ALIGN CHIROPRACTIC WELLNESS CENTER

NEW PATIENT NUTRITIONAL INTAKE FORM

Many of the health challenges that people face originate from nutritional deficiencies and poor eating habits. By addressing underlying nutritional factors and correlating them with your current health problems, we are able to guide you with proper recommendations to maximize your health and wellness.

Name: _____ Date:_____

Address: _____ Apt: _____

City: _____ State: ____ Zip: _____

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____- _____

E-mail Address: _____ Marital Status: S M D W

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):

_____

_____

Previous treatments for this complaint: _____

_____

Other complaints or problems: _____

_____

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

_____

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

_____

Past Accidents or injuries: _____

_____

Any family history of serious illnesses (circle those which apply:

Cancer/Diabetes/Heart/Other)_____

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

(If yes, please give name and date of last visit): _____

_____

Current medications/drugs being taken: _____

_____

Nutritional supplements you are taking:

_____

_____

_____

How much of the following do you use or consume daily?

Cigarettes_____ Coffee_____ Alcohol_____ Soda_____

Water Intake_____ Fast Food/Processed Food_____

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

_____

What can we do to make you happier? _____

_____

Signature:_____ 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

Maestro

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

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

GROUP 2

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

GROUP 3

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

GROUP 4

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

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

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

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

(A)

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)

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)

1 2 3
134 ○○○ Failing memory with age
135 ○○○ Increased sex drive
136 ○○○ Episodes of tension in head
137 ○○○ Decreased sugar tolerance

(D)

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 ○○○ Immune system challenges
144 ○○○ Menstrual disorders

(E)

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)

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

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

FEMALE ONLY

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

MALE ONLY

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

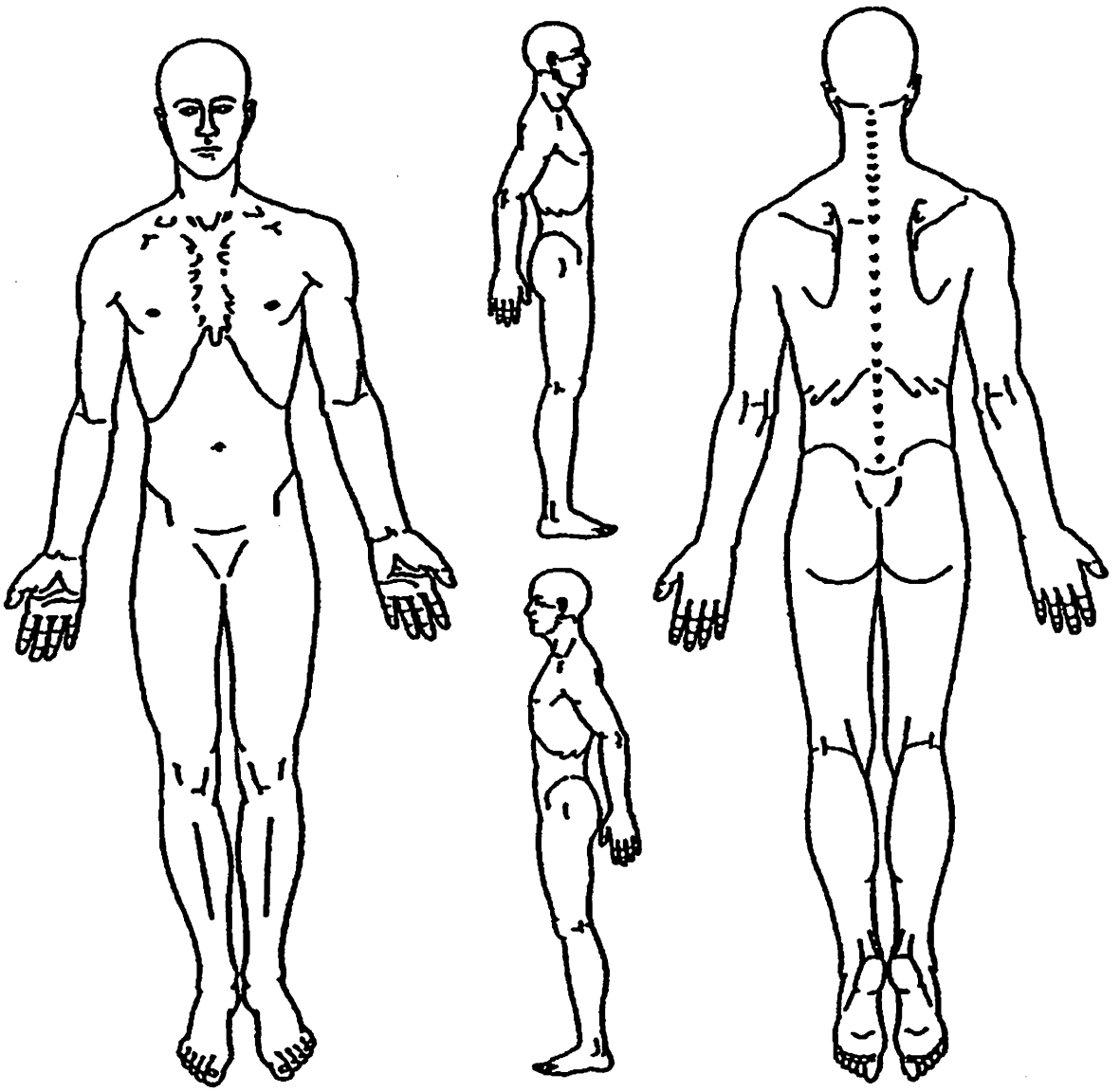
THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES 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 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 _____