Zionsville Holistic Chiropractic and Wellness Center  Confidential Health History

***Welcome***

Name: _____ Date:____/____/____

Home Phone: ____-_____-_____ Cell Phone: ____-_____-_____ Work phone: ____-____-____

Home Address: _____City:_____

State: _____ Zip: _____ Date of Birth: ____/____/_____ Age:_____ Marital Status: S M D W #of Children: ____

Your Occupation: _____ Email: _____ _____Yes, I would like to receive our FREE bi weekly e-newsletter. In case of Emergency call: _____

Referred By:_____ Employer Name: _____
Previous Chiropractic care? (Yes or No) _____ When? _____ Whom?_____
Is your condition due to an auto accident?___ or work related?___ Date of Injury_____ Claim#_____

**PRESENT COMPLAINTS**

1._____Date Started: ____/____/____

Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating (shooting) Numbness Tingling Weakness Spasm

What makes it better? _____ Worse?_____

What times of day is it worse or better? _____ Is it getting worse?_____

Does it interfere with certain activities? _____ Work Sleep Daily Routine Other:_____

Have you seen other doctors for this condition? _____Who?_____

Other Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/____ _____ 2.____/____/____ _____

3.____/____/____ _____ 4. ____/____/___ _____

**Other Complaints**

2._____Date Started: ____/____/____ Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating (shooting) Numbness Tingling Weakness Spasm

Does it interfere with certain activities? _____Work Sleep Daily Routine Other: _____

Have you seen other doctors for this condition? _____ Who?_____ Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/____ _____ 2.____/____/____ _____3.____/____/____ _____ 4. ____/____/____ _____

**PAST HEALTH HISTORY**

Please list **all** accidents injured or not, hospitalizations, surgeries, broken bones and the year they occurred.

_____

_____

There are some herbs that should not be taken in conjunction with prescription medications. Please list all current medications and duration of use including birth control pills/injections/patches and over the counter medications.

_____

List all past, including childhood, medications, and duration of use, including oral contraceptives and antibiotics.

_____

_

List all current vitamins, herbs, homeopathy and any other supplements.

_____

_____

*Physical Chemical and Emotional Stresses play a big part in our overall health. These questions are used to identify what stresses you have experienced both in the past and presently that could be contributing to your current health condition.*

**CHEMICAL STRESS** **Circle all that applies**

Alcohol Past Present
How often? _____

Soft drinks Past Present
How often? _____

Smoking Past Present
How often? _____ How long? _____

Second Hand Smoke Past Present
How many years? _____

Coffee/Tea Past Present
How often? _____

Excessive Sugar Past Present
How often? _____

Artificial Sweeteners Past Present
What kind? _____

Junk foods Past Present
How often? _____

Recreational Drugs Past Present
What kind? _____
How often? _____

Over-the-Counter Meds. (ex. Tylenol, Advil, etc.)
Past Present
What kind? _____
How often? _____

**EMOTIONAL STRESS** **Circle all that applies**

Relationships Past Present
Explain_____

Career Past Present
Explain_____

Children Past Present
Explain_____

Money Past Present
Explain_____

Hectic Life Past Present
Explain_____

Hold in feelings Past Present
Explain_____

Verbal abuse Past Present
Explain_____

Physical abuse Past Present
Explain_____

Sickness or Loss of Loved One Past Present
Explain_____

What do you feel is you greatest stress?
_____
_____
_

**DIET HISTORY**

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Snacks: _____-_____

Water consumption: How many glasses a day? _____

What are your daily activities and hobbies? _____

What kind of exercise do you do? _____

How often? _____

**FAMILY HISTORY**

Cancer: _____ Stroke: _____Diabetes: _____ Arthritis: _____ Heart Disease: _____

Auto Immune Disorders: _____ Other: _____

**Our priority is helping you achieve your health goals. What are your goals?** _____

_____

_____

__

*Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.*

**O - OCCASIONAL**
**F - FREQUENT**
**C - CONSTANT**

**O F C**

**GENERAL**

□□□ Allergy
□□□ Chills
□□□ Convulsions
□□□ Dizziness
□□□ Fainting
□□□ Fatigue
□□□ Fever
□□□ Headache
□□□ Loss of sleep
□□□ Loss of weight
□□□Nervousness/depression
□□□ Neuralgia
□□□ Numbness
□□□ Sweats
□□□ Tremors

**MUSCLE & JOINT**

□□□ Arthritis
□□□ Bursitis
□□□ Foot trouble
□□□ Hernia
□□□ Low back pain
□□□ Lumbago
□□□ Neck pain or stiffness
□□□ Pain between shoulders

Pain or numbness in:

□□□ Shoulders
□□□ Arms
□□□ Elbows
□□□ Hands
□□□ Hips
□□□ Legs
□□□ Knees
□□□ Feet
□□□ Painful tail bone
□□□ Poor posture
□□□ Sciatica
□□□ Spinal curvature
□□□ Swollen joints

**O F C**

**GASTRO-UNTESTINAL**

□□□ Belching or gas
□□□ Colitis
□□□ Colon trouble
□□□ Constipation
□□□ Diarrhea
□□□ Difficult digestion
□□□ Distension of abdomen
□□□ Excessive hunger
□□□ Gall bladder trouble
□□□ Hemorrhoids
□□□ Intestinal worms
□□□ Jaundice
□□□ Liver trouble
□□□ Nausea
□□□ Pain over stomach
□□□ Poor appetite
□□□ Vomiting
□□□ Vomiting of blood

**EYES, EARS, NOSE & THROAT**

□□□ Asthma
□□□ Colds
□□□ Crossed eyes
□□□ Deafness
□□□ Dental decay
□□□ Earache
□□□ Ear discharge
□□□ Ear noises
□□□ Enlarged glands
□□□ Enlarged thyroid
□□□ Eye pain
□□□ Failing vision
□□□ Far sightedness
□□□ Gum trouble
□□□ Hay fever
□□□ Hoarseness
□□□ Nasal obstruction
□□□ Near sightedness
□□□ Nosebleeds
□□□ Sinus infection
□□□ Sore throat
□□□ Tonsillitis

**O F C**

**CARDIO-VASCULAR**

□□□ Hardening of arteries
□□□ High blood pressure
□□□ Low blood pressure
□□□ Pain over heart
□□□ Poor circulation
□□□ Rapid heart beat
□□□ Slow heart beat
□□□ Swelling of ankles

**RESPIRATORY**

□□□ Chest pain
□□□ Chronic cough
□□□ Difficult breathing
□□□ Spitting up blood
□□□ Spitting up phlegm
□□□ Wheezing

**SKIN**

□□□ Boils
□□□ Bruise easily
□□□ Dryness
□□□ Hives or allergy
□□□ Itching
□□□ Skin eruptions (rash)
□□□ Varicose veins

**GENITO-URINARY**

□□□ Bed-wetting
□□□ Blood in urine
□□□ Frequent urination
□□□ Inability to control kidneys
□□□ Kidney infection or stones
□□□ Painful urination
□□□ Prostate trouble
□□□ Pus in urine

**FOR WOMEN ONLY**

□□□ Congested breasts
□□□ Cramps or backache
□□□ Excessive menstrual flow
□□□ Hot flashes
□□□ Irregular cycle
□□□ Menopausal symptoms
□□□ Painful menstruation
□□□ Vaginal discharge

□ Yes □ No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:**

□ Alcoholism
□ Anemia
□ Appendicitis
□ Arteriosclerosis
□ Arthritis
□ Cancer
□ Chorea
□ Cold sores
□ Diabetes
□ Diphtheria
□ Eczema
□ Emphysema
□ Epilepsy
□ Fever blisters
□ Goiter
□ Gout
□ Heart disease
□ HIV/AIDS
□ Influenza
□ Lumbago
□ Malaria
□ Measles
□ Miscarriage
□ Multiple sclerosis
□ Mumps
□ Pleurisy
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Scarlet fever
□ Stroke
□ Tuberculosis
□ Typhoid fever
□ Ulcers
□ Venereal Disease

**ZIONSVILE HOLISTIC CHIROPRACTIC AND WELLNESS CENTER, LLC**
**PATIENT-INFORMED CONSENT**
**The Doctor-Patient Relationship in Chiropractic**

## CHIROPRACTIC

Welcome to our office! It is very important to acknowledge the difference between the health care specialties of Chiropractic and Medicine. Chiropractic strives to enhance your health by natural means, without the use of drugs or surgery. Our job, if you are accepted as a patient, will be to help you raise your levels of health, not merely suppress your symptoms. As your health levels go up, very often your symptoms will go down. This is because the body is a self-healing organism, and Chiropractic assists the natural recuperative powers of the body to heal itself. The success of Chiropractic procedures often depend upon environment, underlying causes, and your physical, emotional, mental and spinal conditions. It is important to understand what to expect from our chiropractic health care services.

## ANALYSIS

We will be conducting a clinical analysis for the express purpose of determining whether or not you have one or more Vertebral Subluxation Complex(s)(VSC) or Vertebral Subluxation Syndrome(s)(VSS). If a VSC or VSS is in evidence, then Chiropractic adjustments and ancillary procedures may be given to you in an effort to stabilize and restore spinal integrity. It is a main Chiropractic premise that proper spinal alignment allows optimal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no ethical doctor, chiropractic or medical, can promise specific results. The results you receive will depend upon the natural inherent recuperative powers of your body.

## DIAGNOSIS

Chiropractors are not medical doctors, and just as a medical doctor is incompetent to render a chiropractic opinion because they have not had the proper training to do so, too, Dr. Whalen will not make a medical diagnosis or opinion. He will provide the very finest Chiropractic diagnosis, opinion, and care for you that he may see fit for his/her optimal health. Dr. Whalen may express her opinion to you in an effort to help you understand your situation better, but your health is your responsibility and you are responsible for the final decision.

## INFORMED CONSENT REGARDING CHIROPRACTIC CARE

Chiropractic provides a specialized non-duplicating health care service by the location, analysis, and stabilization of VSC or VSS. No other health care provider does this. If you are accepted as a patient, you are giving Dr. Whalen permission and authority to care for you in accordance with Chiropractic tests, analyses, and procedures. The Chiropractic adjustment or any other of our procedures are usually beneficial. In very rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. No adjustment or any other procedure will be performed if they are not indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/he is suffering from, be it latent pathological defects, illnesses, deformities, or other problems which would otherwise not come to the attention of Dr. Whalen. Careful attention must be taken to accurately complete our case history and any other forms required. Help us help you- please give us the information we request. Your attendance at one Health Seminar within the first 4-6 weeks of care is required so we may assist you completely as possible once you are accepted as a patient at our clinic.

## RESULTS

Our purpose is to help you by the location, analysis, and stabilization of VSC or VSS. This will assist in the natural promotion of health. Since there are many variables, it is difficult to predict results or the time necessary for them. Sometimes the results are exceptional! Sometimes not. Usually there will be a gradual satisfactory response. In any case, the fact is that no science, medical or chiropractic, is so exact as to have all the answers to all problems. Both have made great strides in helping millions of people and helping to alleviate pain and suffering.

PLEASE DISCUSS ANY QUESTIONS YOU MAY HAVE WITH DR. WHALEN BEFORE YOU SIGN THIS STATEMENT OF POLICY.

Date:_____Signature:_____

*Please check the appropriate box for any of the following symptoms which you now have or have had previously. We want all the facts about your health before we accept your case. THIS IS A CONFIDENTIAL HEALTH REPORT.*

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□ Yes □ No Are you pregnant?

**CHECK THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD:**

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□ Epilepsy
□ Fever blisters
□ Goiter
□ Gout
□ Heart disease
□ HIV/AIDS
□ Influenza
□ Lumbago
□ Malaria
□ Measles
□ Miscarriage
□ Multiple sclerosis
□ Mumps
□ Pleurisy
□ Pneumonia
□ Polio
□ Rheumatic fever
□ Scarlet fever
□ Stroke
□ Tuberculosis
□ Typhoid fever
□ Ulcers
□ Venereal Disease

# SYSTEMS SURVEY FORM

Maestro SYSTEMS SURVEY

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian ☐ Gluten-free ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

## GROUP 1 - Sympathetic Dominance

| | 1 2 3 | |
|---|---|---|
| 1 | ○○○ | Acid foods upset |
| 2 | ○○○ | Get chilled often |
| 3 | ○○○ | "Lump" in throat |
| 4 | ○○○ | Dry mouth-eyes-nose |
| 5 | ○○○ | Pulse speeds after meal |
| 6 | ○○○ | Keyed up - fail to calm |
| 7 | ○○○ | Gag occasionally |
| 8 | ○○○ | Unable to relax; startles easily |
| 9 | ○○○ | Extremities cold, clammy |
| 10 | ○○○ | Strong light irritates |
| 11 | ○○○ | Occasionally weak urine flow |
| 12 | ○○○ | Heart pounds after retiring |
| 13 | ○○○ | "Nervous" stomach |
| 14 | ○○○ | Appetite reduced occasionally |
| 15 | ○○○ | Cold sweats often |
| 16 | ○○○ | Get heated easily |
| 17 | ○○○ | Nerve discomfort |
| 18 | ○○○ | Staring, blinks little |
| 19 | ○○○ | Sour stomach frequent |

## GROUP 2 - Parasympathetic Dominance

| | 1 2 3 | |
|---|---|---|
| 20 | ○○○ | Joint stiffness on arising |
| 21 | ○○○ | Muscle-leg-toe cramps at night |
| 22 | ○○○ | "Butterfly" stomach, cramps |
| 23 | ○○○ | Eyes or nose watery |
| 24 | ○○○ | Eyes blink often |
| 25 | ○○○ | Eyelids swollen, puffy |
| 26 | ○○○ | Indigestion soon after meals |
| 27 | ○○○ | Always seems hungry; feels "lightheaded" often |
| 28 | ○○○ | Digestion rapid |
| 29 | ○○○ | Vomiting occasionally |
| 30 | ○○○ | Hoarseness frequent |
| 31 | ○○○ | Uneven breathing |
| 32 | ○○○ | Pulse slow |
| 33 | ○○○ | Gagging reflex slow |
| 34 | ○○○ | Difficulty swallowing |
| 35 | ○○○ | Temporary constipation or diarrhea |
| 36 | ○○○ | "Slow starter" |
| 37 | ○○○ | Get "chilled" |
| 38 | ○○○ | Perspire easily |
| 39 | ○○○ | Sensitive to cold |
| 40 | ○○○ | Upper respiratory challenges |

## GROUP 3 - Sugar Handling

| | 1 2 3 | |
|---|---|---|
| 41 | ○○○ | Eat when nervous |
| 42 | ○○○ | Excessive appetite |
| 43 | ○○○ | Hungry between meals |
| 44 | ○○○ | Irritable before meals |
| 45 | ○○○ | Get "shaky" if hungry |
| 46 | ○○○ | Fatigue, eating relieves |
| 47 | ○○○ | "Lightheaded" if meals delayed |
| 48 | ○○○ | Heart palpitates if meals missed or delayed |
| 49 | ○○○ | Fatigue in afternoons |
| 50 | ○○○ | Overeating sweets upsets |
| 51 | ○○○ | Awaken after few hours sleep - hard to get back to sleep |
| 52 | ○○○ | Crave candy or coffee in afternoons |
| 53 | ○○○ | Moods of "blues" or melancholy |
| 54 | ○○○ | Craving for sweets or snacks |

## GROUP 4 - Cardio-Vascular

| | 1 2 3 | |
|---|---|---|
| 55 | ○○○ | Hands and feet go to sleep easily, numbness |
| 56 | ○○○ | Sigh frequently, "air hunger" |
| 57 | ○○○ | Aware of "breathing heavily" |
| 58 | ○○○ | High altitude discomfort |
| 59 | ○○○ | Opens windows in closed rooms |
| 60 | ○○○ | Immune system challenges |
| 61 | ○○○ | Afternoon "yawner" |
| 62 | ○○○ | Get "drowsy" often |
| 63 | ○○○ | Swollen ankles, worse at night |
| 64 | ○○○ | Muscle cramps, worse during exercise; get "charley horses" |
| 65 | ○○○ | Difficulty catching breath especially during exercise |
| 66 | ○○○ | Tightness or pressure in chest, worse on exertion |
| 67 | ○○○ | Skin discolors easily after impact |
| 68 | ○○○ | Tendency to anemia |
| 69 | ○○○ | Noises in head, or "ringing in ears" |
| 70 | ○○○ | Fatigue upon exertion |

# SYSTEMS SURVEY FORM - PAGE 2

## GROUP 5 - Biliary / Liver

1 2 3

71 ○○○ Dizziness
72 ○○○ Dry skin
73 ○○○ Burning feet
74 ○○○ Blurred vision
75 ○○○ Itching skin and feet
76 ○○○ Hair loss
77 ○○○ Occasional skin rashes
78 ○○○ Bitter, metallic taste in mouth in mornings
79 ○○○ Occasional constipation
80 ○○○ Worrier, feels insecure
81 ○○○ Nausea occasionally after eating
82 ○○○ Greasy foods upset
83 ○○○ Stools light colored
84 ○○○ Skin peels on foot soles
85 ○○○ Discomfort between shoulder blades
86 ○○○ Occasional laxative use
87 ○○○ Stools alternate from soft to watery
88 ○○○ Sneezing attacks
89 ○○○ Dreaming, nightmare type bad dreams
90 ○○○ Bad breath (halitosis)
91 ○○○ Milk products cause upset
92 ○○○ Sensitive to hot weather
93 ○○○ Burning or itching anus
94 ○○○ Crave sweets

## GROUP 6 - Digestive

1 2 3

95 ○○○ Loss of taste for meat
96 ○○○ Lower bowel gas several hours after eating
97 ○○○ Burning stomach sensations, eating relieves
98 ○○○ Coated tongue
99 ○○○ Pass large amounts of foul-smelling gas
100 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours after
101 ○○○ Watery or loose stool
102 ○○○ Gas shortly after eating
103 ○○○ Stomach "bloating"

## GROUP 7 - Endocrine

### (A) - Hyperthyroid

1 2 3

104 ○○○ Difficulty sleeping
105 ○○○ On edge
106 ○○○ Can't gain weight
107 ○○○ Intolerance to heat
108 ○○○ Highly emotional
109 ○○○ Flush easily
110 ○○○ Night sweats
111 ○○○ Thin, moist skin
112 ○○○ Inward trembling
113 ○○○ Heart races
114 ○○○ Increased appetite without weight gain
115 ○○○ Pulse fast at rest
116 ○○○ Eyelids and face twitch
117 ○○○ Irritable and restless
118 ○○○ Can't work under pressure

### (B) - Hypothyroid

1 2 3

119 ○○○ Increase in weight
120 ○○○ Decrease in appetite
121 ○○○ Fatigue easily
122 ○○○ Ringing in ears
123 ○○○ Sleepy during day
124 ○○○ Sensitive to cold
125 ○○○ Dry or scaly skin
126 ○○○ Temporary constipation
127 ○○○ Mental sluggishness
128 ○○○ Hair coarse, falls out
129 ○○○ Tension in head upon arising wears off during day
130 ○○○ Slow pulse, below 65
131 ○○○ Changing urinary function
132 ○○○ Sounds appear diminished
133 ○○○ Reduced initiative

### (C) - Hyperpituitary

1 2 3

134 ○○○ Failing memory with age
135 ○○○ Increased sex drive
136 ○○○ Episodes of tension in head
137 ○○○ Decreased sugar tolerance

### (D) - Hypopituitary

1 2 3

138 ○○○ Abnormal thirst
139 ○○○ Bloating of abdomen
140 ○○○ Weight gain around hips or waist
141 ○○○ Sex drive reduced or lacking
142 ○○○ Tendency for stomach issues
143 ○○○ Increased sugar tolerance
144 ○○○ Menstrual disorders

### (E) - Hyperadrenal

1 2 3

145 ○○○ Dizziness
146 ○○○ Headaches
147 ○○○ Hot flashes
148 ○○○ Hair growth on face or body (female)
149 ○○○ Sugar in urine (not diabetes)
150 ○○○ Masculine tendencies (female)

### (F) - Hypoadrenal

1 2 3

151 ○○○ Weakness, dizziness
152 ○○○ Tired throughout day
153 ○○○ Nails weak, ridged
154 ○○○ Sensitive skin
155 ○○○ Stiff joints
156 ○○○ Perspiration increase
157 ○○○ Bowel discomfort
158 ○○○ Poor circulation
159 ○○○ Swollen ankles
160 ○○○ Crave salt
161 ○○○ Areas of skin darkening
162 ○○○ Upper respiratory sensitivity
163 ○○○ Tiredness
164 ○○○ Breathing challenges

# SYSTEMS SURVEY FORM - PAGE 3

## GROUP 8 - Foundational

| | 1 | 2 | 3 | |
|---|---|---|---|---|
| 165 | ○ | ○ | ○ | Muscle weakness |
| 166 | ○ | ○ | ○ | Lack of Stamina |
| 167 | ○ | ○ | ○ | Drowsiness after eating |
| 168 | ○ | ○ | ○ | Muscular soreness |
| 169 | ○ | ○ | ○ | Heart races |
| 170 | ○ | ○ | ○ | Hyper-irritable |
| 171 | ○ | ○ | ○ | Feeling of a band around your head |
| 172 | ○ | ○ | ○ | Melancholia (feeling of sadness) |
| 173 | ○ | ○ | ○ | Swelling of ankles |
| 174 | ○ | ○ | ○ | Change in urinary function |
| 175 | ○ | ○ | ○ | Tendency to consume sweets or carbohydrates |
| 176 | ○ | ○ | ○ | Muscle spasms |
| 177 | ○ | ○ | ○ | Blurred vision |
| 178 | ○ | ○ | ○ | Involuntary muscle action |
| 179 | ○ | ○ | ○ | Numbness |
| 180 | ○ | ○ | ○ | Night sweats |
| 181 | ○ | ○ | ○ | Rapid digestion |
| 182 | ○ | ○ | ○ | Sensitivity to noise |
| 183 | ○ | ○ | ○ | Redness of palms of hands and bottom of feet |
| 184 | ○ | ○ | ○ | Visible veins on chest and abdomen |
| 185 | ○ | ○ | ○ | Hemorrhoids |
| 186 | ○ | ○ | ○ | Apprehension (feeling that something bad will happen) |
| 187 | ○ | ○ | ○ | Nervousness causing loss of appetite |
| 188 | ○ | ○ | ○ | Nervousness with indigestion |
| 189 | ○ | ○ | ○ | Gastritis |
| 190 | ○ | ○ | ○ | Forgetfulness |
| 191 | ○ | ○ | ○ | Thinning hair |

## FEMALE ONLY

| | 1 | 2 | 3 | |
|---|---|---|---|---|
| 192 | ○ | ○ | ○ | Very easily fatigued |
| 193 | ○ | ○ | ○ | Premenstrual tension |
| 194 | ○ | ○ | ○ | Menses more painful than usual |
| 195 | ○ | ○ | ○ | Depressed feelings before menstruation |
| 196 | ○ | ○ | ○ | Painful breasts during menses |
| 197 | ○ | ○ | ○ | Menstruate too frequently |
| 198 | | | ○ | Hysterectomy / ovaries removed |
| 199 | ○ | ○ | ○ | Menopausal hot flashes |
| 200 | ○ | ○ | ○ | Menses scanty or missed |
| 201 | ○ | ○ | ○ | Acne, worse at menses |

## MALE ONLY

| | 1 | 2 | 3 | |
|---|---|---|---|---|
| 202 | ○ | ○ | ○ | Less involved in exercise/social activities |
| 203 | ○ | ○ | ○ | Difficult to postpone urination |
| 204 | ○ | ○ | ○ | Weak urinary stream |
| 205 | ○ | ○ | ○ | Feeling of "blues" or melancholy |
| 206 | ○ | ○ | ○ | Feeling of incomplete bowel evacuation |
| 207 | ○ | ○ | ○ | Lack of energy |
| 208 | ○ | ○ | ○ | Muscles in arms and legs seem softer/smaller |
| 209 | ○ | ○ | ○ | Tire too easily |
| 210 | ○ | ○ | ○ | Avoids activity |
| 211 | ○ | ○ | ○ | Leg nervousness at night |
| 212 | ○ | ○ | ○ | Diminished sex drive |

## IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

## BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

**PRE-MENSES FEMALES AND MENOPAUSAL FEMALES**

Any two days during the month

**FEMALES HAVING MENSTRUAL CYCLES**

The 2nd and 3rd day of flow OR any 5 days in a row

**MALES**

Any 2 days during the month

## RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.

# SYSTEMS SURVEY FORM - PAGE 4

**Please list any medications you are taking:** ☐ No Medications

**Please list any vitamins, herbs, or supplements you are taking:** ☐ No Vitamins

**Please list any allergies you have:** ☐ No Allergies

**Please list any surgeries you have had in the past 12 months:** ☐ No Recent Surgeries

**Please list any other surgeries or medical procedures you have had:** ☐ No Other Surgeries

**TO BE COMPLETED BY DOCTOR**

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

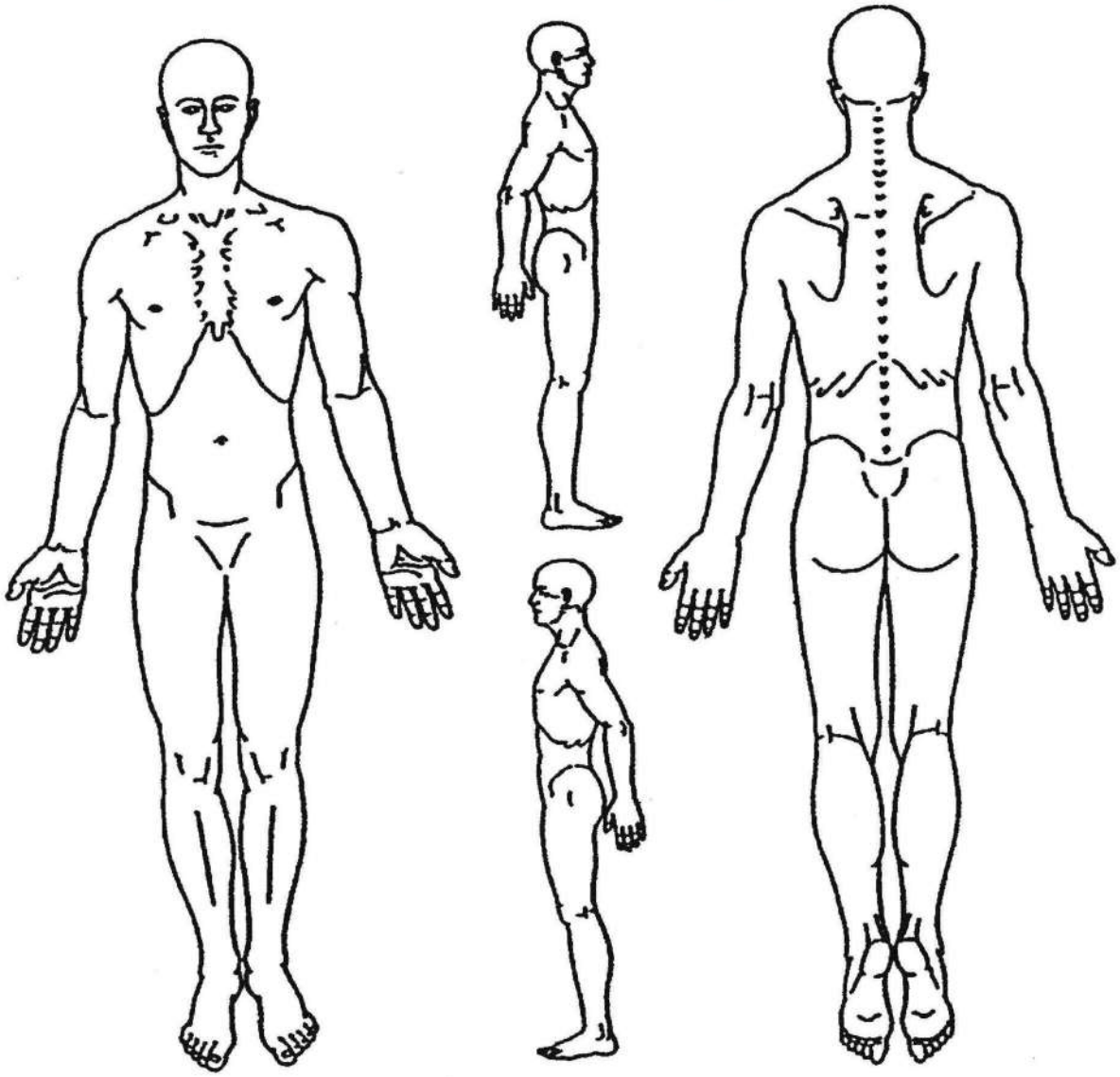
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

## SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

**KEY**

A = ACHE
B = BURNING
S = STABBING
N = NUMBNESS
P = PINS & NEEDLES
O = OTHER



**PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING**

NO PAIN SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

**ZIONSVILE HOLISTIC CHIROPRACTIC**
**PATIENT-INFORMED CONSENT**
**The Doctor-Patient Relationship in Chiropractic**

## CHIROPRACTIC

Welcome to our office! It is very important to acknowledge the difference between the health care specialties of Chiropractic and medicine. Chiropractic strives to enhance your health by natural means, without the use of drugs or surgery. Our job, if you are accepted as a patient, will be to help you raise your levels of health, not merely suppress your symptoms. As your health levels go up, very often your symptoms will go down. This is because the body is a self-healing organism, and Chiropractic assists the natural recuperative powers of the body to heal itself. The success of Chiropractic procedures often depend upon environment, underlying causes, and your physical, emotional, mental and spinal conditions. It is important to understand what to expect from our chiropractic health care services.

## ANALYSIS

We will be conducting a clinical analysis for the express purpose of determining whether or not you have one or more Vertebral Subluxation Complex(s)(VSC) or Vertebral Subluxation Syndrome(s)(VSS). If a VSC or VSS is in evidence, then Chiropractic adjustments and ancillary procedures may be given to you in an effort to stabilize and restore spinal integrity. It is a main Chiropractic premise that proper spinal alignment allows optimal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no ethical doctor, chiropractic or medical, can promise specific results. The results you receive will depend upon the natural inherent recuperative powers of your body.

## DIAGNOSIS

Chiropractors are not medical doctors, and just as a medical doctor is incompetent to render a chiropractic opinion because they have not had the proper training to do so, too, Dr. Whalen will not make a medical diagnosis or opinion. He will provide the very finest Chiropractic diagnosis, opinion, and care for you that He may see fit for his/her optimal health. Dr. Whalen may express his opinion to you in an effort to help you understand your situation better, but your health is your responsibility and you are responsible for the final decision.

## INFORMED CONSENT REGARDING CHIROPRACTIC CARE

Chiropractic provides a specialized non-duplicating health care service by the location, analysis, and stabilization of VSC or VSS. No other health care provider does this. If you are accepted as a patient, you are giving Dr. Whalen permission and authority to care for you in accordance with Chiropractic tests, analyses, and procedures. The Chiropractic adjustment or any other of our procedures are usually beneficial. In very rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. No adjustment or any other procedure will be performed if they are not indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/He is suffering from, be it latent pathological defects, illnesses, deformities, or other problems which would otherwise not come to the attention of Dr. Whalen. Careful attention must be taken to accurately complete our case history and any other forms required. Help us help you- please give us the information we request. Your attendance at one Health Seminar within the first 4-6 weeks of care is highly recommended so we may assist you completely as possible once you are accepted as a patient at our clinic.

## RESULTS

Our purpose is to help you by the location, analysis, and stabilization of VSC or VSS. This will assist in the natural promotion of health. Since there are many variables, it is difficult to predict results or the time necessary for them. Sometimes the results are exceptional! Sometimes not. Usually there will be a gradual satisfactory response. In any case, the fact is that no science, medical or chiropractic, is so exact as to have all the answers to all problems. Both have made great strides in helping millions of people and helping to alleviate pain and suffering.

PLEASE DISCUSS ANY QUESTIONS YOU MAY HAVE WITH DR. WHALEN BEFORE YOU SIGN THIS STATEMENT OF POLICY.

Date:_____ Signature:_____

Date:_____ Patient Name _____

# The Holmes and Rahe Stress Scale

- Slowly, read down through the list.
- Each life event is assigned a Stress Score– the number after it.
- If this event has occurred in your life ***over the past year***, circle that stress score or write it on the corresponding line.
- If it doesn't apply to you, leave the line blank.
- At the bottom, total up the scores you have written on the lines and compare them to the Scoring Key.

| | | |
|---|---|---|
| **Death of spouse** | **100** | _____ |
| Divorce | 73 | _____ |
| **Marital separation** | **65** | _____ |
| Imprisonment | 63 | _____ |
| **Death within family** | **63** | _____ |
| Personal illness or injury | 53 | _____ |
| **Marriage** | **50** | _____ |
| Redundancy from work | 47 | _____ |
| **Reconciliation of marriage** | **45** | _____ |
| Retirement | 45 | _____ |
| **Illness within family** | **44** | _____ |
| Pregnancy | 40 | _____ |
| **Sexual difficulties** | **39** | _____ |
| New family member | 39 | _____ |
| **Business changes or restructuring** | **39** | _____ |
| Changes in financial situation | 38 | _____ |
| **Death of close friend** | **37** | _____ |
| Change of occupation | 36 | _____ |
| **Increased conflict with spouse** | **35** | _____ |
| Large mortgage or loan | 31 | _____ |
| **Foreclosure of mortgage or loan** | **30** | _____ |
| New responsibilities at work | 29 | _____ |
| **Children leaving home** | **29** | _____ |
| Trouble with in-laws | 29 | _____ |
| **Great personal achievement** | **28** | _____ |
| Spouse starts or stops work | 26 | _____ |
| **Start or end of school or college** | **26** | _____ |
| Change in living conditions | 25 | _____ |

Date:_____ Patient Name _____

| | | |
|---|---|---|
| **Change in personal habits** | **24** | _____ |
| Trouble with employer or boss | 23 | _____ |
| **Change in work conditions** | **20** | _____ |
| Moving house | 20 | _____ |
| **Changing school or college** | **20** | _____ |
| Change in recreation | 19 | _____ |
| **Change in church activity** | **19** | _____ |
| Change in social activity | 18 | _____ |
| **Moderate mortgage or loan** | **17** | _____ |
| Change in sleep patterns | 16 | _____ |
| **Change in number of family meetings** | **15** | _____ |
| Change in eating habits | 15 | _____ |
| **Holiday** | 13 | _____ |
| Christmas | 12 | _____ |
| **Minor law infringements** | 11 | _____ |

**Your Total Score** _____

This allows you to determine the total amount of stress you are experiencing by adding up the relative stress values, known as Life Change Units (LCU), for various events.

A score of 250 or more is considered high. Persons with a low stress tolerance may find themselves overstressed with a score of 150. The test is used to determine disease susceptibility.

## SCORING KEY

— These scores are a *general* measure of stress. People handle stress differently. Some are able to carry stress more than others.

**Score less than 150 or Less:** You have a 37% chance of becoming seriously ill.

**If your score is 150+, your health is at considerable risk.**

**Score between 150 to 300:** You have a 51% chance of becoming seriously ill.

**Score over 300:** You have an 80% chance of serious illness in the next 2 years.

Adapted from the "Social Readjustment Rating Scale" by Thomas Holmes and Richard Rahe. This scale was first published in the Journal of Psychosomatic Research. 1967, vol. II p. 214.