ADVANCED NUTRITIONAL CONSULTING

Steven Salyers DC MS CNS DACBN
Certified Nutrition Specialist, Diplomat American Clinical Board for Nutrition

Last Name: _____ First Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

Would you like text reminders for your appointments? Y N If yes, please provide cell carrier: _____

Email: _____ Would you like email reminders? Y N

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

SS#: _____

Employer: _____ Occupation: _____

Who may we thank for referring you to us? _____

Present Complaint: _____

Other health care providers you are seeing, with their specialty: _____

_____

What diagnosis were you given? _____

Women Only: Age of onset of menopause (if applicable): _____

How was your health as a child? Excellent Good Fair Poor

Serious Illness/Injuries/Surgeries	**Date**	**Outcome**

Test History	**Year**	**Test**	**Year**
Chest X-Ray	_____	Pap Smear	_____
Kidney X-Ray	_____	Mammogram	_____
GI Series	_____	Sigmoidoscopy	_____
Colon X-Ray	_____	Rectal Exam	_____
Spine X-Ray	_____	PSA	_____
Blood Tests	_____	Complete Physical Exam	_____
Other:	_____	Other:	_____

Please circle any medications you are currently taking or have taken in the last 3 months:

Allergy Medication	Chemotherapy	Oral Contraceptives	Other: _____
Antacids	Cortisone	Pain Medication	_____
Anti-Inflammatory	Heart Medication	Radiation	_____
Antibiotic/Antifungal	High Blood Pressure	Relaxants	_____
Antidepressants	Hormones	Sleeping Pills	
Anti-diabetic/Insulin	Laxatives	Thyroid	
Asprin/ Tylenol/ Advil	Lithium	Ulcer Medication	

Do you (circle day or week as appropriate):

Use Tobacco	_____ packs per day / week	Drink Soda	_____ cups per day / week
Drink Coffee	_____ cups per day / week	Use Artificial Sweeteners	_____ packs per day / week
Drink Black Tea	_____ cups per day / week	Use Margarine	_____ pats per day / week
Drink Alcohol	_____ drinks per day / week		

How many times a week do you eat in restaurants?

Breakfast: _____ Lunch: _____ Dinner: _____

What types of restaurants? _____

Health & Lifestyle Overview

1. Please tell me what is bothering you. If this involves a specific health condition or illness, please tell me about it in as much detail as possible. List the very first time that you noticed the condition and describe carefully any factors that you think may have played a role in it's onset and progression:

2. Is your health currently getting better, worse or staying the same. Why do you think so?

3. What have you tried to do to improve your state of health (e.g. doctors, treatments, etc.)?

4. Have you had stressful occurrences that you believe have negatively affected your health? Are any of these situations continuing to impact your life?

5. Please list any other health concerns, even if you think they may not be important:

6. Why did you choose our office?

7. For our time together to be a true win for you, what do you want to take place over the course of your health care here?

8. How long do you feel this will take?

9. Do you think the pain/symptoms that you are experiencing could be your body's way of saying "I need some help… Let's change things here." Please explain:

10. What areas of your lifestyle are likely involved with your condition and you would like to improve? (Prioritize #1, 2, 3, etc)

_____ My level of anxiety
_____ Me pace of living
_____ My spiritual life
_____ Not enough quiet time & rest
_____ My diet & nutrition
_____ My lifestyle choices
_____ My exercise program
_____ My relationships

11. Please list any **self-destructive lifestyle habits** (e.g. smoking, lack of exercise, alcohol, excessive sweets, fast food, overeating, etc.)

13. What is your present level of commitment to change **the underlying cause** of problem(s) which relate to your lifestyle? (rate from 1 to 10, with 10 being 100% committed).

14. What obstacles could prevent you from changing those lifestyle factors that are undermining your health?

15. What might stop you from following the therapeutic protocols that I may prescribe for you?

16. Who will be your greatest support for you in your health goals?

Family Health History

	Age	State of Health	Age at Death	Cause of Death
Father:				
Mother:				

Any blood relative has/had: ____ Diabetes ____ Cancer ____ Heart Disease/Stroke ____ High Blood Pressure

Relationship: _____

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Relationship: _____

Diet Survey

Please list everything you eat & drink for 2 – 3 Days

Time	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						
Day 3						

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment.

Patient Signature: _____ Date: _____