NEW CLIENT EVALUATION

NATURAL HEALTH IMPROVEMENT CENTER

First Name__________________ Last Name______________________ Date____________

Address________________________________ City____________________ Zip__________

Home #_____________ Cell #_____________ Work #_____________

Email Address____

Height__________ Weight__________ Age__________ Date of Birth________________

No. of Children_____________ Marital Status ☐S ☐M ☐D ☐W

What is your occupation?____

How did you hear about us?____

My Main Health Concerns: (Check all that apply)

☐Allergies ☐Fatigue ☐Chronic Pain ☐Digestive Issues ☐Headaches

☐Weight Loss ☐Overall Wellness ☐Other________________________________

Complaints Please tell us the reason why you are here__________________________________

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Secondary Complaints Please let us know any other health concerns that you have __________

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____

Previous Treatment for these Complaint ____

____

____

Medication Please let us know all prescription Medications you are taking_________________

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____

Major Illnesses Please list any major illnesses and approximate dates_____________________

____

____

Surgeries Please list any surgeries and approximate dates_____________________________

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____

Injuries Please list any accidents or injuries and approximate dates_____________________

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Chiropractic Care When was your last spinal examination_____________________________

Women Only

Are you pregnant?______________ Are you nursing?_____________

Please List any Gynecologic surgeries (hysterectomy, endometriosis, ovarian cysts)________________

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Menstrual Cycle: What was the 1st day of your last menstrual period? __________________________
Do you have regular monthly periods?____________________

Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moody Cravings Heavy Bleeding Back Pain Headaches Clots

Sleep (please circle) Trouble falling asleep Can't stay asleep Bad dreams
Any other sleep problems? ____

Pets Any pets? ________ If so, what kind and how many? ____________________________

Exercise What kind of exercise do you do? ____
How often? ______________________________ Duration _______________________________

Food Allergies Please list ____

Food Cravings

Regardless of whether or not you let yourself eat these foods, If you could have any Breakfast, Lunch or Dinner which would you choose?

Breakfast (choose 1)

- ☐Poached eggs w/ hollandaise sauce
- ☐Bacon and eggs
- ☐Granola and yogurt
- ☐Toast and oatmeal and coffee or tea

Lunch (choose 1)

- ☐Barbecued ribs or teriyaki and chips
- ☐Hamburger and French Fries
- ☐A cheese sandwich and/or a milkshake
- ☐A sandwich, pretzels and a soda or coffee

Dinner (Choose 1)

- ☐Thai food
- ☐A nice steak
- ☐Pizza
- ☐Pasta with Sauce

MEDICAL HISTORY (check all that apply)
ARE YOU CURRENTLY:

- ❑Diabetic _____Insulin _____Oral Medication
- ❑Controlling diabetes through your diet
- ❑On blood pressure medication/ how many?___
- ❑Under a doctor's care for stroke
- ❑Taking high doses of psychotropic drugs
- ❑Being treated for anxiety or depression
- ❑Receiving chemotherapy or radiation for cancer
- ❑In remission from cancer. ______ years.
- ❑Being treated for anorexia nervosa or bulimia
- ❑Under treatment for Alcohol / Drug addictions
- ❑Under the age of 14
- ❑Pregnant
- ❑Breast feeding a child. If so, is this the child's sole source of food? Y/____________________

DO YOU HAVE:

- ❑A history of cardiovascular problems
- ❑Less than one full functioning kidney
- ❑Kidney Stones
- ❑Cirrhosis of the liver
- ❑Diverticulitis or Colitis
- ❑Crohn's Disease
- ❑Active Ulcer
- ❑Multiple Sclerosis
- ❑Blood disorders (Hemophiliac)
- ❑Uncontrollable Epilepsy
- ❑A systemic diseases (Lupus, Lymes)
- ❑Untreated Graves Disease
- ❑Tuberculosis
- ❑Electrolyte Imbalance
- ❑Gout
- ❑AIDS or are you HIV positive
- ❑Active Sickle Cell Anemia
- ❑Increased Uric Acid
- ❑Low Blood Pressure
- ❑Blood pressure exceeding 160/90 (with or without medication)
- ❑Cardiac Arrhythmia
- ❑Hypothyroidism
- ❑Any other medical conditions that we should know of. If yes, what?____________
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HAVE YOU HAD:

- ❑Any major surgery within the last 60 days?
- ❑Heart attack and/or angina in past year?
- ❑Any heart condition? If yes, what? When?
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