

Patient Name \_\_\_\_\_ File#/HRN \_\_\_\_\_ Date \_\_\_\_\_

## INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? \_\_\_\_\_

What speed was the collision? \_\_\_\_\_

Type of impact: Front Impact / Side Impact / Rear Impact

Was treatment received? Please describe \_\_\_\_\_

When was your most recent strain / stress at work? \_\_\_\_\_

Please describe the manner of the injury \_\_\_\_\_

Was treatment received? Please describe \_\_\_\_\_

Does your job require you remain in long term stressful postures? \_\_\_\_\_

(i.e. all day seating, repeated lifting, long term computer use)

Spinal traumas in the past? \_\_\_\_\_

Collision, quick burst, or repetitive motion sports: football, wrestling, basketball, baseball, soccer, tennis, golf, track and field \_\_\_\_\_

Trauma as a child! i.e. fall on your head, impact to your head, concussion, fall onto your back or tailbone, biking accident \_\_\_\_\_

Work around the house – lifting, bending, woke up with stiff neck, “back went out”

---

## INITIAL NUTRITIONAL PROFILE

Have you tested with high triglycerides or high cholesterol? (Y / N) Values? \_\_\_\_\_

Have you tested with high blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

Do you eat breakfast daily from Monday to Friday? (Y / N) \_\_\_\_\_

How many days per week do you skip one meal? (0) (1) (2) (3) (4+)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have on a given day? (0-1) (2-3) (4+)

How many servings of vegetables do you have on a given day? (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)

Diet Soda    Coffee    Juice    Milk    Soda    Alcohol

Please list any supplements you take regularly:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## INITIAL FITNESS PROFILE

How many times per week do you exercise?

Cardiovascular \_\_\_ Hours \_\_\_ Days/Wk                      Weight Training \_\_\_ Hours \_\_\_ Days/Wk

Low Impact (Yoga, etc.) \_\_\_ Hours \_\_\_ Days/Wk

What is your target weight? \_\_\_\_\_ What is your current weight? \_\_\_\_\_

How willing are you to change any of these things to reach your health goals? (*Scale of 1-10*) \_\_\_\_\_

## INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Does your home, work, school, or car have damp or mildew smell? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? \_\_\_\_\_ (estimate)

Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

Do you have symptoms of hormonal system imbalance (thyroid, reproductive, adrenal)? (Y / N)

## INITIAL STRESS PROFILE

Do you get an average of 8 hours of sleep per night (Y/N)

Do you average less than 7 hours of sleep per night (Y/N)

Do you ever take pills to go to sleep or relax (Y/N)

Do you often feel short on time and procrastinate on projects? (Y / N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel like you don't give enough time or attention to important areas in your life like family, personal growth, or a hobby? (Y / N)

Do you rely more on your memory than a planner and action list to get things done? (Y / N)

Do you take time to pray, meditate, or visualize on a regular basis? (Y / N)

Doctor Signature \_\_\_\_\_ Date \_\_\_\_\_