Functional Medicine Health Coaching

1. Please complete & return this comprehensive health form no later than 2 weeks prior to your Initial Consultation. This will give you an opportunity to think through & remember your past medical history, your current medical concerns and reasons for seeking my help. This also gives me time to put together a comprehensive plan for you. Please type in the answers, save the PDF, and email it back to abelchiro.team@gmail.com.

2. During your initial consultation we will discuss in-depth your health concerns and overall health picture. A recommended care plan will be explained and together we will put together your ultimate plan for success.

3. Any additional procedures such as laboratory and x-ray tests, will be recommended and completed outside of the office, as necessary.

4. Functional Medicine Health Coaching sessions will begin and continue as scheduled until your condition has been fully corrected, or until maximum medical improvement has been obtained.

5. Treatments will begin and continue as scheduled until your condition has been fully corrected, or until maximum medical improvement has been obtained.

Thank you for sharing all of this personal and important information with me.
Everything you share is completely confidential.

I look forward to helping you reach your health and personal goals!

Please complete the following questionnaire before arriving to your appointment. Please type in your answers, save the PDF and email it to abelchiro.team@gmail.com no later than 2 weeks prior to your Initial Consultation. Thank you.

CONTACT INFORMATION

Today's Date: _____

Legal Name: _____

Preferred Name: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F ☐ Other

Check One: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated # of Kids: _____

Address: _____
Street City State Zip

Home Phone: _____ Cell Phone: _____ Office Phone: _____

Preferred Method of Contact: ☐ Home ☐ Cell ☐ Office ☐ Call ☐ Text ☐ Email

Email Address: _____

May we contact you via email regarding your care? ☐ Y ☐ N

Employer: _____ Type of Work: _____

Emergency Contact: _____ Phone Number: _____

Who Referred You? _____

Can we thank them for the referral? ☐ Y ☐ N

How did you hear about us? _____

PERSONAL HISTORY

Past providers for this condition? ☐ Y ☐ N Where? _____ When? _____

Reason for coming in today: _____

_____

When did this condition begin? _____

Have you experienced this condition in the past? Please explain: _____

_____

Please list other doctors you have seen for this condition and the approximate date you were seen:

_____

Have you been treated for any health condition in the past year? ☐Y ☐N If yes, explain:

_____

Major illnesses: _____

Accidents/falls: _____

Hospitalizations: _____

Surgeries: _____

Current Medications: _____

Current Nutritional Supplements: _____

Exercise: ☐ None ☐ 1-2 Times a Week ☐ 3-4 Times a Week ☐ 5-7 Times a Week

Type of exercise and duration: _____

Habits: ☐Smoker: _____ packs a day for _____ years ☐Former Smoker

Alcohol consumption per week: _____ Caffeine consumption per day: _____

Water consumption per day: _____ Soda consumption per day: _____

Date of last physical: _____

YOUR HEALTH STORY

Please rank your current and ongoing health concerns in order of priority

Describe Problem & Severity	Mild	Moderate	Severe	Prior Treatment / Approach Success	Excellent	Good	Fair
Example: Post Nasal Drip	X			Elimination Diet	X		
1.	☐	☐	☐		☐	☐	☐
2.	☐	☐	☐		☐	☐	☐
3.	☐	☐	☐		☐	☐	☐
4.	☐	☐	☐		☐	☐	☐
5.	☐	☐	☐		☐	☐	☐
6.	☐	☐	☐		☐	☐	☐
7.	☐	☐	☐		☐	☐	☐
8.	☐	☐	☐		☐	☐	☐
9.	☐	☐	☐		☐	☐	☐
10.	☐	☐	☐		☐	☐	☐

TELL ME YOUR STORY

Hearing your story written out in your words is very helpful in my understanding of your health in the context of your life. Please feel free to write out, in a few sentences, words, or filling up this whole space, anything you'd like to tell me about your health, health concerns, or how you think your background may have impacted your current health.

LIFE EVENTS & LIFE CONTEXT

Please briefly describe any major life events or crises during:

Childhood:

Adolescence:

Recent Years:

HEALTH GOALS

When was the last time you felt really well?

Do you have any insights or hunches into what's going on with your health?

How do you really want to feel? What does health look like or mean to you?

What will a successful outcome look like to you and in what time frame?

YOUR MEDICAL HISTORY

ALLERGIES:

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

ELIMINATION HISTORY:

Please fill in the chart below with information about your bowel movements:

Frequency:	☐ More than 3x/day ☐ 1 or fewer x/week	☐ 1-3x/day	☐ 4-6x/week	☐ 2-3x/week
Consistency:	☐ Soft / well-formed	☐ Often float	☐ Difficult to pass	☐ Diarrhea
Color:	☐ Medium brown ☐ Dark brown	☐ Very dark or black ☐ Yellow, light brown	☐ Greenish color ☐ Greasy or shiny	☐ Blood is visible

YOUR MEDICAL HISTORY : YES = a condition you currently have, PAST = a condition in the past

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐

Musculoskeletal (continued)	Mild	Moderate	Severe
Muscle weakness	☐	☐	☐
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty concentrating	☐	☐	☐
Difficulty with balance	☐	☐	☐
Difficulty with thinking	☐	☐	☐
Difficulty with judgment	☐	☐	☐
Difficulty with speech	☐	☐	☐
Difficulty with memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal spasms	☐	☐	☐
Bad teeth	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of lower abdomen	☐	☐	☐
Bloating of whole abdomen	☐	☐	☐
Bloating after meals	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to lactose	☐	☐	☐
Intolerance to all dairy products	☐	☐	☐
Intolerance to gluten (wheat)	☐	☐	☐
Intolerance to corn	☐	☐	☐
Intolerance to eggs	☐	☐	☐
Intolerance to fatty foods	☐	☐	☐
Intolerance to yeast	☐	☐	☐
Liver disease/jaundice (yellow eyes or skin)	☐	☐	☐
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐

Digestion (continued)	Mild	Moderate	Severe
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever: spring	☐	☐	☐
Hayfever: summer	☐	☐	☐
Hayfever: fall	☐	☐	☐
Hayfever: change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of finger nails	☐	☐	☐
Thickening of toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender lymph nodes	☐	☐	☐
Skin Dryness			
Dry eyes	☐	☐	☐
Dry feet	☐	☐	☐
Skin cracking on feet	☐	☐	☐
Skin peeling on feet	☐	☐	☐
Dry hair	☐	☐	☐
Unmanageable hair	☐	☐	☐
Dry hands	☐	☐	☐
Skin cracking on hands	☐	☐	☐
Skin peeling on hands	☐	☐	☐
Dry mouth / throat	☐	☐	☐
Dry scalp	☐	☐	☐
Dandruff?	☐	☐	☐
Dry skin in general	☐	☐	☐
Skin Problems			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐

Skin Problems (continued)	Mild	Moderate	Severe
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐

GYNECOLOGIC AND OBSTETRIC HISTORY

MENSTRUAL HISTORY:

Age of first period: Date of last period?

Length of cycle: Time between cycles

Regular cycles? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No

If yes, please describe:

Use of birth control:
☐ Birth control pills ☐ Patch
☐ Nuva Ring ☐ Other:

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain:

Are you in menopause? ☐ Yes ☐ No If yes, age last period:

Was it surgical menopause? ☐ Yes ☐ No

If yes, explain surgery:

Do you currently have symptomatic problems with menopause?

☐ Hot flashes
☐ Vaginal dryness
☐ Concentration/ memory problems
☐ Mood swings
☐ Weight gain
☐ Decreased libido problems
☐ Headaches
☐ Joint pain
☐ Loss of control of urine
☐ Palpitations
☐ Vaginal dryness

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

OTHER GYNECOLOGICAL SYMPTOMS:

Check if applicable

- ☐ Endometriosis
- ☐ Ovarian cysts
- ☐ Infertility
- ☐ Pelvic inflammatory disease
- ☐ Fibrocystic breasts
- ☐ Vaginal infection
- ☐ Fibroids
- ☐ Reproductive cancer
- ☐ Sexually transmitted disease (describe):

OBSTETRIC HISTORY:

Pregnancies:		Miscarriages:	
Vaginal deliveries:		Cesareans:	
Regular cycles?	☐ Yes ☐ No	Pain?	☐ Yes ☐ No
Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.?		☐ Yes	☐ No

If yes, please explain:

MEDICATIONS/SUPPLEMENTS

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date	Reason for Use
1.			
2.			
3.			
4.			
5.			

Nutritional supplements (vitamins/minerals/herbs etc.)

Name/Brand	Dosage	Start Date	Reason for Use
1.			
2.			
3.			
4.			
5.			

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe:

Have you ever used any of these for a long time: NSAIDs (ADVIL, Aleve, etc.), Motrin, Aspirin, Tylenol (acetaminophen)? ☐ Yes ☐ No

Have you ever used any of these for a long time: Acid-blocking drugs (Zantac, Prilosec, or Nexium etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

	<5	>5	Reason for Use
Infancy/Childhood			
Teen			
Adult			

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain:

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	<5	>5	Reason for Use
Infancy/Childhood			
Teen			
Adult			

FAMILY HISTORY

Check family members that have/had any of the following

	Mother	Father	Brother(s)	Sister(s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Other:

LIFESTYLE REVIEW

SLEEP:

How many hours of sleep do you get each night on average?

Do you have problems falling asleep?	☐ Yes	☐ No
Do you have problems staying asleep?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Do you feel rested upon?	☐ Yes	☐ No
Do you use sleeping aids?	☐ Yes	☐ No

If yes, explain:

EXERCISE:

Do you feel motivated to exercise?	☐ Yes	☐ No	☐ A little
Are there any problems that limit exercise?	☐ Yes		☐ No

If yes, explain:

Do you feel unusually fatigued or sore after exercise?	☐ Yes	☐ No

If yes, explain:

NUTRITION:

Do you currently follow any of the following special diets or nutritional programs? (Check all that apply)

☐ Vegetarian	☐ Blood Type	☐ Paleo	☐ Macrobiotic
☐ Vegan	☐ Gluten Free	☐ Low Fat	☐ Other
☐ Kosher	☐ Elimination	☐ Low Carb	
☐ Allergy	☐ Low sodium	☐ No Dairy	

Do you have sensitivities to certain foods?	☐ Yes	☐ No

If yes, list food and symptoms:

When you drink caffeine do you feel:	☐ Irritable or wired	☐ Aches or pains
Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc.?	☐ Yes	☐ No
If yes, are these symptoms associated with any particular food(s) or supplement(s)?	☐ Yes	☐ No

Please name the food or supplement and symptom(s). Example: Milk = gas and diarrhea:

Do you feel you have delayed symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.?	☐ Yes	☐ No

If yes, explain:

Do you eat 3 meals a day?	☐ Yes	☐ No	If no, how many?	
Does skipping a meal greatly affect you?	☐ Yes		☐ No	
How many meals do you eat out per week?	☐ 0-1	☐ 1-3	☐ 3-5	☐ >5

STRESS:

Do you feel you have an excessive amount of stress in your life?	☐ Yes	☐ No
Do you feel you can easily handle the stress in your life?	☐ Yes	☐ No
How much stress do each of the following cause on a daily basis (Rate on scale of 1-10, 10 being highest)	☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other	
Have you ever sought counseling?	☐ Yes	☐ No
Are you currently in therapy?	☐ Yes	☐ No

If yes, describe:

Have you ever been abused, a victim of crime, or experienced a significant trauma?	☐ Yes	☐ No

OVERCOMING POTENTIAL OBSTACLES AND ALIGNING FOR SUCCESS

What is your primary health goal at this time?

Rate how willing you are, on a scale of 5 (very willing) to 1 (not willing), to:

Modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a food journal periodically	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Adjust your lifestyle (e.g., work demands, sleep habits) relaxation technique Practice a relaxation technique)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Rate on a scale of 5 (very supportive) to 1 (not supportive): how supportive do you think the people in your household will be to your implementing the changes you want to make?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

TERMS & CONDITIONS

ABEL CHIROPRACTIC'S CANCELLATION, LATE, & NO-SHOW POLICY

At Abel Chiropractic, we emphasize high quality chiropractic care and health services with appointments reserved specifically for you. Due to our dedication to your health care, we often have a waiting list for appointment times. If you cancel on short notice, do not show up, or show up very late- it is a lost opportunity for another patient.

We understand unanticipated events happen occasionally in everyone's life and we will take that into consideration, however in our desire to be fair to all patients and maintain a viable practice, the following policies are honored.

Thank you for allowing us to be a part of your health care team! We appreciate your understanding and support.

Cancellations

We ask that you please notify the office with a minimum of 4 hours in advance of your scheduled appointment if you need to change or reschedule. This ensures we best assist those patients who are waiting for care. To reschedule or change your appointment, please call (319) 389-5885. If you do not reach someone from the office, you may leave a detailed message on the answering machine.

If you are unable to give us the full advance notice for appointments, **you will be charged half of the scheduled appointment price. Due before your next appointment.***

Initial: _____

Late Arrivals

If you are running late, please call our office to reschedule. Your appointment will likely be shortened to accommodate those whose appointments follow yours. On occasion, we may be able to work-in late arrivals; however, this is at the discretion of our staff. Regardless of the length of the treatment given, **you will be responsible for the "full" appointment.** If you arrive more than 5 minutes late, we may ask you to reschedule. If this occurs, it will be **considered a Missed Appointment.**

Initial: _____

No Show/Missed Appointments

Anyone who either forgets or consciously forgoes their appointment for whatever reason will be considered a "No-Show" and **will be charged the full amount of their missed appointment.***

Three or more No Shows or Missed Appointments may result in the patient being released from care. We have the right to dismiss from care at any time.

*Exclusions to any Missed Appointments include death, severe illness, and as always, are at the discretion of the Abel Chiropractic Staff. We have the right to determine exclusions on a case-by-case basis.

I do agree to give the office notification of appointment rescheduling or cancellation 4 hours prior to my scheduled appointment. I understand that I am responsible for maintaining my appointment time & for proper notification of appointment changes and that if, for circumstances excluding emergencies I am unable to notify or fail to maintain my appointment that actions will be taken as described above including being charged a fee and/or dismissal from care.

Initial: _____

Patient Name: _____

Patient or Guardian's Signature _____ Date _____