

Name: _____ Nickname: _____ Age: _____ Date of Birth: _____

Sex at Birth: _____ Pronoun: _____

Address _____ City _____ State _____ Zip _____

Phone (h) _____ Phone (w) _____ Cell _____

Occupation _____ Employer _____

Marital Status(circle one) Single Married Divorced Widow Domestic Partner Email: _____

Partner's Name & Occupation _____

Number of Children: _____ Children's Names & Ages: _____

Have you ever received Chiropractic Care? Yes No If yes, doctor's name/location _____

Referred by _____ Hobbies: _____

About Your Health The human body is designed to be healthy. Throughout life, events occur which damage your health expression. This case history will uncover the layers of damage, especially to your nerve system, that resulted in poor health. Following your exam, Dr. Ella will outline a course of care to begin to correct these layers of damage and recover your innate health potential.

Let's begin at birth to find when you first damaged your nerve system, lost your wellness and began towards ill health.

Yes	No		If Yes, Please Comment	Dr. Ella's Comment
1. Birth Process				
<input type="radio"/>	<input type="radio"/>	Do you know any history of your birth?	_____	_____
<input type="radio"/>	<input type="radio"/>	Was it difficult? Breech?	_____	_____
<input type="radio"/>	<input type="radio"/>	Caesarean?	_____	_____
		Home birth? Hospital birth? (Circle one)	_____	_____
2. Growth and Development				
<input type="radio"/>	<input type="radio"/>	Were you breast fed?	_____	_____
<input type="radio"/>	<input type="radio"/>	Childhood sicknesses or accidents?	_____	_____
<input type="radio"/>	<input type="radio"/>	Drugs?(Prescriptive and non-prescriptive)	_____	_____
<input type="radio"/>	<input type="radio"/>	Childhood vaccinations?	_____	_____
<input type="radio"/>	<input type="radio"/>	Exposure to toxins?	_____	_____
<input type="radio"/>	<input type="radio"/>	Did you have any other traumas? What? When?	_____	_____
		(examples: divorce, death, loss of job in household)		
3. Current Health Habits				
<input type="radio"/>	<input type="radio"/>	Did/do you smoke?	_____	_____
<input type="radio"/>	<input type="radio"/>	Did/do you drink alcohol?	_____	_____
<input type="radio"/>	<input type="radio"/>	Diet (Do you eat healthy foods)?	_____	_____
<input type="radio"/>	<input type="radio"/>	Have you been in accidents?	_____	_____
<input type="radio"/>	<input type="radio"/>	Have you had surgery?	_____	_____
<input type="radio"/>	<input type="radio"/>	organs removed/replaced?	_____	_____
<input type="radio"/>	<input type="radio"/>	Use recreational drugs?	_____	_____
<input type="radio"/>	<input type="radio"/>	Exercise Regularly?	_____	_____
<input type="radio"/>	<input type="radio"/>	Have you ever had a concussion?	_____	_____
<input type="radio"/>	<input type="radio"/>	Are you a caregiver for someone?	_____	_____

Circle to rate your **STRESS level based on a frequency scale of 1-5.** **1= Never 2=Rarely 3=Occasional 4= Regularly 5= Constantly**
 Work: 1 2 3 4 5 Financial: 1 2 3 4 5 Family: 1 2 3 4 5 Mental & Emotional Stress: 1 2 3 4 5
 Chemical: 1 2 3 4 5 Physical Stress: 1 2 3 4 5 Other: _____ 1 2 3 4 5
 (Comment) _____

Sleeping Posture: Side Stomach Back (Comment) _____

Circle to rate each: **1= Very Poor 2= Poor 3= Fair 4= Good 5= Excellent**

Sleep Quality	1	2	3	4	5	Energy Level	1	2	3	4	5
Life Enjoyment	1	2	3	4	5	Motivation	1	2	3	4	5

Symptoms and Ill Health (Present State of Ill Health)

Finally, the years of continuing damage show up as acute or chronic symptoms. What brought you here?

Present Complaint _____

This started on _____

It feels like: (circle) Sharp Dull Aching Burning Radiating Itching Stabbing Other: _____

Is condition interfering with work? _____ Sleep? _____ Routine? _____ Other? _____

Is this condition getting progressively worse or better? _____

Other Doctors seen for this condition? _____ Any home remedies? _____

⇒ Please note **ANY** of the following signals that have presented, even if you feel they are unrelated:

<Under-Aroused>	<Un-Stable>	<Over -Aroused>
<input type="checkbox"/> Poor Attention	<input type="checkbox"/> Migraines	<input type="checkbox"/> Cold hands
<input type="checkbox"/> Impulsive	<input type="checkbox"/> Headaches	<input type="checkbox"/> Cold feet
<input type="checkbox"/> Easily Distracted	<input type="checkbox"/> Seizures	<input type="checkbox"/> Tight Muscles
<input type="checkbox"/> Disorganized	<input type="checkbox"/> Sleepwalking	<input type="checkbox"/> Teeth grinding
<input type="checkbox"/> Depressed	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Lacking motivation	<input type="checkbox"/> PMS	<input type="checkbox"/> Heart Palpitations
<input type="checkbox"/> Poor Concentration	<input type="checkbox"/> Food sensitivities	<input type="checkbox"/> Restless Sleep
<input type="checkbox"/> Spaciness	<input type="checkbox"/> Bed wetting	<input type="checkbox"/> Poor expression of emotions
<input type="checkbox"/> Constipation	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> poor immune system
<input type="checkbox"/> Low Pain Threshold	<input type="checkbox"/> Bipolar Disorder	<input type="checkbox"/> Racing Mind
<input type="checkbox"/> Difficulty waking up	<input type="checkbox"/> Mood Swings	<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Worry	<input type="checkbox"/> Panic Attacks	<input type="checkbox"/> Accelerated Aging
<input type="checkbox"/> Irritable		<input type="checkbox"/> Irritable Bowel
<input type="checkbox"/> Low Energy		
	<Exhausted>	
<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Depression	<input type="checkbox"/> Chronic Fatigue Syndrome
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> ALS (Lou Gehrig Disease)	<input type="checkbox"/> Epstein-Barr Syndrome
<input type="checkbox"/> Eczema or Skin problems	<input type="checkbox"/> Pins & Needles in Legs or Arms	<input type="checkbox"/> Buzzing in Ears
<input type="checkbox"/> Low Blood Pressure	<input type="checkbox"/> Loss of Smell or Taste	<input type="checkbox"/> Dyslexia
<input type="checkbox"/> Numbness in Fingers & Toes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Dizziness or Fainting
<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Face Flushed
<input type="checkbox"/> Ear Infections	<input type="checkbox"/> Urinary Infections	<input type="checkbox"/> Speech Difficulty
		<input type="checkbox"/> Vision Problems
		<input type="checkbox"/> Loss of Memory
		<input type="checkbox"/> Sinus Problems
		<input type="checkbox"/> Bladder Problems
		<input type="checkbox"/> ADHD or ADD

Have you been under drug and medical care? _____

What medications are you taking?(use back of page if needed) _____

How long have you been taking them? _____ What side effects have you experienced? _____

Is there a family history of : Heart Disease Arthritis Cancer Diabetes Other _____

On a Scale of 1 – 10, Rate the importance for you to achieve the following: **1 = Not Important** **10= Necessary**

Eat Better	1	2	3	4	5	6	7	8	9	10
Reduce Stress	1	2	3	4	5	6	7	8	9	10
Stop smoking	1	2	3	4	5	6	7	8	9	10
Increase my mobility	1	2	3	4	5	6	7	8	9	10
Improve my sleep	1	2	3	4	5	6	7	8	9	10
Learn about wellness and natural health care	1	2	3	4	5	6	7	8	9	10
Improve immune function	1	2	3	4	5	6	7	8	9	10
Improve mental function	1	2	3	4	5	6	7	8	9	10

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:

(Signature)

(Date)

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____ / ____ / ____ Approx Weight _____ Vegetarian: Yes .. No ..

INSTRUCTIONS: Number only the boxes which apply to you. Leave blank if you don't have the problem.

* Write 1 in the box for MILD symptoms (occurs rarely).

* Write 2 in the box for MODERATE symptoms (occurs several times a month).

* Write 3 in the box for SEVERE symptoms (occurs almost constantly).

Please do not use checkmarks in the boxes - fill in the boxes with a number or leave blank!

GROUP 1

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

GROUP 2

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

GROUP 3

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

GROUP 4

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

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

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

GROUP 6

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

GROUP 7

- | | | |
|---|---|---|
| <p>(A)</p> 107 <input type="checkbox"/> Insomnia
108 <input type="checkbox"/> Nervousness
109 <input type="checkbox"/> Can't gain weight
110 <input type="checkbox"/> Intolerance to heat
111 <input type="checkbox"/> Highly emotional
112 <input type="checkbox"/> Flush easily
113 <input type="checkbox"/> Night sweats
114 <input type="checkbox"/> Thin, moist skin
115 <input type="checkbox"/> Inward trembling
116 <input type="checkbox"/> Heart palpitates
117 <input type="checkbox"/> Increased appetite without weight gain
118 <input type="checkbox"/> Pulse fast at rest
119 <input type="checkbox"/> Eyelids and face twitch
120 <input type="checkbox"/> Irritable and restless
121 <input type="checkbox"/> Can't work under pressure | <p>(C)</p> 137 <input type="checkbox"/> Failing memory
138 <input type="checkbox"/> Low blood pressure
139 <input type="checkbox"/> Increased sex drive
140 <input type="checkbox"/> Headaches, "splitting or rending" type
141 <input type="checkbox"/> Decreased sugar tolerance | <p>(E)</p> 150 <input type="checkbox"/> Dizziness
151 <input type="checkbox"/> Headaches
152 <input type="checkbox"/> Hot flashes
153 <input type="checkbox"/> Increased blood pressure
154 <input type="checkbox"/> Hair growth on face or body (female)
155 <input type="checkbox"/> Sugar in urine (not diabetes)
156 <input type="checkbox"/> Masculine tendencies (female) |
| <p>(B)</p> 122 <input type="checkbox"/> Increase in weight
123 <input type="checkbox"/> Decrease in appetite
124 <input type="checkbox"/> Fatigue easily
125 <input type="checkbox"/> Ringing in ears
126 <input type="checkbox"/> Sleepy during day
127 <input type="checkbox"/> Sensitive to cold
128 <input type="checkbox"/> Dry or scaly skin
129 <input type="checkbox"/> Constipation
130 <input type="checkbox"/> Mental sluggishness
131 <input type="checkbox"/> Hair coarse, falls out
132 <input type="checkbox"/> Headaches upon arising, wear off during day
133 <input type="checkbox"/> Slow pulse, below 65
134 <input type="checkbox"/> Frequency of urination
135 <input type="checkbox"/> Impaired hearing
136 <input type="checkbox"/> Reduced initiative | <p>(D)</p> 142 <input type="checkbox"/> Abnormal thirst
143 <input type="checkbox"/> Bloating of abdomen
144 <input type="checkbox"/> Weight gain around hips or waist
145 <input type="checkbox"/> Sex drive reduced or lacking
146 <input type="checkbox"/> Tendency to ulcers, colitis
147 <input type="checkbox"/> Increased sugar tolerance
148 <input type="checkbox"/> Women: menstrual disorders
149 <input type="checkbox"/> Young girls: lack of menstrual function | <p>(F)</p> 157 <input type="checkbox"/> Weakness, dizziness
158 <input type="checkbox"/> Chronic fatigue
159 <input type="checkbox"/> Low blood pressure
160 <input type="checkbox"/> Nails weak, ridged
161 <input type="checkbox"/> Tendency to hives
162 <input type="checkbox"/> Arthritic tendencies
163 <input type="checkbox"/> Perspiration increase
164 <input type="checkbox"/> Bowel disorders
165 <input type="checkbox"/> Poor circulation
166 <input type="checkbox"/> Swollen ankles
167 <input type="checkbox"/> Crave salt
168 <input type="checkbox"/> Brown spots or bronzing of skin
169 <input type="checkbox"/> Allergies - tendency to asthma
170 <input type="checkbox"/> Weakness after colds, influenza
171 <input type="checkbox"/> Exhaustion - muscular and nervous
172 <input type="checkbox"/> Respiratory disorders |

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking:

No Medications

Please list any vitamins, herbs, or supplements you are taking:

No Vitamins

Please list any allergies you have:

No Allergies

Please list any surgeries you have had in the past 12 months:

No Recent Surgeries

Please list any other surgeries or medical procedures you have had:

No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

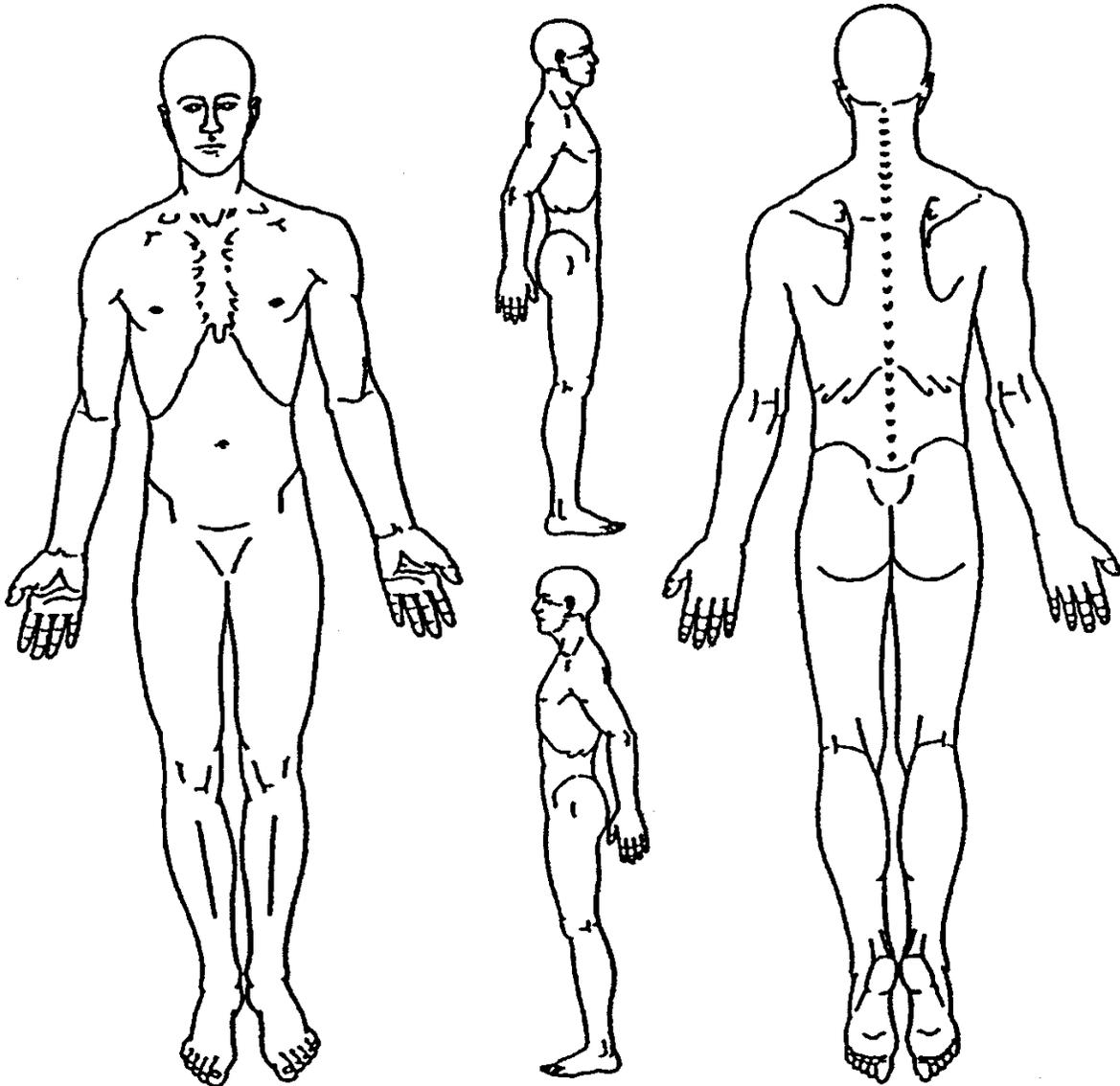
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

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 _____