Name: _____ Date _____

Nutritional Case History

The questions asked below related to your physiology – how your body is working (or not working) so that we can find ways to support it working better for you to live healthier… and longer. Fill in the blank or circle which applies.

Privacy: All information provided will be kept confidential according to the HIPAA regulations. Phone and e-mail are for our communication with you related to your health and any program or meeting changes.

Basic information

Address: _____ City: _____

State: _____ Zip: _____ Marital Status: _____ # of children: _____

Date of Birth: _____ Age: _____ M or F Social Security #_____

Occupation: _____ Preferred contact Phone: _____

Cell Carrier: _____ E-mail: _____

Height: _____ Weight: _____ Is weight an issue? NO YES

Dietary Restrictions:

- ☐ Paleo
- ☐ Keto
- ☐ Non Dairy
- ☐ Vegan
- ☐ Vegetarian
- ☐ Gluten Free
- ☐ Other_____

Referred by: _____

Symptoms or health concerns:

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

Are your symptoms getting worse? Yes No

Is there a medical diagnosis? _____

Physician's name: _____

Why are you motivated to get better now?_____

How would you rate your stress 1-10? _____

History:

Have you been hospitalized? For what? _____

Have you had surgeries? _____

Name: _____ Date _____

Have you had any recent procedures? For what?_____

Have you had any recent lab tests, X-rays or MRI's ? NO YES--- (Please provide us a report or let us request one)

Are you taking any prescriptions, OTC, vitamins or supplements? NO YES--- (Please list below)

_____ _____

_____ _____

Do you drink coffee? NO YES Smoke? NO YES Drink Alcohol? RARE SOCIAL DAILY MORE

Do you drink soda? NO YES Sugar Free drinks? NO YES

Do you feel you overeat? NO YES---- by GRAZING BIG MEALS

Do you crave? NO YES----- SWEET SALTY BOTH

Do you feel satisfied after a meal YES NO

Do you feel EMOTIONAL MENTAL FOG DIFFICULTY CONCENTRATING?

Do you feel your digestion is working well? NO YES Do you sleep well? NO YES

Do you exercise? YES NO If yes HOW OFTEN: _____ How intense (1-10) _____

Women: Do you have menstrual or menopausal concerns? NO YES

Do you have low libido or low energy? NO YES

Do you have fertility or childbearing concerns? NO YES

Men: Do you have prostate or urination issues? NO YES

Do you have libido or erection issues? NO YES

Learning Style (circle which apply)

I like to know details	or	give me the big picture
I like flexibility	or	tell me what do exactly
If I decide I stick to it	or	I need help with my focus and motivation
I am comfortable with alternative health care	or	I only do what my primary physician says
I prefer direct/firm guidance	or	I prefer gentle guidance

Name: _____ Date _____

What did you eat and drink yesterday?

Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Legal Stuff:

By signing below you acknowledge that any dietary or supplement suggestions made by Julie Miller or representatives of Miller Family Chiropractic are nutritional in nature and are not intended to diagnose, cure or treat any disease or ailment.

You acknowledge that your physician is your primary health provider and is responsible for supervising changes in diet, exercise and nutrient intake.

The information and recommendations provided by Julie Miller or her designees is not intended to be medical advice. The information is meant to inspire and motivate you to make your own decisions surrounding your health care and dietary needs. It is intended for educational and informational purposes only.

You should not rely upon the information to determine dietary changes, a medical diagnosis or course of treatment. You should perform your own research and make decisions in partnership with your health care providers.

Any statements or claims about the possible health benefits obtained from any foods or supplements mentioned have not been evaluated by the Food & Drug Administration and are not intended to diagnose, treat, cure or prevent any disease.

For minors: I hereby authorize S. Brad Miller D.C. and whomever he may designate as his assistant to administer treatment and/or make health related recommendations as he so deems necessary

Parent/Legal Guardian (print)_____ Date_____

Witness _____ Date_____

Signed: _____ Date _____