Inner Rhythms Chiropractic

Health Questionnaire

First Name:_____ Last Name:_____ Date:_____
Cell Phone:_____ E-Mail: _____
How did you discover our office and the professional services we offer?_____

EXTREMELY IMPORTANT TO YOUR HEALTH AND VITALITY THAT YOU FILL OUT COMPLETELY
Please use back of sheet to elaborate on any/all answers- the more info the better!

How do you grade your physical health? Great (10-8) Good (8-6) Fair (6-4) Poor (4-0)
How do you grade your emotional/mental health? Great (10-8) Good (8-6) Fair (6-4) Poor (4-0)
What is your goal for your Overall health? Great (10-8) Good (8-6) Fair (6-4) Poor (4-0)

Please list **'P' = past or "C' = current** *AND* the **YEAR the symptom started**). Please list all the symptoms you feel, regardless if they bother you or not.

Low Back Pain_____	Arm/Hand Pain_____	Carpal Tunnel _____
Indigestion_____	Constipation _____	Diarrhea _____
IBS/Chrons _____	Leaky Gut _____	Gasy/Bloated _____
Swollen Joints _____	Painful Joints _____	Upper/Mid Back Pain_____
Neck Pain _____	Shoulder Pain _____	Leg/Foot Pain _____
Hip Pain _____	Ear Infections _____	Chronic Fatigue _____
Allergies/Sinus _____	Ashtma _____	Colds/Flus _____
Headaches _____	Migraines _____	High Blood Pressure_____
Depression _____	Anxiety _____	Memory Issues_____
Weight Gain _____	Sluggish _____	Low Libedo _____
Heart Arythmia_____	Heart Concerns_____	Psoriasis_____
TMJ pain_____	Sleep Issues_____	Diverticulitis_____
Skin rashes_____	Eczema_____	Carb cravings_____
Fibromyalgia_____	Food allergies_____	Respiratory allergies_____
Brain Fog_____	Dizziness_____	Tinnitius_____
Mood Swings_____	Pressure on Chest_____	Heart Pounding_____
Nausea_____	Twitching_____	Speaking Difficulty_____
Cold hands/feet_____	Hair Loss_____	Brittle Nails_____
Swollen Face_____	Hand/Foot Tingling_____	Gout_____
Dry Skin/Eczema_____	Temp Intolerance_____	Endometriosis/Cysts_____
_____	_____	_____

Please list the primary health concerns you are experiencing that you're looking for the most help with:
1)_____ 2)_____ 3)_____
Please describe your experience with these health concerns:_____
_____
What have you tried as a treatment that hasn't worked?_____
_____

Please grade the level to which this health concern(s) affects these aspects of your functioning/ quality of life. **0 -Non-existent 1 - Poor 2 - Mediocre 3 -Great**

Work	0 1 2 3	Recreation/Play	0 1 2 3	Rest/Sleep	0 1 2 3
Social life	0 1 2 3	Walking	0 1 2 3	Sitting	0 1 2 3
Exercise	0 1 2 3	Eating	0 1 2 3	Love life	0 1 2 3

Any Cancer?____If so-types & Tx:_____

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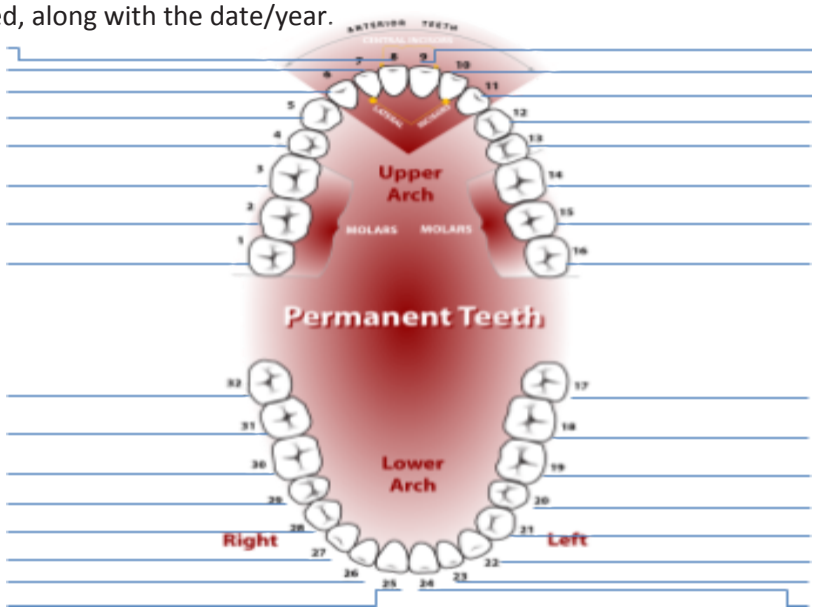
Have any other family members experienced your health concerns? Any thing appear to 'Run in the Family'???_____

Please grade the following on a scale of 0 to 10 (**0-NOT AT ALL 10-MOST)**

a) Currently, how inconvenient is your situation, condition, or symptom? 0 1 2 3 4 5 6 7 8 9 10

b) How committed are you to getting optimal health & well-being? 0 1 2 3 4 5 6 7 8 9 10

Please mark on the tooth chart any work that you have had done. Mark the tooth and label what type of work was performed, along with the date/year.



The type of diet I usually follow is classified as: _____

Please check the foods that you eat and list how often you eat them:

Refined Starchy Foods:

Pasta _____
Rice_____
Potatoes__ _____
Potato Chips_ _____
Milk _____
Bread __ _____
Tortillas _____ _____
Pastries __ _____
Grain Flour _____
Cookies____ _____
Crackers _____
Cereal _____
Contain casein A-1 yogurt_____
Greek Yogurt_____
Frozen Yogurts_____
American Cheese_____
Ricotta_____
Cottage Cheese_____
Kefir_____
Kashi/Spelt_____

Sugar _____
Agave ____ _____
Splenda/Nutrasweet _____
Diet Drinks__ _____
Maltodextrin _____

VEGETABLES

Tomatoes _____
Cucumbers _____
Peas _____
Sugar Snap peas _____
Soy/Tofu/Edamame_____
All beans/lentils_____
Casein Protein Powder_____
Whole Grains_____
Wheat Einkorn_____
Wheat Kamut_____
Oats_____
Quinoa _____
Rye/Bulgur_____
Soy Oils_____

NUTS & SEEDS

Pumpkin _____
Sunflower _____
Chia _____
Peanuts_____
Chasews_____

FRUITS/VEGGIES

All Fruits (when)_____
Ripe Bananas_____
Zucchini___ _____
Pumpkins_____
Squashes_____
Melons_____
Eggplants_____
Bell Peppers_____
Chili Peppers_____
Goji Berries_____
Brown/White Rice_____
Corn/Corn Products-_____
Grapeseed Oil_____

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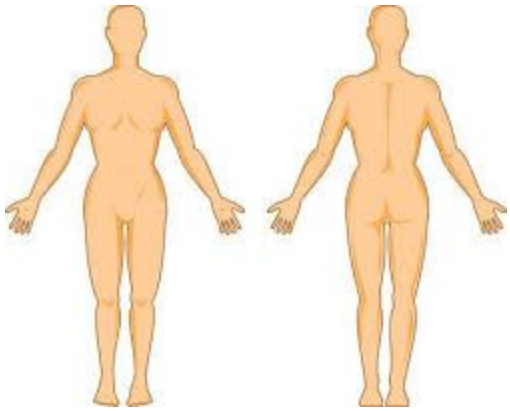
Corn/Peanut Oil_____ Cottonseed oil_____ Safflower/Sunflower oil_____
Part. Hydrog Oil/Canola_____

How many servings of Veggies do you eat per day? (1 serving = size of fist)_____
How many servings of Fruits do you eat per day? (1 serving = size of fist)_____
Do you eat any seaweed/ Kelp / Supplement Iodine?_____If so, how much?_____
Have you ever been diagnosed for a thyroid condition?_____
Do you suspect that you may have one?_____
If you have any Lab Testing on Blood work, please bring to your next visit! TSH____T4_____T3_____

Please perform the Basal Body Temperature Test attached at the end of this questionnaire.

Do you have any scars or tattoos on your body? (Please mark on body below)



Do you use a microwave for food/water?_____How often?_____Use glass or plastic ?
Do you put hot things in plastic?_____
Do you drink Pop &/or Diet Pop?_____ If so, how much per day?_____
How much processed foods (in a wrapper) do you eat per day?_____
Do you buy/store food in plastic containers/wrapping? _____
How much water do you drink per day in ounces?_____Do you filter it?_____
How many bowel movements per day do you have?_____
How long of a shower/bath do you take?_____ Daily?_____Warm/hot water used?_____
Are you aware/concerned about the quality of your water?_____ Why?_____
Are you aware that there are cell towers on our water towers?_____
How much sleep per night do you get?_____
Rate quality of sleep on 1-10 scale, 10 = best?_____
Do you consistently wake up at night?_____**Please list consistent times!**_____
Any difficulty with sleep?_____
Do you have a chronic sore area of your body that won't get better? _____
Is it worse at night &/or in the AM??_____if so, what exact time is it the worst?_____
Have you heard of GeoPathic Stress / Laylines?_____
Have you heard of Dirty Electricity?_____
Do you own a cell phone?_____
Do you own a cordless phone?_____
Do you sleep with either near you at night?_____How close to you?_____
Do you put your cell phone on airplane mode ever?_____When?_____
Do you talk on your phone near your head?_____# of minutes per day?_____
How do you carry your phone during the day?_____
Do you use a computer/laptop/phone for social media/word processing/internet etc?_____
If so, how many total hours per day are you on a 'smart' device?_____

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Is preventing macular degeneration and eye health something your interested in?_____
Do you live in an apartment/townhouse/house?_____
Do you have a wifi router in your residence?_____Do you turn it off ever?_____
Where is your wifi router located in your house?_____Smart meter?_____
What room is adjacent to the wall of the smart meter? _____
What are you thoughts on the chemical trails following the airplanes?_____
Do you know what Aluminum and other heavy metals do to health?_____
Have you noticed any memory concerns in the last few years?_____
Is preventing Alzheimers, Dementia, Autism, ADHD a priority for you?_____
How many hours per day do you sit?_____ At a computer/phone?_____
Has your home ever flooded?_____if so, when?_____Any water leaks?_____
What type of flooring do you have in your home?_____carpet type?_____
What cleaning products do you use: floors_____ clothes_____Dishes_____Wood_____
Do you use any air fresheners? _____Spray/outlet/etc?_____
What type of toothpaste do you use?_____Shampoo/BodySoap_____
What type of deodorant do you use?_____Make up?_____

AUTOMOBILE ACCIDENTS:

Have you (even as a passenger and even if you do not think you were hurt) been involved in a vehicular collision, or near collision?

_____

Please list approximate dates, severity (Mild, Moderate, or Extreme), speed, description. (N/A if no accident).Most Recent Major Accident:_____

2nd most major accident:_____

With each of the following potential spinal stress situations, please fill in MI – mild, MO- moderate, EX – extreme, NA- Not aware, in either the past (P) column or current (C).

	P	C		P	C
Childhood stress			Work related Stress		
School stress			Commuting Stress		
Play/Recreation			Loss of loved one		
Family Stress			Change in Lifestyle		
Personal Relationships			Change in vocation		
Sickness Stress			Abuse		

Medications

Please list any/all medications that you are/have consumed:_____

_____

How many rounds of Antibiotics have you taken in your life?_____
Have you ever taken a probiotic?_____If so, how many times?_____
Are you currently taking a probiotic?_____
How many vaccinations have you had?(Please list years received)_____
How many flu shots? (Please list years received)_____
Have you ever been hospitalized? ☐ Yes ☐ No If yes, what was actually done to you?_____
Have you had: surgery? ☐ Yes ☐ No If yes, please explain:

_____

☐ a spinal tap ☐ spinal injections ☐ physiotherapy ☐ neck collar ☐ transfusion

☐ spinal brace ☐ heel lift ☐ x-ray treatments ☐ traction

☐extensive diagnostic x - rays ☐acupuncture ☐chemotherapy ☐body/arm cast

Is there anything else you wish to communicate about your health today?

_____

_____

Please review you answers and fill out every question as thoroughly as possible.
The next page highlights the instructions for taking your Basal Body Temperature.

The following guidelines should be followed when charting Basal Body Temperature

- Take your temperature at as close to the same time every morning as possible.
- Take your temperature as soon as you wake up, after a solid block of sleep, **before moving around and getting up!**
- Use an accurate thermometer (basal thermometer available at your drugstore/pharmacy).
- Record your temperature as soon as possible after taking it.
- You can take your temperature under your armpit for 5 minutes, use the same armpit to measure each day. Record for 3-5 days and be consistent throughout the cycle.

More...

Thermometer

It is important to use an accurate thermometer. We recommend using a digital BBT thermometer. A digital BBT thermometer gives a quick reading, beeps when it is finished recording the temperature, and is easy to read. This can make a difference when you are bleary-eyed first thing in the morning. Your thermometer will likely store your reading for you, though we recommend to record it right away, either using a bedside notepad.

Digital BBT thermometer are inexpensive and available at most drugstores and online retailers. The brand does not matter much but you may want to look at the features provided (such as memory or backlighting).