ALIGN CHIROPRACTIC WELLNESS CENTER
NEW PATIENT INFORMATION FORM

Please print clearly:

Name: _____ Date:_____

Address: _____ Apt: _____

City: _____ State: ____ Zip: _____

Home Phone: (___) ___-_____ Work Phone: (___) ___- _____

e-mail address: _____

REFERRED BY: _____

Occupation: _____ Employer: _____

Date of Birth: _____ Age: ____ Sex: M/F Height: _____ Weight: _____

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

Chief complaint (reason you are here): (Use separate sheet if more room needed)

_____

Previous treatments for this complaint: _____

_____.

Other complaints or problems: _____

_____

Current medications/drugs being taken: _____

_____

Are you currently under the care of a physician or other health care professional?

(If yes, ple' &ase give name and date of last visit): _____

_____.

Nutritional supplements you are taking: _____

Do your smoke, drink coffee or alcohol? (If yes, indicate how much) _____

Cigarettes_____ Coffee_____ Alcohol_____

new patient information form (continued pg 2)

Name:_____ Date:_____

HISTORY:

List any major illnesses with approximate date(s):_____

_____

List any surgery or operations with approximate date(s): _____

_____

Past Accidents or injuries: _____

_____

Marital status: S M D W Name of Spouse:_____

Describe health of spouse:_____ Number of children, if any _____

Name of Child Age Sex Any physical conditions or concerns?

_____ ____ M/F _____

_____ ____ M/F _____

_____ ____ M/F _____

Any family history of serious illnesses (circle those which apply: Cancer/Diabetes/Heart/Other

_____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

Signed:_____ Date: _____

440 Pellis Road, Suite 7 Greensburg, PA 15601 Phone 724.834.5600 Fax 724.834.5700

ALIGN
CHIROPRACTIC
WELLNESS CENTER, LLC

PERMISSION AND AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize Align Chiropractic Wellness Center practitioners to perform a **Nutrition Response Testing** health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc., in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that **Nutritional Response Testing** is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of **Nutrition Response Testing** or any natural health, nutritional or dietary programs recommended, but rather I understand that **Nutrition Response Testing** is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name:_____

Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) ____-_____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT_____ AGE_____ DOCTOR_____ DATE_____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 "Nervous" stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 "Butterfly" stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels "lightheaded" often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels "irregular"
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 "Slow starter"
38 – 1 2 3 Get "chilled" infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get "shaky" if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 "Lightheaded" if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - "blues" or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, "air hunger"
58 – 1 2 3 Aware of "breathing heavily"
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon "yawner"
63 – 1 2 3 Get "drowsy" often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, "black and blue" spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 "Nose bleeds" frequent
71 – 1 2 3 Noises in head, or "ringing in ears"
72 – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP FIVE

73 – 1 2 3 Dizziness
74 – 1 2 3 Dry skin
75 – 1 2 3 Burning feet
76 – 1 2 3 Blurred vision
77 – 1 2 3 Itching skin and feet
78 – 1 2 3 Excessive falling hair
79 – 1 2 3 Frequent skin rashes
80 – 1 2 3 Bitter, metallic taste in mouth in mornings
81 – 1 2 3 Bowel movements painful or difficult
82 – 1 2 3 Worrier, feels insecure
83 – 1 2 3 Feeling queasy; headache over eyes
84 – 1 2 3 Greasy foods upset
85 – 1 2 3 Stools light-colored
86 – 1 2 3 Skin peels on foot soles
87 – 1 2 3 Pain between shoulder blades
88 – 1 2 3 Use laxatives
89 – 1 2 3 Stools alternate from soft to watery
90 – 1 2 3 History of gallbladder attacks or gallstones
91 – 1 2 3 Sneezing attacks
92 – 1 2 3 Dreaming, nightmare type bad dreams
93 – 1 2 3 Bad breath (halitosis)
94 – 1 2 3 Milk products cause distress
95 – 1 2 3 Sensitive to hot weather
96 – 1 2 3 Burning or itching anus
97 – 1 2 3 Crave sweets

GROUP SIX

98 – 1 2 3 Loss of taste for meat
99 – 1 2 3 Lower bowel gas several hours after eating
100 – 1 2 3 Burning stomach sensations, eating relieves
101 – 1 2 3 Coated tongue
102 – 1 2 3 Pass large amounts of foul-smelling gas
103 – 1 2 3 Indigestion 1/2 - 1 hour after
104 – 1 2 3 Mucous colitis or "irritable bowel"
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can't gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can't work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
130 – 1 2 3 Mental sluggishness
131 – 1 2 3 Hair coarse, falls out
132 – 1 2 3 Headaches upon arising wear off during day
133 – 1 2 3 Slow pulse, below 65
134 – 1 2 3 Frequency of urination
135 – 1 2 3 Impaired hearing
136 – 1 2 3 Reduced initiative

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, "splitting or rendering" type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Muscle weakness
174 – 1 2 3 Lack of Stamina
175 – 1 2 3 Drowsiness after eating
176 – 1 2 3 Muscular soreness
177 – 1 2 3 Rapid heart beat
178 – 1 2 3 Hyper-irritable
179 – 1 2 3 Feeling of a band around your head
180 – 1 2 3 Melancholia (feeling of sadness)
181 – 1 2 3 Swelling of ankles
182 – 1 2 3 Diminished urination
183 – 1 2 3 Tendency to consume sweets or carbohydrates
184 – 1 2 3 Muscle spasms
185 – 1 2 3 Blurred vision
186 – 1 2 3 Loss of muscular control
187 – 1 2 3 Numbness
188 – 1 2 3 Night sweats
189 – 1 2 3 Rapid digestion
190 – 1 2 3 Sensitivity to noise
191 – 1 2 3 Redness of palms of hands and bottom of feet
192 – 1 2 3 Visible veins on chest and abdomen
193 – 1 2 3 Hemorrhoids
194 – 1 2 3 Apprehension (feeling that something bad is going to happen)
195 – 1 2 3 Nervousness causing loss of appetite
196 – 1 2 3 Nervousness with indigestion
197 – 1 2 3 Gastritis
198 – 1 2 3 Forgetfulness
199 – 1 2 3 Thinning hair

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

✳ IMPORTANT ✳

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

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

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

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.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____

CASE RECORD

Name _____ Date _____ Telephone _____

Address _____ City _____ State _____ Zip _____

Age _____ Weight _____ Height _____ Sex _____

Occupation _____ Married _____

History of Illness and Treatment: _____

_____

Operations, Accidents or Injuries: _____

_____

_____

Present Illness or Complaints: _____

_____

_____

Diagnostic Summary: _____

_____

_____

Treatment, Recommendations and Progress: _____

_____

_____

_____

_____

_____

_____