PISKER FAMILY CHIROPRACTIC

Initial Nutrition Form

PLEASE PRINT

Name:_____ Date:_____ Date of Birth:_____

Address:_____ City: _____State:_____ Zip:_____

Best contact number to reach you:_____ Email:_____

Chief Complaints (reasons you are here) describe problem fully:

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

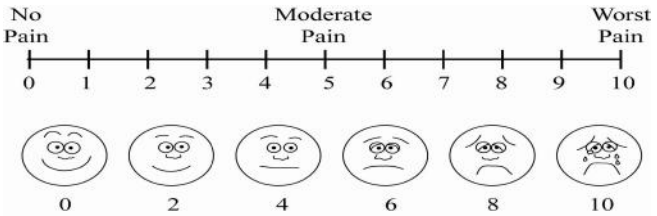
Previous treatment for these complaints:

_____

Current meds or supplements taken:

_____

If applies, please circle your pain level:



History:

List any major illnesses (with approx. Dates):

_____

List any surgery or operations with approx. date:

_____

Past Accidents or injuries:

_____

Martial Status: S M D W Name of Spouse_____

Describe health of spouse:_____ number of childen(if any)_____

Name of child	Age	Sex	Any health challenges
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Any Family history of serious illness (circle those which apply) : Cancer/ Diabetes/ Heart/ Other_____

Any seasonal or pet allergies? Y or N If yes, please describe

_____

What can we do to make you happier?_____

Using the chart below please answer the following questions:

1. **What number best describes how you feel about your health today? _____**
2. **What health goal do you want to achieve? _____**

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
I have serious concerns about my overall health	I feel worried about my health	I have constant concerns about my health	I have challenges That affect me on a daily basis	I have some minor complaints about my health	I feel ok about my health no complaints	I feel good most days	I feel well on a daily basis	I feel energetic and healthy	I feel active, energetic and fit	I feel great and am proactive about my health

I am interested in (*circle any/all that apply*):

family wellness plan chiropractic care weight loss detoxification hormone balancing exercise program nutritional therapy

Would you be interested in the doctor doing a nutritional class at your place of employment or organization? Y or N

Patient Signature:_____ Date:_____