NTC Health and Fitness

2540 East Plano Pkwy. #142
Plano TX 75074
(972) 881-4343

Steps for your appointment:

1) Please fill out <u>all</u> New Patient forms in their entirety.

2) If you have any recent labs (within 12 months), please bring them to your appointment.

3) If you are married or in a relationship, **please bring your spouse or significant other** with you to your appointment.
(*There will be much information covered concerning your unique condition as well as the fundamentals of the program.)*

4) Please arrive on time.

5) We require a 24-hour notice to change or cancel your appointment.

Note: *If these steps are not followed it may compromise the full value of your consultation and therefore we will kindly reschedule your appointment.*

Initial Consultation

NAME:_____ DATE:_____

DATE OF BIRTH _____ AGE _____ MALE / FEMALE

ADDRESS_____

BEST CONTACT # _____ WORK # _____

MARITAL STATUS_____ SPOUSE'S NAME_____ # OF CHILDREN _____

EMPLOYER _____ REFERRED BY_____

EMAIL_____

Main Complaints:

1)_____ 2)_____

3)_____ 4)_____

How long have you suffered with these problems? _____
Any other complaints: _____

_____

Would you like improvement with any of the following?:

☐ Digestion: Reflux, Gas, Constipation
☐ Sleep: Falling asleep or staying asleep
☐ Sense of Well Being
☐ Energy

Have you become discouraged or stressed about handling this problem? Yes or No_____
When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?
Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at it's worst, how much older does this make you feel? _____
Do you know how this problem may have started? _____

Are you here visiting us to:

a) Resolve my immediate problem
b) Life style program for optimized living
c) Both
d) Other: _____

What have you tried doing to resolve this problem? PLEASE CIRCLE

Medications Routine Medical Exercise Diet and Nutrition Holistic Vitamins
Chiropractic Other: _____

What methods did not work? _____

What are you afraid this might be or will be affecting without change? Please circle
Job Kids Marriage Sleep Freedom
Future Abilities Finances Time

Are there any health conditions you are afraid this might turn into?
Diminished Future Abilities Stress Weight Gain Heart Disease Depression Surgery
Arthritis Cancer Diabetes Other _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of?

Please be specific _____

_____

What would be different or better without this problem? Please circle:

Diminished Stress More Energy Self Esteem Confidence Sleep Work Outlook Family

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress? (Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____
_____
_____
_____

What potential barriers do you foresee that would prevent these things from happening?

_____
_____
_____

Do you feel it is possible to eliminate or prevent these potential barriers? Yes or No
Explain? _____

What are your strengths that will enable you to accomplish your goals?

_____
_____
_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

Thank You!

Confidential Patient History for NTC Health and Fitness

NAME_____ DATE_____

Please check the appropriate box for any of the following symptoms that you have or have had previously. I want all the facts about your health before I accept your case.

O-OCCASIONAL
F-FREQUENT
C-CONSTANT

O F C

GENERAL

☐☐☐ Allergy
☐☐☐ Chills
☐☐☐ Convulsions
☐☐☐ Dizziness
☐☐☐ Fainting
☐☐☐ Fatigue
☐☐☐ Fever
☐☐☐ Headache
☐☐☐ Loss of sleep
☐☐☐ Weight loss
☐☐☐ Nervousness/depression
☐☐☐ Nerve pain
☐☐☐ Numbness
☐☐☐ Sweats
☐☐☐ Tremors

MUSCLE AND JOINT

☐☐☐ Arthritis
☐☐☐ Bursitis
☐☐☐ Foot trouble
☐☐☐ Hernia
☐☐☐ Low back pain
☐☐☐ Neck pain or stiffness
☐☐☐ Osteoporosis
☐☐☐ Pain between shoulders

Pain or Numbness in:

☐☐☐ Shoulders
☐☐☐ Arms
☐☐☐ Elbows
☐☐☐ Hands
☐☐☐ Hips
☐☐☐ Legs
☐☐☐ Knees
☐☐☐ Feet

☐☐☐ Painful tailbone
☐☐☐ Poor posture
☐☐☐ Sciatica
☐☐☐ Spinal curvature

PLEASE TURN OVER

O F C

GASTRO-INTESTINAL

☐☐☐ Belching or gas
☐☐☐ Colitis
☐☐☐ Colon trouble
☐☐☐ Constipation
☐☐☐ Diarrhea
☐☐☐ Difficult digestion
☐☐☐ Distention of abdomen
☐☐☐ Excessive hunger
☐☐☐ Gall bladder trouble
☐☐☐ Hemorrhoids
☐☐☐ Intestinal worms
☐☐☐ Jaundice
☐☐☐ Liver trouble
☐☐☐ Nausea
☐☐☐ Pain over stomach
☐☐☐ Poor appetite
☐☐☐ Vomiting
☐☐☐ Vomiting of blood

EARS, EYES, NOSE, & THROAT

☐☐☐ Asthma
☐☐☐ Colds
☐☐☐ Crossed eyes
☐☐☐ Deafness
☐☐☐ Tooth ache
☐☐☐ Earache
☐☐☐ Ear discharge
☐☐☐ Ear noises
☐☐☐ Enlarged glands
☐☐☐ Enlarged thyroid
☐☐☐ Eye pain
☐☐☐ Failing vision
☐☐☐ Far sightedness
☐☐☐ Gum trouble
☐☐☐ Hay fever
☐☐☐ Hoarseness
☐☐☐ Nasal obstruction
☐☐☐ Near sightedness
☐☐☐ Nosebleeds
☐☐☐ Sinus infection
☐☐☐ Sore throat
☐☐☐ Tonsillitis

O F C

CARDIO-VASCULAR

☐☐☐Hardening of arteries
☐☐☐High blood pressure
☐☐☐Low blood pressure
☐☐☐Pain over heart
☐☐☐Poor circulation
☐☐☐Rapid heart beat
☐☐☐Slow heart beat
☐☐☐Swelling of ankles

☐☐☐RESPIRATORY

☐☐☐Chest pain
☐☐☐Chronic cough
☐☐☐Difficult breathing
☐☐☐Spitting up blood
☐☐☐Spitting up phlegm
☐☐☐Wheezing

SKIN

☐☐☐Boils
☐☐☐Bruise easily
☐☐☐Dryness
☐☐☐Hives or allergy
☐☐☐Itching
☐☐☐Skin eruptions
☐☐☐Varicose veins

GENITO-URINARY

☐☐☐Bed-wetting
☐☐☐Blood in urine
☐☐☐Frequent urination
☐☐☐Inability to control urination
☐☐☐Kidney infection or stones
☐☐☐Painful urination
☐☐☐Prostate trouble
☐☐☐Pus in urine

FOR WOMEN ONLY

☐☐☐Congested breasts
☐☐☐Cramps or backache
☐☐☐Excessive menstrual flow
☐☐☐Hot flashes
☐☐☐Irregular cycle
☐☐☐Menopausal symptoms
☐☐☐Painful menstruation
☐☐☐Vaginal discharge

Are you pregnant? Yes ☐ No ☐

CHECK THE FOLLOWING CONDITIONS YOU HAVE HAD OR HAVE NOW:

☐ AIDS	☐ Chorea	☐ Fever blisters	☐ Miscarriage	☐ Scarlet fever
☐ Alcoholism	☐ Cold sores	☐ Goiter	☐ Multiple sclerosis	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Gout	☐ Mumps	☐ Tuberculosis
☐ Appendicitis	☐ Diphtheria	☐ Heart disease	☐ Pleurisy	☐ Typhoid fever
☐ Arteriosclerosis	☐ Eczema	☐ Lumbago	☐ Pneumonia	☐ Ulcers
☐ Arthritis	☐ Emphysema	☐ Malaria	☐ Polio	☐ Venereal disease
☐ Cancer	☐ Epilepsy	☐ Measles	☐ Rheumatic fever	☐ Whooping cough

Have you ever had previous chiropractic care?_____ When/Where _____
What activities aggravate your condition _____
Is this condition getting progressively worse? ☐Yes ☐No ☐Constant ☐ Comes and goes
How long has it been since you really felt good? _____
List previous diagnoses and treatments you have received for present condition

_____
List surgical operations and years_____
Are you wearing: ☐ heel lifts ☐ sole lifts ☐ inner soles ☐ arch supports
Have you been in an auto accident? ☐past year☐past five years☐over five years☐ never
Describe_____

List below all conditions for which you have been treated in the past 10 years.

HABITS	Heavy	Moderate	Light	None
Tobacco	☐	☐	☐	☐
Artificial Sweeteners (list)		_____	_____	
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Soft Drinks	☐	☐	☐	☐

_____ _____
_____ _____
_____ _____

Name of relative or close friend not living in your home who can be contact in case of emergency.
NAME_____ PHONE_____
ADDRESS_____

PAYMENT IS EXPECTED AT THE TIME OF VISIT:

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this chiropractic office will prepare any necessary reports and forms to assist me in making collections for the insurance company and that any amount authorized to be paid directly to this chiropractic office will be credited to me on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment.

I hereby give my consent to be examined at this office. I consent to allow the doctor to seek inter-and intra-professional advice relating to my particular case in order to obtain additional or collateral information that may be required to reach a complete and accurate diagnosis. Notwithstanding the foregoing, complete confidentiality of my records is assured.

I understand that my acceptance as a patient at this office is contingent upon the opinion of the examining doctor that I have a condition that is amenable to chiropractic care. If chiropractic cannot help me, I will not be accepted as a patient, but will be referred to an appropriate health care faculty.

24 hours notice is required for cancellation of an appointment. Without advance notice, full price will be charged.
A $25.00 service charge will apply to all N.S.F. checks.

SIGNATURE OF PATIENT OR GUARDIAN_____
DATE_____

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI *(Cont.)*				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Neurotransmitter Assessment Form™ (NTAF)

Name: ______________________ **Age:** _____ **Sex:** _______ **Date:** ______________

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn new things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament generally getting worse? 0 1 2 3
- Is your attention span decreasing? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you become fatigued when driving compared to in the past? 0 1 2 3
- How often do you become fatigued when reading compared to in the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

SECTION C

SECTION C1

- How often do you get irritable, shaky, or have light-headedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

SECTION C2

- How often do you get fatigued after meals? 0 1 2 3
- How often do you crave sugar and sweets after meals? 0 1 2 3
- How often do you feel you need stimulants, such as coffee, after meals? 0 1 2 3
- How often do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite increased? 0 1 2 3
- How often do you gain weight when under stress? 0 1 2 3
- How often do you have difficulty falling asleep? 0 1 2 3

SECTION 1

- Are you losing interest in hobbies? 0 1 2 3
- How often do you feel overwhelmed? 0 1 2 3
- How often do you have feelings of inner rage? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are not enjoying life? 0 1 2 3
- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing your enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep, restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

SECTION 2

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested, even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

SECTION 3

- How often do you feel anxious or panicked for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

SECTION 4

- Do you feel your visual memory (shapes & images) has decreased? 0 1 2 3
- Do you feel your verbal memory has decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity decreased? 0 1 2 3
- Has your comprehension diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing a slower mental response? 0 1 2 3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Serotonergic Antidepressants (NaSSAs)

- ☐ Remeron®
- ☐ Zispin®
- ☐ Avanza®
- ☐ Norset®
- ☐ Remergil®
- ☐ Axit®

Tricyclic Antidepressants (TCAs)

- ☐ Elavil®
- ☐ Endep®
- ☐ Tryptanol®
- ☐ Trepiline®
- ☐ Asendin®
- ☐ Asendis®
- ☐ Defanyl®
- ☐ Demolox®
- ☐ Moxadil®
- ☐ Anafranil®
- ☐ Norpramin®
- ☐ Pertofrane®
- ☐ Thaden™
- ☐ Prothiaden®
- ☐ Adapin®
- ☐ Sinequan®
- ☐ Tofranil®
- ☐ Janamine®
- ☐ Gamanil®
- ☐ Aventyl®
- ☐ Pamelor®
- ☐ Opipramol®
- ☐ Vivactil®
- ☐ Rhotrimine®
- ☐ Surmontil®
- ☐ Norpramin®

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil®
- ☐ Zoloft®
- ☐ Prozac®
- ☐ Celexa®
- ☐ Lexapro®
- ☐ Esertia®
- ☐ Luvox®
- ☐ Cipramil®
- ☐ Emocal®
- ☐ Seropram®
- ☐ Cipralex®
- ☐ Fontex®
- ☐ Priligy®
- ☐ Seromex®
- ☐ Seronil®
- ☐ Sarafem®
- ☐ Fluctin®
- ☐ Faverin®
- ☐ Seroxat®
- ☐ Aropax®
- ☐ Deroxat®
- ☐ Rexetin®
- ☐ Paroxat®
- ☐ Lustral®
- ☐ Serlain®

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor®
- ☐ Pristiq®
- ☐ Meridia®
- ☐ Serzone®
- ☐ Dalcipran®
- ☐ Cymbalta®

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon®
- ☐ Coaxil®
- ☐ Tatinol®

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan®
- ☐ Aurorix®
- ☐ Manerix®
- ☐ Moclodura®
- ☐ Nardil®
- ☐ Adeline®
- ☐ Eldepryl®
- ☐ Azilect®
- ☐ Marsilid®
- ☐ Iprozid®
- ☐ Ipronid®
- ☐ Rivivol®
- ☐ Propilniazida®
- ☐ Zyvox®
- ☐ Zyvoxid®

Dopamine Receptor Agonists

- ☐ Mirapex®
- ☐ Sifrol®
- ☐ Requip®

Norepinephrine–Dopamine Reuptake Inhibitors (NDRIs)

- ☐ Wellbutrin XL®

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine®
- ☐ Prolixin®
- ☐ Trilafon®
- ☐ Compazine®
- ☐ Mellaril®
- ☐ Stelazine®
- ☐ Vesprin®
- ☐ Nozinan®
- ☐ Depixol®
- ☐ Navane®
- ☐ Fluanxol®
- ☐ Clopixol®
- ☐ Acuphase®
- ☐ Haldol®
- ☐ Orap®
- ☐ Clozaril®
- ☐ Zyprexa®
- ☐ Zydis®
- ☐ Seroquel XR®
- ☐ Geodon®
- ☐ Solian®
- ☐ Invega®
- ☐ Abilify®

GABA Antagonist Competitive Binder

- ☐ Romazicon®

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax®
- ☐ Lexotanil®
- ☐ Lexotan®
- ☐ Librium®
- ☐ Klonopin®
- ☐ Valium®
- ☐ Prosom®
- ☐ Rohypnol®
- ☐ Magadon®
- ☐ Dalmane®
- ☐ Ativan®
- ☐ Loramet®
- ☐ Sedoxil®
- ☐ Dormicum®
- ☐ Serax®
- ☐ Restoril®
- ☐ Halcion®

Agonist Modulators of GABA Receptors (non-benzodiazepines)

- ☐ Ambien CR®
- ☐ Sonata®
- ☐ Lunesta®
- ☐ Imovane®

Acetylcholine Receptor Agonists

- ☐ Urecholine®
- ☐ Evoxac®
- ☐ Salagen®
- ☐ Isopto®
- ☐ Nicotone

Acetylcholine Receptor Antagonists (antimuscarinic agents)

- ☐ AtroPen®
- ☐ Scopace®
- ☐ Atrovent®
- ☐ Spiriva®

Acetylcholine Receptor Antagonists (ganglionic blockers)

- ☐ Inversine®
- ☐ Hexamethonium
- ☐ Nicotine (high doses)
- ☐ Arfonad®

Acetylcholine Receptor Antagonists (neuromuscular blockers)

- ☐ Tracrium®
- ☐ Nimbex®
- ☐ Nuromax®
- ☐ Metubine®
- ☐ Mivacron®
- ☐ Pavulon®
- ☐ Zemuron®
- ☐ Anectine®
- ☐ Tubocurarine®
- ☐ Norcuron®
- ☐ Hemicholinium-3®

Acetylcholinesterase Reactivators

- ☐ Protopam®

Cholinesterase Inhibitors (reversible)

- ☐ Aricept®
- ☐ Razadyne®
- ☐ Exelon®
- ☐ Cognex®
- ☐ THC
- ☐ Carbamate insecticides
- ☐ Enlon®
- ☐ Prostigmin®
- ☐ Antilirium®
- ☐ Mestinon®

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate insecticides
- ☐ Organophosphate-containing nerve agents

*Please refer to prescribing physician for nutritional interactions with any medications you are taking.

Doctor-Patient Relationship in Chiropractic

INFORMED CONSENT

CHIROPRACTIC

It is important to acknowledge the difference between the health care specialties of chiropractic, osteopathy and medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the chiropractic doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is important to understand what to expect from chiropractic health care services.

ANALYSIS

A doctor of chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When such VSS and VSC complexes are found, chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS

Although doctors of chiropractic are experts in chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every chiropractic patient should be mindful of his/her total condition. Your doctor of chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE

A patient, in coming to the doctor of chiropractic, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. The doctor, of course, will not give chiropractic adjustments, or health care, if he/she is aware that such care may be contraindicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illnesses, or deformities which would otherwise not come to the attention of the doctor of chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The doctor of chiropractic provides a specialized, non-duplicating health service. The doctor of chiropractic is licensed in a special practice and is available to work with other types of licensed providers in your health care regime.

RESULTS

The purpose of chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same chiropractic care. Many medical failures find quick relief through chiropractic. In turn, we must admit that conditions, which do not respond to chiropractic care, may come under the control or be helped through medical science. The fact is that the science of chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have made great strides in alleviating pain and controlling disease.

TO THE PATIENT

Please discuss any questions or problems with the doctor BEFORE signing this statement of policy.

I have read, and understand the foregoing.

Signature _____ Date _____

NTC Health and Fitness

Optimized Living Programs

At NTC Health and Fitness we practice in a holistic manner, but believe in the science of appropriate testing. This type of practice is actually called "functional medicine".

We use testing, whether it is blood analysis, urine, saliva, stool, MRI and other means to give us objective evidence of your current state of health. We then can use these same tests to re-measure for positive functional changes.

All of our treatment is directed towards the *cause* of dysfunction and not to simply cover up your symptoms with medication. By no means do we claim to treat specific diseases, nor offer any cure. No doctor or medication can actually cure the body. Healing is the responsibility of your own body's intelligence.

We offer solutions to help balance the body using specific and customized nutritional and nutriceutical protocols, allowing the body to do what it is programmed to do...*Heal Itself.*

Dr. Shwaluk is not able to and does not accept every case. Dr. Shwaluk's schedule is extremely busy; therefore the number of patients is strictly limited to ensure a high quality of care.

If you are currently on prescription medication, we ask you not to make any changes or go off of these medications without first consulting with your doctor.

It is the responsibility of your prescribing doctor to make these changes and work with us toward helping you become as drug free as possible.

I have read this disclaimer and understand its content,

_____ Date: _____

Signature

_____

Print Name

Please list below the name of your physician that you are currently under care.

_____ Phone: _____

Family Health History

Patient Name:_____ Date_____

Please review the conditions below and indicate those that are current health problems of a family member by the designation C under his/her column. The designation P should be used to indicate a past problem. Leave blank those spaces that do not apply.

Condition	Father	Mother	Spouse	Grandmother	Grandfather	Grandmother	Grandfather
	Age	Age	Age	Age	Age	Age	Age
Allergies							
Anxiety							
Asthma							
ADD/ADHD							
Back trouble							
Bed wetting							
Cancer							
Colic							
Colitis							
Constipation							
Depression							
Diabetes							
Disc problems							
Ear Infections							
Emotional Issues							
Emphysema							
Epilepsy							
Headaches							
Heart trouble							
Heart burn/Reflux							
High Blood Pressure							
IBS							
Indigestion							
Infertility							
Insomnia							
Kidney trouble							
Neck Pain							
Nervousness							
Pinched nerve							
Scoliosis							
Sinus Trouble							
Thyroid Issues							
Other							
Additional Comments _____							
_____							