

Quintessential Wellness PATIENT DATA SHEET



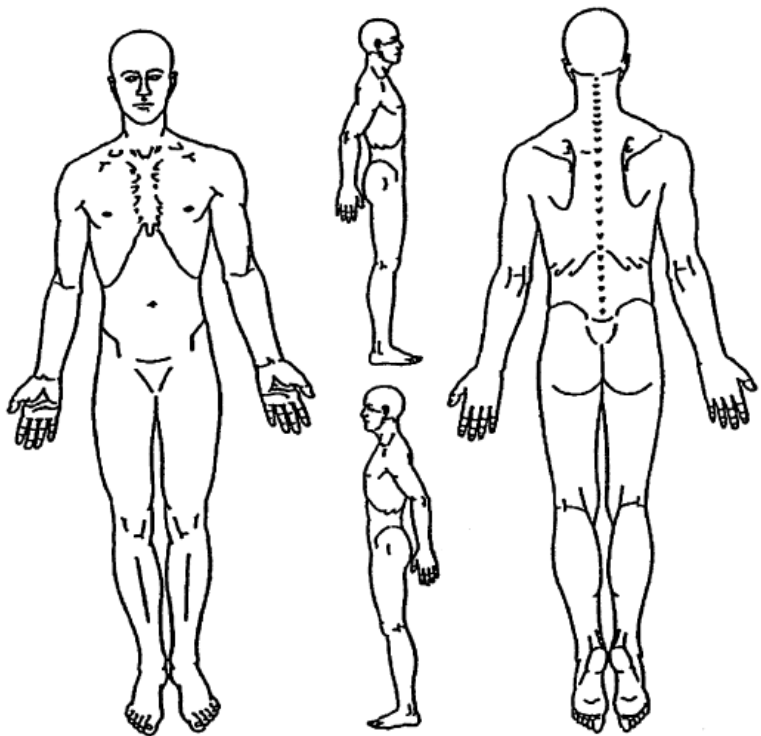
General Information

First Name _____	Sex _____	Male Female
Middle Initial _____	Race _____	American Indian, Alaska Native, Asian,
Last Name _____		Black or African America, Native Hawaiian,
Suffix _____	Ethnicity _____	Other Pacific Islander, White, Declined to State
Called Name _____		Declined to State, Hispanic or Latino,
Address _____	Language _____	Not Hispanic or Latino
City _____	Marital Status _____	Single Married Other _____
State _____	Birthdate _____	
Zip Code _____	Social Security _____	
Home Phone _____	Referred By _____	
Work Phone _____	Work Status _____	Employed Full-time student Part-time student
Cell Phone _____	Appt Reminder _____	Text to Cell/ Voice to Cell/Voice to
Email Address _____	Home/Email _____	

Are you experiencing pain?

Use the following letters to indicate the type and location of your pain.

- 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

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____
 Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male `` Female ``
 Pulse: Recumbent _____ Standing _____ Vegetarian `` Gluten-free ``
 Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive ``

INSTRUCTIONS: Fill in only the circles which apply to you.

- ○ ○ MILD symptoms (occurs rarely).
- ● ○ MODERATE symptoms (occurs several times a month).
- ○ ● SEVERE symptoms (occurs almost constantly)
- ○ ○ Leave circles **BLANK** if they don't apply to you!

1 2 3 GROUP 1

- 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 ○ ○ ○ Cut heals slowly
- 8 ○ ○ ○ Gag easily
- 9 ○ ○ ○ Unable to relax; startles easily
- 10 ○ ○ ○ Extremities cold, clammy
- 11 ○ ○ ○ Strong light irritates
- 12 ○ ○ ○ Urine amount reduced
- 13 ○ ○ ○ Heart pounds after retiring
- 14 ○ ○ ○ "Nervous" stomach
- 15 ○ ○ ○ Appetite reduced
- 16 ○ ○ ○ Cold sweats often
- 17 ○ ○ ○ Fever easily raised
- 18 ○ ○ ○ Neuralgia-like pains
- 19 ○ ○ ○ Staring, blinks little
- 20 ○ ○ ○ Sour stomach often

GROUP 2

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

GROUP 3

- 42 ○ ○ ○ Eat when nervous
- 43 ○ ○ ○ Excessive appetite
- 44 ○ ○ ○ Hungry between meals
- 45 ○ ○ ○ Irritable before meals
- 46 ○ ○ ○ Get "shaky" if hungry
- 47 ○ ○ ○ Fatigue, eating relieves
- 48 ○ ○ ○ "Lightheaded" if meals delayed
- 49 ○ ○ ○ Heart palpitates if meals missed or delayed
- 50 ○ ○ ○ Afternoon headaches
- 51 ○ ○ ○ Overeating sweets upsets

1 2 3

- 52 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
- 53 ○ ○ ○ Crave candy or coffee in afternoons
- 54 ○ ○ ○ Moods of depression - "blues" or melancholy
- 55 ○ ○ ○ Abnormal craving for sweets or snacks

GROUP 4

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

GROUP 5

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

GROUP 6

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

1 2 3 GROUP 7A

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

GROUP 7B

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

GROUP 7C

- 137 Failing memory
- 138 Low blood pressure
- 139 Increased sex drive
- 140 Headaches, "splitting or rending" type
- 141 Decreased sugar tolerance

GROUP 7D

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

GROUP 7E

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

GROUP 7F

- 157 Weakness, dizziness
- 158 Chronic fatigue
- 159 Low blood pressure
- 160 Nails weak, ridged
- 161 Tendency to hives
- 162 Arthritic tendencies
- 163 Perspiration increase
- 164 Bowel disorders
- 165 Poor circulation
- 166 Swollen ankles
- 167 Crave salt
- 168 Brown spots or bronzing of skin
- 169 Allergies - tendency to asthma

1 2 3

- 170 Weakness after colds, influenza
- 171 Exhaustion - muscular and nervous
- 172 Respiratory disorders

GROUP 8

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

FEMALE ONLY

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

MALE ONLY

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

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

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

MEDICATIONS

List any supplements/vitamins you are taking: _____

Are you taking any medication (prescription or over-the-counter)? Yes No

If Yes, please indicate the following:

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

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Route: Oral
Intravenous
Other: _____
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Discontinued Use: _____

Medication: _____
Route: Oral
Intravenous
Other: _____
Frequency: _____
Began Use: _____
Discontinued Use: _____

Have you taken any medications in the past? Yes No If yes, which ones?: _____

Do you have allergies to medication? Yes No

If Yes, please indicate the following:

Allergy: _____ Allergy: _____
Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

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Reaction: _____ Reaction: _____
Start Date: _____ Start Date: _____
End Date: _____ End Date: _____

Have you ever had any surgeries? Yes No (If yes, please enter the approximate date of surgery.)

DATE **DATE** **DATE**
_____ Back Operation _____ Hernia _____ Gall Bladder
_____ Female Organs _____ Thyroid _____ Stomach

Other _____

Have you ever had X-rays taken? Yes No When? _____ By Whom? _____

For what ailments were these X-rays taken? _____

DATE OF LAST PHYSICAL EXAMINATION: _____

Are you currently pregnant? Yes No Do you have a pacemaker? Yes No

PRINT NAME: _____ **DOB:** _____ **ACCOUNT #:** _____

CONSTITUTIONAL

- Deny All
- Chills
- Drowsiness
- Fainting
- Fatigue
- Fever
- Night Sweats
- Weakness
- Weight Gain
- Weight Loss

EYES

- Deny All
- Blindness
- Blurred Vision
- Cataracts
- Change in Vision
- Double Vision
- Dry Eyes
- Eye Pain
- Field Cuts
- Glaucoma
- Sensitivity to Light
- Tearing
- Wears Glasses

CARDIOVASCULAR

- Deny All
- Angina
- Chest Pain
- Claudication
- Heart Murmur
- Heart Problems
- High Blood Pressure
- Low Blood Pressure
- Orthopnea
- Palpitations
- Shortness of Breath
- Swelling of Legs
- Varicose Veins

RESPIRATORY

- Deny All
- Asthma
- Bronchitis
- Dry Cough
- Productive Cough
- Coughing up Blood
- Difficulty Breathing
- Difficulty Sleeping
- Hemoptysis
- Pneumonia
- Sputum Production
- Wheezing

MUSCULOSKELETAL

- Deny All
- Arthritis
- Neck Pain
- Decreased Motion
- Gout
- Injuries
- Joint Pain
- Joint Stiffness
- Locking Joints
- Back Pain
- Muscle Cramps
- Muscle Pain
- Muscle Twitching
- Muscle Weakness
- Swelling

INTEGUMENTARY

- Deny All
- Breast Lumps / Pain
- Change in Nail Texture
- Change in Skin Color
- Eczema
- Hair Growth
- Hair Loss
- History of Skin Disorders
- Hives
- Itching
- Paresthesia
- Rash
- Skin Lesions

GASTROINTESTINAL

- Deny All
- Abdominal Pain
- Belching
- Black, Tarry Stools
- Constipation
- Diarrhea
- Heartburn
- Hemorrhoids
- Indigestion
- Jaundice
- Nausea
- Rectal Bleeding
- Abnormal Stool Caliber
- Abnormal Stool Color
- Abnormal Stool Consistency
- Vomiting
- Vomiting Blood

GENITOURINARY

- Deny All
- Birth Control Therapy
- Burning Urination
- Cramps
- Erectile Dysfunction
- Frequent Urination
- Hesitancy / Dribbling
- Hormone Therapy
- Irregular Menstruation
- Lack of Bladder Control
- Prostate Problems
- Urine Retention
- Vaginal Bleeding
- Vaginal Discharge

ENMT

- Deny All
- Bad Breath
- Dentures
- Deviated Septum
- Difficulty Swallowing
- Discharge
- Dry Mouth
- Ear Drainage
- Ear Pain
- Frequent Sore Throats
- Head Injury
- Hearing Loss
- Hoarseness
- Loss of Smell
- Loss of Taste
- Nasal Congestion
- Nose Bleeds
- Post Nasal Drip
- Sinus Infections
- Runny Nose
- Snoring
- Sore Throat
- Ringing in Ears
- TMJ Problems
- Ulcers

NEUROLOGICAL

- Deny All
- Change in Concentration
- Change in Memory
- Dizziness
- Headache
- Imbalance
- Loss of Consciousness
- Loss of Memory
- Numbness
- Seizures
- Sleep Disturbance
- Slurred Speech
- Stress
- Strokes
- Tremors

PSYCHIATRIC

- Deny All
- Agitation
- Anxiety
- Appetite Changes
- Behavioral Changes
- Bipolar Disorder
- Confusion
- Convulsions
- Depression
- Homicidal Indication
- Insomnia
- Location Disorientation
- Memory Loss
- Substance Abuse
- Suicidal Indication
- Time Disorientation

ENDOCRINE

- Deny All
- Cold Intolerance
- Diabetes
- Excessive Appetite
- Excessive Hunger
- Excessive Thirst
- Goiter
- Hair Loss
- Heat Intolerance
- Unusual Hair Growth
- Voice Changes

HEMATOLOGIC / LYMPHATIC

- Deny All
- Anemia
- Bleeding
- Blood Clotting
- Blood Transfusions
- Bruise Easily

ALLERGIC / IMMUNOLOGIC

- Deny All
- History of Anaphylaxis
- Itchy Eyes
- Sneezing
- Specific Food Intolerance

I have read the above information and certify it to be true and correct to the best of my knowledge, and hereby authorize this office of chiropractic to provide me with chiropractic care in accordance with this state's statutes. I understand that it is my responsibility to bring to the attention of the providing physician ANY new information regarding my health and well-being or any changes in health status that would be pertinent to my case management.

Patient's Signature: _____

Date: _____

Parent or Guardian Signature: _____

Date: _____

PRINT NAME: _____

DOB: _____

ACCOUNT #: _____



Quintessential Wellness Dr. Amanda Keates
NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

I have read and understand the above:

Signature:

Date:

I hereby, attest to the following:

1. I fully understand that the Chiropractor I am seeing in this office is not a Medical Doctor, and I am not consulting for medical, diagnostic, or treatment procedures. The chiropractor treats for whole health and not any specific disease when you present for an Applied Kinesiology (AK)/Nutrition appointment.
2. The AK services performed by the Chiropractor are at all times restricted to helping me gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.
3. I understand that any recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only pertains to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.
4. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

Signature:

Date:

ACCT: