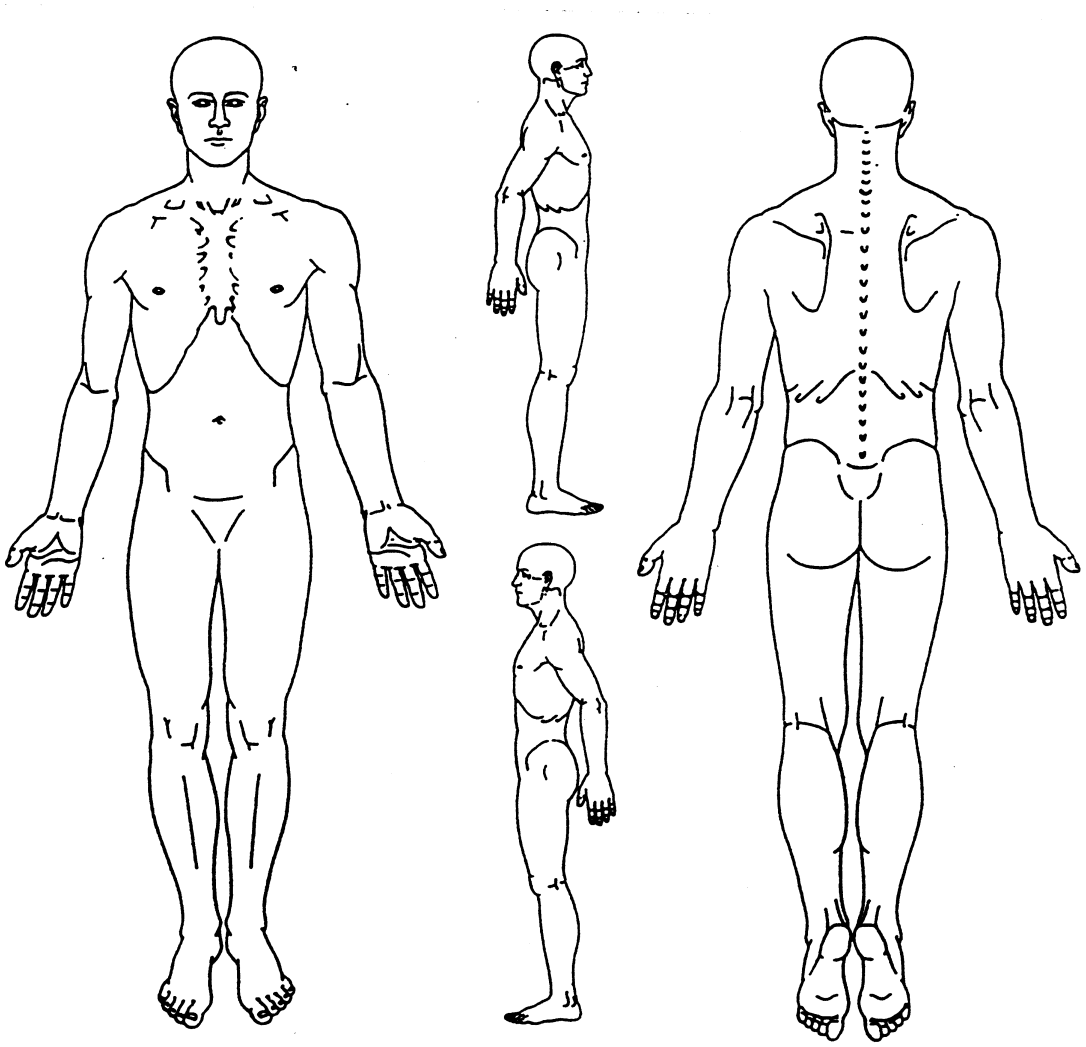
Name: _____ Date_____

SCARS

Your "automatic" body functions (heart rate, blood pressure, digestion, elimination of waste, rebuilding the body and growth) are coordinated by your nervous system.[1]

Scars, just like exposures to toxins, food sensitivities, nutrient deficiencies and spinal misalignments, can disrupt proper nervous system function. Much (80 percent!) of the nerves that coordinate how your body responds to things around it are in your skin, organized into patterns, or "meridians," that form distinct patterns. Scars cut across these ordered patterns and can block or disorder nerve flow.

For proper healing, we need to evaluate any scars. Please draw all "scars" from surgery, injury, stretch marks, burns, scrapes, etc. Please write the cause of the scar and how long it has been there.



[1] The autonomic nervous system is divided into two portions: the sympathetic nervous system activates glands and organs that produce action and defend the body from attack. It is sometimes called the "fight or flight" system. The parasympathetic system is concerned with nourishing, healing, and regeneration of the body. It is more active at rest.