DRAEGER
Chiropractic & Laser Center
2114 Schofield Ave. Weston, WI 54476

NUTRITIONAL PATIENT QUESTIONAIRE

GENERAL INFORMATION – PLEASE PRINT DATE_____/_____/_____

PATIENT NAME _____ HOME ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

E-MAIL ADDRESS _____@_____ (We do not share your address)

DATE OF BIRTH _____/_____/_____ AGE _____ SEX M___ F___ MARITAL STATUS M___S___D___W___

YOUR EMPLOYER_____ CITY_____

OCCUPATION_____ SSN _____-_____-_____

HOME PHONE (_____)_____-_____ WORK PHONE (_____)_____-_____ CELL (____)_____-_____

SPOUSE'S NAME_____ BIRTH DATE_____/_____/_____ OCCUPATION_____

SPOUSE'S EMPLOYER_____ CITY_____ PHONE (_____)_____-_____

YOUR PRIMARY PHYSICIAN_____ DATE OF LAST PHYSICAL_____

DENTIST_____ DATE OF LAST VISIT_____

DATE OF LAST CHIROPRACTIC ADJUSTMENT_____/_____/_____ GIVEN BY _____

WHO SHOULD BE CONTACTED IN CASE OF EMERGENCY_____ PHONE (____)_____-_____

WHO MAY WE THANK FOR REFERRING YOU TO US? _____ PHONE(____)_____-_____

PLEASE FILL OUT THE FOLLOWING AS COMPLETELY AS YOU CAN. USE ADDITIONAL BLANK SHEETS AS NECESSARY. OBTAINING THE BEST POSSIBLE HEALTH HISTORY IS A PROCESS THAT CAN ONLY OCCUR WITH YOUR PARTICIPATION. THE INFORMATION YOU PROVIDE WILL HELP THE DOCTOR MAKE INFORMED RECOMMENDATIONS. THANK YOU.

HEALTH HISTORY

PLEASE GIVE THE PRIMARY REASON FOR YOUR CONSULTATION. BE SURE TO GIVE A DETAILED ACCOUNT INCLUDING WHEN AND WHY IT STARTED, WHAT HAS BEEN DONE TO DATE, THE RESULTS YOU HAVE HAD AND IF THE PROBLEM IS GETTING BETTER, WORSE OR STAYING THE SAME.

PLEASE LIST SECONDARY HEALTH PROBLEMS YOU ARE EXPERIENCING.

LIST ALL NUTRITIONAL SUPPLEMENT PRODUCTS YOU ARE CURRENTLY TAKING.

PLEASE BRING ALONG ALL BOTTLES WITH YOU TO YOUR CONSULTATION.

NAME	COMPANY	AMOUNT	WHY TAKING	HOW LONG?

LIST ALL PRESCRIPTION AND NON-PRESCRIPTION DRUGS YOU ARE TAKING AND ALL THAT YOU HAVE TAKEN IN THE PAST THAT YOU CAN RECALL.

NAME	AMOUNT	WHY TAKING	HOW LONG?	RESULTS

LIST ALL SURGERIES YOU HAVE HAD IN THE PAST.

SURGERY	DATE	WHY DONE	RESULTS

LIST ALL ALLERGIES YOU HAVE TO FOOD, DRUGS OR OTHER SUBSTANCES.

ALLERGY	SYMPTOMS	HOW LONG?

ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY.

IF YOU DON'T KNOW THE ANSWER, JUST LEAVE IT BLANK.

( ) YES ( ) NO MY MOTHER WAS HEALTHY WHILE PREGNANT WITH ME. IF NO, DESCRIBE_____

( ) YES ( ) NO WAS YOUR BIRTH NATURAL? IF NO, PLEASE CHECK ( ) FORCEPS ( ) C-SECTION

( ) YES ( ) NO WERE YOU BREAST FED FOR AT LEAST THE FIRST 6 MONTHS?

( ) YES ( ) NO WERE YOU FED ANYTHING OTHER THAN BREAST OR COW MILK IN THE FIRST 6 MONTHS?

LIST ITEMS._____

( ) YES ( ) NO WERE YOU A COLICKY BABY?

( ) YES ( ) NO HAVE YOU EVER BEEN TO OR LIVED IN A FOREIGN COUNTRY? LIST._____

( ) YES ( ) NO HAVE YOU EVER FAINTED OR HAD A CONVULSION? DESCRIBE._____

MARK ANY YOU HAVE HAD: ( ) MEASLES ( ) HEPATITIS ( ) HIV/AIDS ( ) MONONUCLEOSIS

( ) MUMPS ( ) VENEREAL DISEASE ( ) SHINGLES ( ) SCARLET FEVER

( ) LYMES ( ) GERMAN MEASLES ( ) HERPES ( ) RHEUMATIC FEVER

( ) CHICKEN POX

DIET HISTORY

MARK EACH ONE AND GIVE THE AMOUNT YOU CONSUME (USING A "0" OR NONE WHEN APPROPRIATE).

_____	OUNCES WATER	_____ PER DAY	_____ PER WEEK
_____	OUNCES ALCOHOL	_____ PER DAY	_____ PER WEEK
_____	OUNCES COFFEE/TEA	_____ PER DAY	_____ PER WEEK
_____	OUNCES SODA	_____ PER DAY	_____ PER WEEK
_____	OUNCES JUICE	_____ PER DAY	_____ PER WEEK
_____	OTHER_____	_____ PER DAY	_____ PER WEEK

LIST YOUR 10 FAVORITE FOODS EATEN MOST FREQUENTLY.

_____ _____ _____

_____ _____ _____

_____ _____ _____

GIVE PERCENTAGE FOR EACH OF THE FOLLOWING (TOTAL FOR EACH LINE SHOULD = 100%).

WHERE DIET PREPARED: _____ HOME _____ RESTAURANT _____ FAST FOOD _____ VENDING MACH

HOW PREPARED: _____ BAKED _____ BROILED _____ FRIED _____ STEAMED _____ MICROWAVED

PREPARED FROM: _____ FRESH _____ CANNED _____ FROZEN _____ PREPACKAGED

MY APPETITE IS: ( ) NORMAL ( ) EXCESSIVE ( ) POOR ( ) NONE

I CRAVE: ( ) SWEETS ( ) SALT ( ) CHOCOLATE ( ) WATER ( ) DIRT ( ) OTHER_____

TYPE OF WATER USED FOR DRINKING/COOKING: ( ) TAP/CITY ( ) SPRING ( ) WELL

( ) REVERSE OSMOSIS ( ) DISTILLED ( ) FILTERED ( ) RAIN

IF WATER IS PURCHASED, IS IT IN: ( ) SOFT PLASTIC ( ) HARD PLASTIC ( ) GLASS

FOODS THAT DISAGREE WITH YOU: ( ) RAW VEGETABLES ( ) HIGHLY SPICED ( ) RAW FRUIT

( ) MILK/DAIRY ( ) FRIED ( ) GREASY ( ) EGGS ( ) ONIONS

( ) BEANS ( ) CABBAGE ( ) SUGAR ( ) OTHER _____

DESCRIBE THE SYMPTOMS YOU GET FROM FOODS THAT DISAGREE WITH YOU:_____

_____

DO YOU FAST? ( ) YES ( ) NO IF YES, HOW OFTEN AND HOW LONG?_____

HAVE YOU EVER DONE A DEXTOXIFICATION PROGRAM? ( ) YES ( ) NO EXPLAIN_____

CHECK ANY OF THE FOLLOWING DIETS YOU HAVE EVER TRIED.

( ) LOW CHOLESTEROL ( ) DIVERTICULITIS ( ) COMPLEX CARB ( ) HIGH PROTEIN

( ) LOW FAT ( ) LOW SALT ( ) LOW PURINE ( ) ALL ENERGY

( ) ULCER ( ) DIABETIC ( ) RENAL/KIDNEY ( ) HIGH FIBER

HOW MANY DAYS A WEEK DO YOU EXERCISE?_____ HOW LONG EACH TIME_____ TYPE_____

BOWEL HEALTH BM = BOWEL MOVEMENT OR STOOL

HOW MANY TIMES DO YOU HAVE A BM? _____ X PER DAY _____ X PER WEEK

( ) YES ( ) NO DO YOU USE LAXITIVES? HOW OFTEN _____ BRAND _____
( ) YES ( ) NO DO YOU GET THE URGE TO HAVE A BM?
( ) YES ( ) NO DO YOU HAVE PAIN WITH A BM?

ANSWER KEY FOR THE FOLLOWING TABLES: 0 = NEVER 1 = RARELY 2 = FREQUENTLY 3 = ALWAYS

STOOL SIZE	STOOL CONSISTENCY	STOOL COLOR
____ 2" WIDE & 6+" LENGTH	____ FLOAT LIKE A SUBMARINE	____ MED/DARK BROWN
____ 2" WIDE & 4+" LENGTH	____ FLOAT ON TOP OF WATER	____ VERY DARK/BLACK
____ THIN, LONG OR NARROW	____ SINK TO THE BOTTOM	____ YELLOW/TAN/CLAY
____ SMALL & HARD	____ LOOSE BUT NOT WATERY	____ GREENISH
____ LARGE & HARD	____ DIARRHEA	____ BLOOD IS VISIBLE
____ DIFFICULT TO PASS	____ ALTERNATE HARD/DIARRHEA	____ MUCUS IN OR AROUND

( ) YES ( ) NO HAVE YOU EVER HAD WORMS OR PARASITES? HOW TREATED?_____
( ) YES ( ) NO DO YOU PRESENTLY HAVE RECTAL ITCHING? ( ) DAY ( ) NIGHT ( ) CONTINUOUSLY

I GET PAIN/HEARTBURN: ( ) BEFORE EATING ( ) AFTER EATING ( ) WHEN LIE DOWN ( ) UPON RISING
DESCRIBE WHERE THE PAIN IS LOCATED._____

I HAVE: ( ) INDIGESTION ( ) BELCHING ( ) GERD ( ) INTESTINAL GAS ( ) BLOATING
( ) IMMEDIATELY AFTER EATING ( ) 1-2 HOURS ( ) 3-5 HOURS ( ) 6+ HOURS
( ) NO ODOR ( ) SOME ODOR ( ) ODOR USUALLY ( ) FOUL SMELLING
( ) HIATAL HERNIA ( ) ESOPHAGEAL BURNING/REFLUX ( ) RAISE HEAD IN BED TO SLEEP

LIST ANY PRESCRIPTION, NON-PRESCRIPTION OR NATURAL REMEDIES YOU TAKE FOR STOMACH OR BOWEL SYMPTOMS.

PRODUCT	DOSE	HOW FREQUENTLY	RESULTS

HEAD, MOUTH & THROAT

MY TEETH ARE: ( ) SOME FILLINGS ( ) BAD ( ) SOME MISSING ( ) ALL MISSING ( ) ROOT CANAL
I WEAR DENTURES: ( ) UPPER ( ) PARTIALS ( ) CROWNS ( ) MORE THAN 1 TYPE OF METAL IN MOUTH
MY BREATH IS: ( ) GOOD ( ) SLIGHT ODOR ( ) ODOR ON/OFF ( ) OFFENSIVE ODOR USUALLY
MY TONGUE IS: ( ) COVERED WITH SMALL TASTE BUDS ( ) SORE ( ) FURROWED ( ) COATED_____COLOR
MY TONGUE COLOR IS: ( ) PINK ( ) RED ( ) RED BLOTCHY ( ) PINK WITH RED TIP
MY TONSILS ARE: ( ) NORMAL ( ) REMOVED AT AGE _____ ( ) ENLARGED ( ) SPOTTED
MY SENSE OF TASTE IS: ( ) NORMAL ( ) POOR ( ) NO TASTE ( ) OVERSALT FOOD ( ) CANKER SORES

MY LIPS ARE: ( ) NORMAL ( ) PEEL A LOT ( ) FEVER BLISTERS OFTEN ( ) CRACKED IN CORNERS

I GET HEADACHES: ( ) DAILY ( ) WEEKLY ( ) RARELY ( ) BEHIND EYES
( ) WAKE UP WITH ( ) GET IN AM ( ) GET IN PM
( ) BACK OF HEAD ( ) FRONT OF HEAD ( ) SIDE OF HEAD ( ) NEVER
( ) WITH AURA ( ) WITH SOME FOOD OR DRINKS
( ) OF DIFFERENT TYPES ( ) WITH NAUSEA/VOMITING

MUSCLE, LIGAMENT, JOINT & NERVES

I HAVE PAIN IN: ( ) NECK ( ) MID BACK ( ) LOW BACK ( ) FEET
( ) HIP ( ) KNEE ( ) ANKLE ( ) HANDS
( ) SHOULDER ( ) ELBOW ( ) WRIST ( ) OTHER_____

I GET: ( ) SWOLLEN JOINTS ( ) SORE JOINTS ( ) JOINTS POP/CRACK ( ) JAW POPS
( ) LEG CRAMPS AT REST ( ) LEG CRAMPS WITH ACTIVITY ( ) WORSE AT NIGHT
( ) FOOT CRAMPS AT REST ( ) FOOT CRAMPS WITH ACTIVITY ( ) FLAT FEET
( ) BURNING FEET ( ) TINGLING IN FEET OR HANDS ( ) RESTLESS LEG SYNDROME

I HAVE:( ) NERVOUS TIC/TWITCHING – WHERE?_____ ( ) BELL'S PALSY
( ) RINGING IN EARS ( ) PARKINSON'S ( ) SCIATIA ( ) MULTIPLE SCLEROSIS
( ) HAD SPINAL SURGERY – WHERE?_____ RESULTS_____

_____
_____
_____
_____
_____
_____
_____
_____

HAIR, SKIN & NAILS

HAIR: ( ) COURSE ( ) FINE ( ) FALLS OUT EXCESSIVELY ( ) TURNED GREY AT AGE____ ( ) OILY ( ) DRY
MALE BEARD: ( ) HEAVY ( ) LIGHT OR SPARSE ( ) NONE ( ) ETHNIC BACKGROUND_____
FEMALE: ( ) FACIAL HAIR ALWAYS ( ) FACIAL HAIR STARTED AT AGE____ ( ) HAIR ON ABDOMEN/BREASTS

FINGER NAILS: ( ) NORMAL ( ) BRITTLE/BREAK EASILY ( ) SPOT ( ) RIDGED VERTICALLY ( ) WHITE SPOTS
( ) RIDGED HORIZONTALLY ( ) GROW FAST ( ) GROW SLOW ( ) SHAPED ODDLY ( ) HANGNAILS

SKIN: ( ) NORMAL ( ) OILY ( ) DRY ( ) FLAKY ( ) ACNE ( ) PSORIASIS ( ) BOILS
( ) SMALL BUMPS ON UPPER ARMS ( ) SKIN CANCER REMOVED ON_____ ( ) SKIN TAGS
( ) ANTIBIOTICS FOR ACNE AT AGE_____ FOR HOW LONG?_____

SPOTS ON SKIN: ( ) WARTS ( ) MOLES ( ) SMALL RED ( ) LARGE RED ( ) BROWN ( ) WHITE

HANDS AND FEET: ( ) DRY, CRACKED OR BLEEDING AREAS ON ( ) HANDS ( ) HEELS ( ) FEET
( ) INGROWN TOENAILS ( ) FUNGUS ON FEET OR NAILS ( ) ATHLETE'S FOOT

CHEST & HEART

I HAVE CHEST PAIN THAT IS: ( ) SHARP ( ) DULL ( ) SEVERE
( ) WORSE AT NIGHT ( ) WORSE UPON EXERTION
( ) BETTER WITH EXERCISE ( ) NO CHANGE WITH EXERCISE
( ) RADIATES TO MY ARM, NECK OR BACK

MY PULSE/HEARTBEAT IS: ( ) TOO FAST ( ) TOO SLOW ( ) SKIPS BEATS

I HAVE: ( ) HIGH BLOOD PRESSURE ( ) LOW BLOOD PRESSURE

I AM: ( ) ON HIGH BP MEDICATION ( ) ON DIURETICS

I HAVE HAD: ( ) HEART ATTACK ( ) STROKE ( ) ANGIOPLASTY ( ) BYPASS SURGERY

I HAVE BEEN TOLD I HAVE: ( ) HEART DISEASE ( ) LUNG DISEASE ( ) CLOGGED ARTERIES

I HAVE: ( ) VARICOSE VEINS ( ) SPIDER VEINS ( ) HEMORRHOIDS ( ) HAD VESSEL SURGERY

DESCRIBE ANY AREAS OF PAIN OR DISCOMFORT YOU ARE EXPERIENCING THAT YOU ASSOCIATE WITH YOUR CHEST AND/OR HEART. _____

_____

RESPIRATORY/LUNGS

I HAVE NASAL CONGESTION: ( ) DAILY ( ) SEVERAL TIMES PER WEEK ( ) ONLY ON OCCASION

I HAVE NASAL DISCHARGE: ( ) DAILY ( ) SEVERAL TIMES PER WEEK ( ) ONLY ON OCCASION
( ) CLEAR ( ) YELLOW ( ) GREEN ( ) BLOOD ( ) OTHER_____

I HAVE: ( ) NON-PRODUCTIVE COUGH (NO MUCUS) ( ) PRODUCTIVE COUGH (W/ MUCUS)
( ) ALLERGIES TO _____ ( ) HOARSENESS OF VOICE ( ) POST-NASAL DRIP
( ) HAYFEVER ( ) ASTHMA ( ) WHEEZING ( ) SNORING

I HAVE/DID HAVE: ( ) FREQUENT COLDS ( ) FLU ONCE OR MORE A YEAR
( ) PNEUMONIA ( ) SINUS INFECTION
( ) ANTIBIOTICS 3 OR MORE TIMES IN MY LIFE
( ) ALLERGIC TO _____

I TAKE: ( ) ALLERGY SHOTS ( ) ALLERGY MEDICATION ( ) DECONGESTANTS ( ) NASAL SPRAYS ( ) STEROIDS

I USE: ( ) CIGARETTES _____ PACKS/DAY ( ) SNUFF/CHEW ( ) CIGARS ( ) EXPOSED TO 2ND HAND SMOKE

I HAVE BEEN TOLD I HAVE: ( ) LUNG DISEASE _____ ( ) EMPHYSEMA ( ) COPD

EMOTIONAL & METABOLISM (MARK ALL THAT APPLY)

I AM/HAVE: ( ) NERVOUS ( ) ANXIOUS ( ) DEPRESSED ( ) SENSITIVE TO NOISE
( ) CONFUSED EASILY ( ) SLEEPY DURING THE DAY ( ) EXHAUSTED A LOT
( ) FATIGUE EASILY ( ) LOSS OF APPETITE ( ) RAGE ( ) FEARFUL
( ) HEAR VOICES ( ) WEAKNESS ( ) POOR MEMORY ( ) IRRITABLE
( ) MORBID THOUGHTS ( ) SUSPICIOUS OF OTHERS ( ) THOUGHTS OF SUICIDE
( ) QUICK MOOD CHANGES ( ) FEAR OF INSANITY
( ) FEAR SERIOUS DISEASE LIKE _____ ( ) AVOID CROWDS
( ) FRIENDS AVOID ME ( ) HAVE LOW BLOOD SUGAR
( ) HAD GLUCOSE TOLERANCE TEST IT WAS ( ) POS ( ) NEG

I: ( ) TAKE DAYTIME NAPS ( ) DREAM TOO MUCH ( ) HAVE NO DREAMS ( ) HAVE NIGHTMARES
( ) WAKE UP TIRED ( ) HAVE COLD FEET ( ) FEEL TOO HOT
( ) HAVE COLD HANDS ( ) AM COLD WHEN OTHERS ARE OK
( ) PERSPIRE TOO MUCH ( ) HAVE INADEQUATE PERSPIRATION WHEN EXERCISING

DO YOU FEEL WELL RESTED WHEN YOU WAKE UP IN THE MORNING? ( ) YES ( ) NO

RATE OF QUALITY OF SLEEP. _____ (1 BEING AWEFUL AND 10 BEING GREAT)

MALE SPECIFIC

I AM: ( ) OVERLY TIRED ( ) EXHAUSTED ( ) GETTING TOO OLD FOR ANYTHING ( ) IMPOTENT

MY PROSTATE: ( ) NORMAL ( ) ENLARGED ( ) HAD CANCER ( ) REMOVED

I HAVE: ( ) PAIN ON URINATION ( ) DIFFICULTY STARTING URINE FLOW ( ) DIFFICULTY STOPPING FLOW
( ) DRIBBLING OF URINE ( ) DECREASED STREAM SIZE ( ) PAIN OR PRESSURE AFTER SEX
( ) GET UP TO URINATE ___ TIMES PER NIGHT ( ) BURNING DISCHARGE

MY URINE COLOR IS: ( ) PALE YELLOW ( ) BRIGHT YELLOW ( ) DARK YELLOW ( ) OTHER
( ) CLEAR ( ) CLOUDY ( ) MUCUS IN IT ( )VARIES A LOT

MY URINE HAS: ( ) ODOR DESCRIBE_____

I HAVE: ( ) HERNIA_____ ( ) PAIN IN TESTICLES OR SCROTUM
I HAVE / HAD: ( ) VENEREAL DISEASE ( ) GENITAL HERPES ( ) HERPES I ( ) HIV / AIDS

MY LIBIDO IS: ( ) NORMAL ( ) EXCESSIVE ( ) INCREASED ( ) DIMINISHED ( )ABSENT

DESCRIBE ANY AREAS OF PAIN YOU HAVE EXPERIENCED IN THE PAST 90 DAYS (LOCATION, DURATION, INTENSITY, ETC.):

_____
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_____

ARE YOU CURRENTLY SEEING ANY OTHER HEALTHCARE PROFESSIONAL SUCH AS A DENTIST, MASSAGE THERAPIST, ACUPUNCTURIST, PSYCHOLOGIST, ETC? PLEASE EXPLAIN:

_____

_____

_____

PLEASE FILL OUT YOUR FAMILY HEALTH HISTORY ON THE CHART BELOW. PUT AN "N" IN THE BOX IF THEY HAVE IT NOW OR A "P" IF THEY HAD IT IN THE PAST.

	ALCOHOLISM	ALLERGIES	ALZEHIMER'S DISEASE	ARTHRITIS	ATHEROSCLEROSIS	CANCER	DIABETES	EPLILEPSY	GLAUCOMA	HEADACHES	HIGH BLOOD PRESSURE	KIDNEY DISEASE	OBESITY	OSTEOPOROSIS	SINUS PROBLEMS	STROKE	THYROID PROBLEM	ULCERS
You																		
Spouse																		
Children																		
Mother																		
Father																		
Maternal grandparents																		
Paternal grandparents																		
Sisters																		
Brothers																		

Use this space to add anything else you would like to share about your health concerns or that you think the doctor should know:

Please review this form to be sure your answers are accurate and sign below.
Thank you for choosing our clinic. We look forward to working with you on your health goals.

Signature_____ Date_____