Peak Wellness
Chiropractic and Nutrition

Please fill out this form ***completely and accurately.*** This information is essential to helping the doctor to develop a safe and effective program that addresses your needs, goals and interests. All information received on this form will be treated as strictly confidential.

Functional Nutrition Intake Form

Demographics					
First Name		Middle		Last Name	
Date of Birth		Age		Gender	☐ Male ☐ Female
Mailing Address					
City		State		Zip Code	
Preferred phone				☐ Home ☐ Work ☐ Cell	
Height			Weight		
Do you have pets?	☐ None ☐ Dog ☐ Cat ☐ Other:				
Email address					
Referred by					

Concerns	
What are you TOP 3 health and/or nutritional concerns?	
1.	
2.	
3.	
Are you currently under the care of a physician or other health care professional?	☐ Yes ☐ No
If yes, please give name and date of last visit.	

Medical History

Please check "yes" for any diagnosed health condition and the approximate date of onset.

CONDITION	YES	Date of Onset	CONDITION	YES	Date of Onset
GASTROINTESTINAL			**INFLAMMATORY/AUTOIMMUNE**		
Irritable Bowel Syndrome			Chronic Fatigue Syndrome		
Inflammatory Bowel Disease			Rheumatoid Arthritis		
Crohn's Disease			Lupus SLE		
Ulcerative Colitis			Frequent Infections		
Celiac Disease			Severe Infectious Disease		
Gastric or Peptic Ulcer Disease			Herpes		
GERD, Reflux or Heartburn			Gout		
Hepatitis C or Liver Disease			Other:		
Food Intolerance			**MUSCULOSKELETAL/PAIN**		
Other:			Osteoarthritis		
RESPIRATORY			Chronic Pain		
Asthma			Fibromyalgia		
Chronic Sinusitis			Migraines		
Sleep Apnea			Other:		
Bronchitis or Emphysema			**URINARY/REPRODUCTIVE**		
Tuberculosis			Kidney Stones		
Other:			Urinary Tract Infections		
CARDIOVASCULAR			Yeast Infection		
Heart Disease/Heart Attack			Prostate Problem		
Stroke			Other:		
Elevated Cholesterol			**METABOLIC/ENDOCRINE**		
Irregular Heart Rate			Type 1 Diabetes		
High Blood Pressure			Type 2 Diabetes		
Other:			Metabolic Syndrome		
NEUROLOGICAL/BRAIN			Hypoglycemia		
Depression			Hypothyroidism		
Anxiety			Hyperthyroidism		
Bipolar Disorder			Polycystic Ovarian Syndrome		
ADD/ADHD			Infertility		
Multiple Sclerosis			Other:		
Seizures			**OTHER**		
Anorexia Nervosa			Chronic Ear Infections		
Bulimia			Chicken Pox/Shingles		
Parkinson's Disease			Bells Palsy		
Other:			Epstein Barr		
			Mononucleosis		
DERMATOLOGICAL			**CANCER: Please list type(s) and treat-**		
Eczema					
Psoriasis					
Acne					
Other:					

Have you ever had an organ removed?

Organ	YES	Date	CONDITION	YES	Date
Tonsils			Colon		
Appendix			Uterus		
Thyroid			Ovary		
Gall Bladder			Other:		

Please list other previous injuries, surgeries and hospitalizations. Provide your age and date, if known.

Your Birth History: ☐ Vaginal ☐ C-Section

Were you breastfed as an infant? ☐ Yes ☐ No

Family History

Have any of your close relatives (parents, sibling, child, grandparent) been diagnosed with the following?
Please check, describe and provide age of onset for those that apply.

Condition	Family Member(s)	Condition	Family Member(s)
Heart Disease		Cancer	
High Blood Pressure		Overweight	
Food Intolerances		Stroke	
Autoimmune Disease		Diabetes	

Oral History

Do you visit a dentist twice per year? ☐ Yes ☐ No

Do your gums bleed when you brush your teeth, getting a pink toothbrush? ☐ Yes ☐ No

Do you have any silver/mercury amalgam fillings? ☐ Yes ☐ No

Known Allergies		Allergic Symptoms Experienced
Food		
Medication		
Supplement		
Environmental		

Medications: Please check any of the medications you are CURRENTLY taking

☐ Antacids	☐ Anxiety	☐ Blood Pressure	☐ Heart Meds	☐ Steroids
☐ Antibiotics	☐ Anti-inflammatory	☐ Laxatives	☐ Cholesterol/Statin	☐ Testosterone
☐ Antifungal	☐ Aspirin	☐ Diabetic/Insulin	☐ Muscle Relaxers	☐ Thyroid
☐ Antidepressents	☐ Birth Control	☐ Estrogen	☐ Progesterone	☐ Tylenol
☐ Other:				☐ Ulcer Meds

Herb/Supplement	Year Started	Reason

Have you EVER had prolonged or regular use of?		Date
NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin	☐ Yes ☐ No	
Tylenol	☐ Yes ☐ No	
Acid-blocking drugs (Zantac, Pepsid, Tums etc.)	☐ Yes ☐ No	
Antibiotics > 3 times per year	☐ Yes ☐ No	
Antibiotics long term (> 1 month continuously)?	☐ Yes ☐ No	
Other:	☐ Yes ☐ No	

Lifestyle Information

Are you currently involved in an exercise program? ☐ Yes ☐ No	How often:
How many hours do you sleep on weeknights? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+	
How many hours do you sleep on weekends? ☐ <6 ☐ 6-8 ☐ 8-10 ☐ 10+	
Check which apply to you: ☐ Trouble falling asleep ☐ Wake up during the night ☐ Don't feel rested	
Rate your stress level: ☐ None ☐ Mild ☐ Moderate ☐ High ☐ Extreme	
What helps you relax?	

Chemical Exposures

What is your occupation?
Are you regularly exposed to any chemicals? ☐ Yes ☐ No
Any significant past or present exposure to substances such as recreational drugs or alcohol? ☐ Yes ☐ No
If yes, please explain:

Nutrition History

Have you ever had an appointment with a dietitian or nutritionist? ☐ Yes ☐ No			
Have you changed your eating habits for a health reason? ☐ Yes ☐ No			
If yes, please explain:			
Are you currently following a particular diet or nutrition plan? ☐ Yes ☐ No			
Do you have any eating preferences?			
☐ Vegan	☐ Low Carb/Keto	☐ Dairy Free	☐ Intermittent Fasting
☐ Vegetarian	☐ Low/No Sugar	☐ Gluten Free	☐ Other:
Do you avoid any particular foods? ☐ Yes ☐ No			
If yes, please explain:			
Do you have any adverse food reactions (intolerances or allergies)? ☐ Yes ☐ No			
If yes, please describe:			
Have you recently lost or gained weight? ☐ Yes ☐ No			
If yes, please describe:			
Do you have or have you had an eating disorder? ☐ Yes ☐ No			
If yes, please describe:			

Nutritional History (continued)					
Please check the following items which apply to you and indicate **amount** consumed:					
☐ Coffee		☐ Candy		☐ Cigarettes	
☐ Tea		☐ Chocolate		☐ Other Tobacco	
☐ Soda		☐ Ice Cream		☐ Alcohol	
☐ Water		☐ Sweetener		☐ Sugar	

Intake Summary	
What type(s) of protein do you consume most days of the week? (Check all that apply)	
☐ Red Meat ☐ Chicken/Turkey ☐ Pork ☐ Soy-based ☐ Dairy ☐ Nuts & Seeds ☐ Eggs ☐ Beans	
How many servings of fruit do you have in a day?	☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ 6+
How many servings of vegetables do you have in a day?	☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ 6+
How many meals do you eat each day?	How many snacks do you eat each day?
How many meals do you buy from a restaurant or fast food **per week**?	☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ 6+
How many desserts do you have in an average week?	☐ 0-1 ☐ 2-3 ☐ 4-6 ☐ 6+
What is your favorite meal?	

Check all of the factors that apply to your eating habits and current lifestyle:		
☐ Love to eat	☐ Fast eater	☐ Live alone or eat alone often
☐ Love to cook	☐ Erratic eating patterns	☐ Do not plan meals or menus
☐ Emotional eater	☐ Eat too much	☐ Time constraints
☐ Late night eater	☐ Rely on convenience foods	☐ Travel frequently
☐ Struggle with eating issues	☐ Eat fast food frequently	☐ Don't know how to cook
☐ Family members have different tastes	☐ Make poor snack choices	☐ Negative relationship with food
	☐ Confused about food/nutrition	☐ Dislike healthy food

Food Diary: Please record what you eat and drink during **one 24 hour period** that represents a typical day.
Please be sure to include all beverages, cream and sweetener added to beverages and condiments added to foods.

What time do you wake up:	Bedtime:	**Indicate the following:**		
Time	Food/Beverage	Homemade	Frozen Pre-Packaged	Take out Fast Food Restaurant

WOMEN ONLY		
Does your menstrual cycle occur monthly? ☐ Yes ☐ No		
If yes, cycle occurs every how many days?		
Period lasts how many days?		
Please indicate any of the following:		
☐ Cysts	☐ Endometriosis	☐ Night sweats
☐ Fibroids	☐ Bloating	☐ Hot flashes
☐ Severe Cramping	☐ Mood swings/Irritability	☐ Fertility issues
☐ Heavy bleeding	☐ Breast tenderness	☐ Fertility treatments
☐ Fatigue	☐ Abnormal pap	☐ Other:

MEN ONLY	
Have you had a vasectomy?	☐ Yes ☐ No
Do you have a history of prostate problems?	☐ Yes ☐ No
Do you have any trouble with urination?	☐ Yes ☐ No
Have you had fertility problems?	☐ Yes ☐ No
Do you have a history of erectile dysfunction?	☐ Yes ☐ No

ALL PATIENTS - Readiness Assessment					
To improve your health, how ready/willing are you to …					
1 (not willing) to 5 (very willing)	**1**	**2**	**3**	**4**	**5**
Significantly modify your diet					
Take nutritional supplements each day					
Keep a record of everything you eat each day					
Modify your lifestyle (ex: work demands, sleep habits, physical activity)					
Practice relaxation techniques					
Engage in regular exercise/physical activity					
Have periodic lab tests to assess your progress					

Patient Signature: ____ Date: __________________

Welcome to Peak Wellness

Chiropractic & Nutrition

In order for us to give you the attention you deserve on your path to wellness, we ask you to please be aware of our Mission, Philosophy, and Policies:

Mission: At Peak Wellness, we believe in partnering with our patients and their families to define and attain their health goals.

Philosophy: To educate and empower you to live in optimal wellness This approach is comprehensive and compliments any existing health care program.

INITIAL: **POLICIES:**

________ **Tardiness:** Please be courteous and arrive on time for your scheduled appointment. Late arrivals force us to deduct time from your appointment in order to keep the schedule for other clients throughout the day. **Anyone arriving more than five minutes past their scheduled time will need to rebook their appointment.**

________ **Cancellations:** We require a minimum of 24 hours advance notice for any cancellation or rescheduling of your appointment. This is a consideration to our practitioners. Less than 24 hour notice will result in an office visit charge.

________ **Payment of Services:** Payment in full is expected at the time of service.

________ **Returned Checks:** A standard fee of $25.00 will be charged for any returned checks.

I have read and understand the office mission, philosophy and policies.

Print Name: ______________________________ Date: ____________________

Signature: ____