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		
O	O	Do you know any history of your birth?		
O	O	Was it difficult? Breech?		
O	O	Caesarean?		
		Home birth? Hospital birth? (Circle one)		
		2. Growth and Development		
O	O	Were you breast fed?		
O	O	Childhood sicknesses or accidents?		
O	O	Drugs?(Prescriptive and non-prescriptive)		
O	O	Childhood vaccinations?		
O	O	Exposure to toxins?		
O	O	Did you have any other traumas? What? When?		
		(examples: divorce, death, loss of job in household)		
Yes	**No**	**3. Current Health Habits**		
O	O	Did/do you smoke?		
O	O	Did/do you drink alcohol?		
O	O	Diet (Do you eat healthy foods)?		
O	O	Have you been in accidents?		
O	O	Have you had surgery?		
O	O	organs removed/replaced?		
O	O	Use recreational drugs?		
O	O	Exercise Regularly?		
O	O	Have you ever had a concussion?		
O	O	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: O Side O Stomach O 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>*
O Poor Attention	O Migraines	O Cold hands
O Impulsive	O Headaches	O Cold feet
O Easily Distracted	O Seizures	O Tight Muscles
O Disorganized	O Sleepwalking	O Teeth grinding
O Depressed	O Hot flashes	O Anxiety
O Lacking motivation	O PMS	O Heart Palpitations
O Poor Concentration	O Food sensitivities	O Restless Sleep
O Spaciness	O Bed wetting	O Poor expression of emotions
O Constipation	O Eating Disorder	O poor immune system
O Low Pain Threshold	O Bipolar Disorder	O Racing Mind
O Difficulty waking up	O Mood Swings	O High Blood Pressure
O Worry	O Panic Attacks	O Accelerated Aging
O Irritable		O Irritable Bowel
O Low Energy		

<Exhausted>		
O Cancer	O Rheumatoid Arthritis	O Diabetes
O Multiple Sclerosis	O Depression	O Chronic Fatigue Syndrome
O Fibromyalgia	O ALS (Lou Gehrig Disease)	O Epstein-Barr Syndrome

O Eczema or Skin problems	O Pins & Needles in Legs or Arms	O Buzzing in Ears	O Vision Problems
O Low Blood Pressure	O Loss of Smell or Taste	O Dyslexia	O Loss of Memory
O Numbness in Fingers & Toes	O Diarrhea	O Dizziness or Fainting	O Sinus Problems
O Shortness of Breath	O Loss of Balance	O Face Flushed	O Bladder Problems
O Ear Infections	O Urinary Infections	O Speech Difficulty	O 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 O Arthritis O Cancer O Diabetes O 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 ☐ Acid foods upset
2 ☐ Get chilled often
3 ☐ "Lump" in throat
4 ☐ Dry mouth-eyes-nose
5 ☐ Pulse speeds after meal
6 ☐ Keyed up - fail to calm
7 ☐ Cut heals slowly
8 ☐ Gag easily
9 ☐ Unable to relax; startles easily
10 ☐ Extremities cold, clammy
11 ☐ Strong light irritates
12 ☐ Urine amount reduced
13 ☐ Heart pounds after retiring
14 ☐ "Nervous" stomach
15 ☐ Appetite reduced
16 ☐ Cold sweats often
17 ☐ Fever easily raised
18 ☐ Neuralgia-like pains
19 ☐ Staring, blinks little
20 ☐ Sour stomach often

GROUP 2

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

GROUP 3

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

GROUP 4

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

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

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

GROUP 6

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

GROUP 7

(A)

- 107 ☐ Insomnia
- 108 ☐ Nervousness
- 109 ☐ Can't gain weight
- 110 ☐ Intolerance to heat
- 111 ☐ Highly emotional
- 112 ☐ Flush easily
- 113 ☐ Night sweats
- 114 ☐ Thin, moist skin
- 115 ☐ Inward trembling
- 116 ☐ Heart palpitates
- 117 ☐ Increased appetite without weight gain
- 118 ☐ Pulse fast at rest
- 119 ☐ Eyelids and face twitch
- 120 ☐ Irritable and restless
- 121 ☐ Can't work under pressure

(B)

- 122 ☐ Increase in weight
- 123 ☐ Decrease in appetite
- 124 ☐ Fatigue easily
- 125 ☐ Ringing in ears
- 126 ☐ Sleepy during day
- 127 ☐ Sensitive to cold
- 128 ☐ Dry or scaly skin
- 129 ☐ Constipation
- 130 ☐ Mental sluggishness
- 131 ☐ Hair coarse, falls out
- 132 ☐ Headaches upon arising, wear off during day
- 133 ☐ Slow pulse, below 65
- 134 ☐ Frequency of urination
- 135 ☐ Impaired hearing
- 136 ☐ Reduced initiative

(C)

- 137 ☐ Failing memory
- 138 ☐ Low blood pressure
- 139 ☐ Increased sex drive
- 140 ☐ Headaches, "splitting or rending" type
- 141 ☐ Decreased sugar tolerance

(D)

- 142 ☐ Abnormal thirst
- 143 ☐ Bloating of abdomen
- 144 ☐ Weight gain around hips or waist
- 145 ☐ Sex drive reduced or lacking
- 146 ☐ Tendency to ulcers, colitis
- 147 ☐ Increased sugar tolerance
- 148 ☐ Women: menstrual disorders
- 149 ☐ Young girls: lack of menstrual function

(E)

- 150 ☐ Dizziness
- 151 ☐ Headaches
- 152 ☐ Hot flashes
- 153 ☐ Increased blood pressure
- 154 ☐ Hair growth on face or body (female)
- 155 ☐ Sugar in urine (not diabetes)
- 156 ☐ Masculine tendencies (female)

(F)

- 157 ☐ Weakness, dizziness
- 158 ☐ Chronic fatigue
- 159 ☐ Low blood pressure
- 160 ☐ Nails weak, ridged
- 161 ☐ Tendency to hives
- 162 ☐ Arthritic tendencies
- 163 ☐ Perspiration increase
- 164 ☐ Bowel disorders
- 165 ☐ Poor circulation
- 166 ☐ Swollen ankles
- 167 ☐ Crave salt
- 168 ☐ Brown spots or bronzing of skin
- 169 ☐ Allergies - tendency to asthma
- 170 ☐ Weakness after colds, influenza
- 171 ☐ Exhaustion - muscular and nervous
- 172 ☐ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

- 173 ☐ Apprehension
- 174 ☐ Irritability
- 175 ☐ Morbid fears
- 176 ☐ Never seems to get well
- 177 ☐ Forgetfulness
- 178 ☐ Indigestion
- 179 ☐ Poor appetite
- 180 ☐ Craving for sweets
- 181 ☐ Muscular soreness
- 182 ☐ Depression; feelings of dread
- 183 ☐ Noise sensitivity
- 184 ☐ Acoustic hallucinations
- 185 ☐ Tendency to cry without reason
- 186 ☐ Hair is coarse and/or thinning
- 187 ☐ Weakness
- 188 ☐ Fatigue
- 189 ☐ Skin sensitive to touch
- 190 ☐ Tendency toward hives
- 191 ☐ Nervousness
- 192 ☐ Headache
- 193 ☐ Insomnia
- 194 ☐ Anxiety
- 195 ☐ Anorexia
- 196 ☐ Inability to concentrate; confusion
- 197 ☐ Frequent stuffy nose; sinus infections
- 198 ☐ Allergy to some foods
- 199 ☐ Loose joints

FEMALE ONLY

- 200 ☐ Very easily fatigued
- 201 ☐ Premenstrual tension
- 202 ☐ Painful menses
- 203 ☐ Depressed feelings before menstruation
- 204 ☐ Menstruation excessive and prolonged
- 205 ☐ Painful breasts
- 206 ☐ Menstruate too frequently
- 207 ☐ Vaginal discharge
- 208 ☐ Hysterectomy/ovaries removed (write number 3)
- 209 ☐ Menopausal hot flashes
- 210 ☐ Menses scanty or missed
- 211 ☐ Acne, worse at menses
- 212 ☐ Depression of long standing

MALE ONLY

- 213 ☐ Prostate trouble
- 214 ☐ Urination difficult or dribbling
- 215 ☐ Night urination frequent
- 216 ☐ Depression
- 217 ☐ Pain on inside of legs or heels
- 218 ☐ Feeling of incomplete bowel evacuation
- 219 ☐ Lack of energy
- 220 ☐ Migrating aches and pains
- 221 ☐ Tire too easily
- 222 ☐ Avoids activity
- 223 ☐ Leg nervousness at night
- 224 ☐ Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

N/A

~~BARNES THYROID TEST~~

~~This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in bed 1 hr before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.~~

N/A

N/A

~~**PRE-MENSES FEMALES AND MENOPAUSAL FEMALES**~~

~~Any two days during the month~~

~~**FEMALES HAVING MENSTRUAL CYCLES**~~

~~The 2nd and 3rd day of flow OR any 5 days in a row~~

~~**MALES**~~

~~Any 2 days during the month~~

~~You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.~~

_____

~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____
~~Date~~	_____	~~Temperature~~	_____

N/A

N/A

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 _____

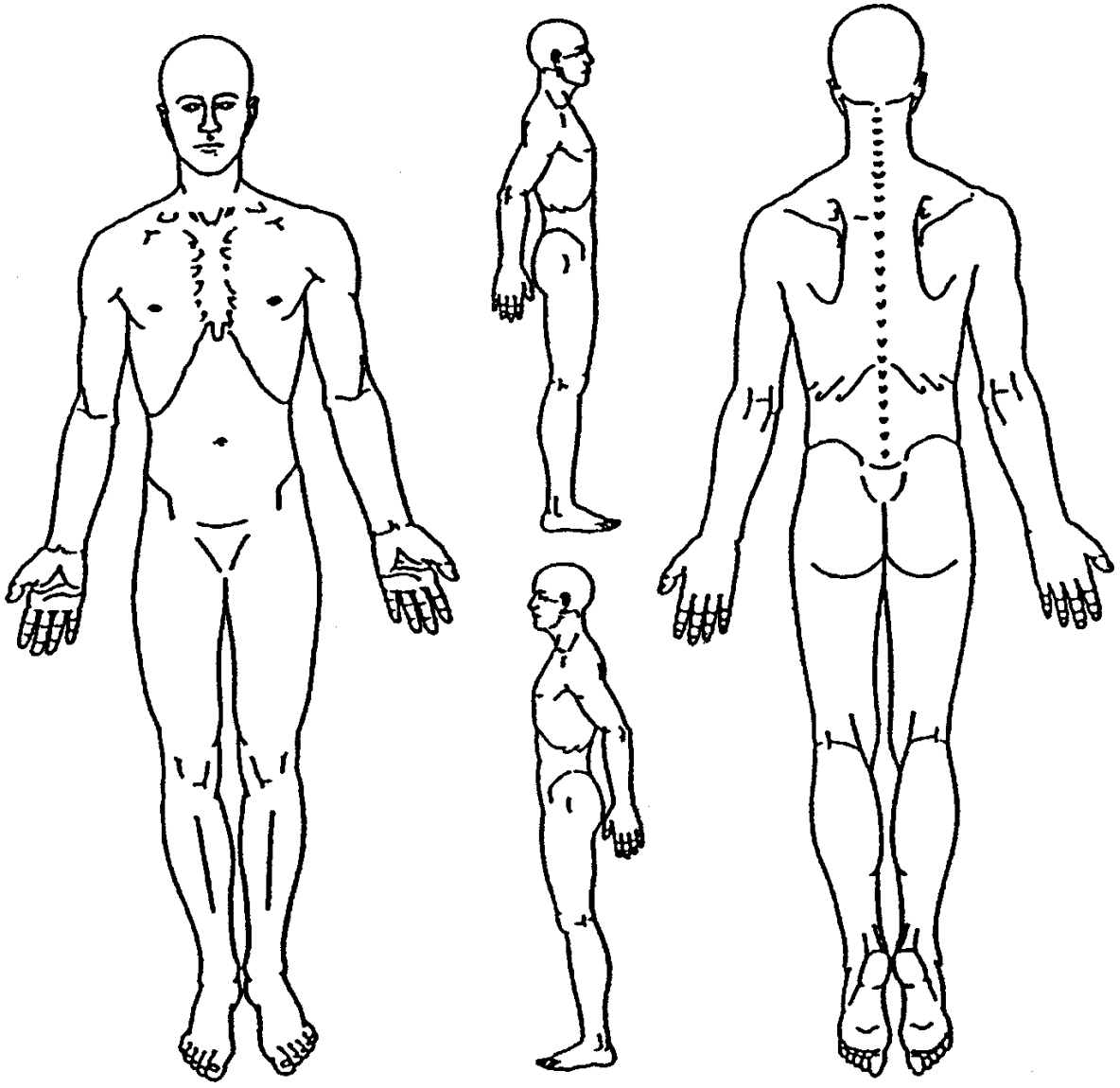
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

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 _____