Advantage CHIROPRACTIC

Health History

Name:________________________________ **Date:**______________

Address:______________________________ City:______________ State:_______ Zip:______________

Phone:______________________________ Email:______________________________

Occupation:______________________________ Age:________ Height:________ Sex:________ # of Children:________

Marital Status: ❑ Single ❑ Partner ❑ Married ❑ Separated ❑ Divorced ❑ Widow(er)

Are you recovering from a cold or flu? ❑ Yes ❑ No Are you pregnant? ❑ Yes ❑ No

Reason for office visit: Date began:

______________________________ ______________

______________________________ ______________

______________________________ ______________

List current health problems for which you are being treated: ______________________________

____

____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

❑Diet Modification ❑ Fasting ❑Vitamins/minerals ❑Herbs ❑Homeopathy ❑Chiropractic ❑Acupuncture ❑Conventional Drugs
❑Other ______________________________

Do you experience any of these general symptoms EVERY DAY?

❑Debilitating fatigue ❑Shortness of breath ❑Insomnia ❑Constipation ❑Chronic pain/inflammation
❑Depression ❑Panic attacks ❑Nausea ❑Fecal incontinence ❑Bleeding
❑Disinterest in sex ❑Headaches ❑Vomiting ❑Urinary incontinence ❑Discharge
❑Disinterest in eating ❑Dizziness ❑Diarrhea ❑Low grade fever ❑Itching/rash

Current medications (prescription or over-the-counter): ______________________________

____

____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis): ______________________________

____

Outcome :______________________________

____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
___________	______________________________	______________
___________	______________________________	______________
___________	______________________________	______________

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): ______________________________

Do you consider yourself: ❑ Underweight ❑ Overweight ❑ Healthy Weight Your weight today ______________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ❑ Yes ❑ No

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)?______________________________

What are your current health goals:______________________________

____

____

____

Medical History

- ❑ Arthritis
- ❑ Allergies/hay fever
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Autoimmune disease
- ❑ Blood pressure problems
- ❑ Bronchitis
- ❑ Cancer
- ❑ Chronic fatigue syndrome
- ❑ Carpal tunnel syndrome
- ❑ Cholesterol, elevated
- ❑ Circulatory problems
- ❑ Colitis
- ❑ Dental problems
- ❑ Depression
- ❑ Diabetes
- ❑ Diverticular disease
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Emphysema
- ❑ Eyes, ears, nose, throat problems
- ❑ Environmental sensitivities
- ❑ Fibromyalgia
- ❑ Food intolerance
- ❑ Gastroesophageal reflux disease
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Gout
- ❑ Heart disease
- ❑ Infection, chronic
- ❑ Inflammatory bowel disease
- ❑ Irritable bowel syndrome
- ❑ Kidney or bladder disease
- ❑ Learning disabilities
- ❑ Liver or gallbladder disease (stones)
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological problems (Parkinson's, paralysis)
- ❑ Sinus problems
- ❑ Stroke
- ❑ Thyroid trouble
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Pneumonia
- ❑ Sexually transmitted disease
- ❑ Seasonal affective disorder
- ❑ Skin problems
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Urinary tract infection
- ❑ Varicose veins

Other____________________________

____

Medical (Men)

- ❑ Benign prostatic hyperplasia
- ❑ Prostate cancer
- ❑ Decreased sex drive
- ❑ Infertility
- ❑ Sexually transmitted disease

Other

____

____

Medical (Women)

- ❑ Menstrual irregularities
- ❑ Endometriosis
- ❑ Infertility
- ❑ Fibrocystic breasts
- ❑ Fibroids/ovarian cysts
- ❑ Premenstrual syndrome (PMS)
- ❑ Breast cancer
- ❑ Pelvic inflammatory disease
- ❑ Vaginal infections
- ❑ Decreased sex drive
- ❑ Sexually transmitted disease

Other ___________________________

Date of last GYN exam ___________

Mammogram ❑ + ❑ —

PAP ❑ + ❑ —

Form of birth control _____________

\# of children ____________________

\# of pregnancies _________________

❑ C-section ____________________

Age of first period _______________

Date of last menstrual cycle ________

Length of cycle _________ days

Interval of time between cycles

_________________ days

Any recent changes in normal men- strual flow (e.g., heavier, large clots, scanty) ___________________

- ❑ Surgical menopause
- ❑ Menopause

Family Health History (Parents and Siblings)

- ❑ Arthritis
- ❑ Asthma
- ❑ Alcoholism
- ❑ Alzheimer's disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Drug addiction
- ❑ Eating disorder
- ❑ Genetic disorder
- ❑ Glaucoma
- ❑ Heart disease
- ❑ Infertility
- ❑ Learning disabilities
- ❑ Mental illness
- ❑ Mental retardation
- ❑ Migraine headaches
- ❑ Neurological disorders (Parkinson's, paralysis)
- ❑ Obesity
- ❑ Osteoporosis
- ❑ Stroke
- ❑ Suicide

Other ___________________________

Health Habits

❑ Tobacco:

Cigarettes: #/day ________________

Cigars: #/day ___________________

❑ Alcohol:

Wine: #glasses/d or wk ___________

Liquor: #ounces/d or wk ___________

Beer: #glasses/d or wk ____________

❑ Caffeine:

Coffee: #6 oz cups/d ______________

Tea: #6 oz cups/d ________________

Soda w/caffeine: #cans/d __________

Other sources ___________________

❑ Water: #glasses/d _____________

Exercise

- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ Less than 30 minutes
- ❑ Walk - #days/wk
- ❑ Run, jog, other aerobic - #days/wk

____

- ❑ Weight lift - #days/wk __________
- ❑ Stretch - #days/wk _____________
- ❑ Other _______________________

Nutrition & Diet

- ❑ Mixed food diet (animal and vegetable sources)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat restriction
- ❑ Starch/carbohydrate restriction
- ❑ The Zone Diet
- ❑ Total calorie restriction

Specific food restrictions:

❑ dairy ❑ wheat ❑ eggs

❑ soy ❑ corn ❑ all gluten

Other ___________________________

Food Frequency

Number of servings per day:

Fruits (citrus, melons, etc.)_________

Dark green or deep yellow/orange vegetables ______________________

Grains (unprocessed) _____________

Beans, peas, legumes ____________

Dairy, eggs______________________

Meat, poultry, fish________________

Eating Habits

❑ Skip meals - which ones _________

____

- ❑ One meal/day
- ❑ Two meals/day
- ❑ Three meals/day
- ❑ Graze (small frequent meals)
- ❑ Generally eat on the run
- ❑ Eat constantly whether hungry or not

Current Supplements

- ❑ Multivitamin/mineral
- ❑ Vitamin C
- ❑ Vitamin E
- ❑ EPA/DHA
- ❑ Evening Primrose/GLA
- ❑ Calcium, source _______________
- ❑ Magnesium
- ❑ Zinc
- ❑ Minerals, describe _____________
- ❑ Friendly flora (acidophilus)
- ❑ Digestive enzymes
- ❑ Amino acids
- ❑ CoQ10
- ❑ Antioxidants (e.g., lutein, resveratrol, etc.)
- ❑ Herbs
- ❑ Homeopathy
- ❑ Protein shakes
- ❑ Superfoods (e.g., bee pollen, phytonutrient blends)
- ❑ Liquid meals (Ensure)

Others_________________________

I Would Like To:

ENERGY - VITALITY

- ❑ Feel more vital
- ❑ Have more energy
- ❑ Have more endurance
- ❑ Be less tired after lunch
- ❑ Sleep better
- ❑ Be free of pain
- ❑ Get less colds and flu
- ❑ Get rid of allergies
- ❑ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleep-ing aids, etc.
- ❑ Stop using laxatives and stool softeners
- ❑ Improve sex drive

BODY COMPOSITION

- ❑ Lose weight
- ❑ Burn more body fat
- ❑ Be stronger
- ❑ Have better muscle tone
- ❑ Be more flexible

STRESS, MENTAL, EMOTIONAL

- ❑ Learn how to reduce stress
- ❑ Think more clearly and be more-focused
- ❑ Improve memory
- ❑ Be less depressed
- ❑ Be less moody
- ❑ Be less indecisive
- ❑ Feel more motivated

LIFE ENRICHMENT

- ❑ Reduce my risk of degenerative disease
- ❑ Slow down accelerated aging
- ❑ Maintain a healthier life longer
- ❑ Change from a "treating-illness" orientation to creating a wellness lifestyle

Health and Wellness questionnaire

NAME ______________________ DATE __________ WEEK ______________

Rate each of the following symptoms based upon your typical health profile for: ☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale	
0	*Never* or *almost never* have the symptom
1	*Occasionally* have it, effect is *not severe*
2	*Ocasionally* have it, effect is *severe*
3	*Frequently* have it, effect is *not severe*
4	*Frequently* have it, effect is *severe*

HEAD

______ Headaches
______ Faintness
______ Dizziness
______ Insomnia
______ TOTAL

EYES

______ Watery or itchy eyes
______ Swollen, reddened or sticky eyelids
______ Bags or dark circles under eyes
______ Blurred or tunnel vision (does not include near- or far-sightedness)
______ TOTAL

EARS

______ Itchy ears
______ Earaches, ear infections
______ Drainage from ear
______ Ringing in ears, hearing loss
______ TOTAL

NOSE

______ Stuffy nose
______ Sinus problems
______ Hay fever
______ Sneezing attacks
______ Excessive mucus formation
______ TOTAL

MOUTH/ THROAT

______ Chronic coughing
______ Gagging, frequent need to clear throat
______ Sore throat, hoarseness, loss of voice
______ Swollen or discolored tongue, gums or lips
______ Canker sores
______ TOTAL

SKIN

______ Acne
______ Hives, rashes, dry skin
______ Hair loss
______ Flushing, hot flashes
______ Excessive sweating
______ TOTAL

HEART

______ Irregular or skipped heartbeat
______ Rapid or pounding heartbeat
______ Chest pain
______ TOTAL

LUNGS

______ Chest congestion
______ Asthma, bronchitis
______ Shortness of breath
______ Difficulty breathing
______ TOTAL

DIGESTIVE TRACT

______ Nausea, vomiting
______ Diarrhea
______ Constipation
______ Bloated feeling
______ Belching, passing gas
______ Heartburn
______ Intestinal/stomach pain
______ TOTAL

JOINTS / MUSCLE

______ Pain or aches in joints
______ Arthritis
______ Stiffness or limitation of movement
______ Pain or aches in muscles
______ Feeling of weakness or tiredness
______ TOTAL

WEIGHT

______ Binge eating/drinking
______ Craving certain foods
______ Excessive weight
______ Compulsive eating
______ Water retention
______ Underweight
______ TOTAL

ENERGY / ACTIVITY

______ Fatigue, sluggishness
______ Apathy, lethargy
______ Hyperactivity
______ Restlessness
______ TOTAL

MIND

______ Poor memory
______ Confusion, poor comprehension
______ Poor concentration
______ Poor physical coordination
______ Difficulty in making decisions
______ Stuttering or stammering
______ Slurred speech
______ Learning disabilities
______ TOTAL

EMOTIONS

______ Mood swings
______ Anxiety, fear, nervousness
______ Anger, irritability, aggressiveness
______ Depression
______ TOTAL

OTHER

______ Frequent illness
______ Frequent or urgent urination
______ Genital itch or discharge
______ TOTAL

GRAND TOTAL ______________

***Name:*____*Date:*______________________**
***(Please print*)**

Please take a moment and carefully read the following information, initial after each statement, and sign where indicated.
By signing, you understand what is written here and have had the opportunity to ask questions.

- I understand that I am here to learn about Natural health and better lifestyle practices and that I will be offered resources that will help me to make informed choices about my health._______

- I understand that I should continue to see any medical doctors I am currently under the care of and that any prescription medication should not be altered without first consulting the doctor who recommended it.

  ______

- I fully understand that those who counsel me are not medical doctors or medical practitioners, that I am choosing to work with a trained and certified natural health practitioner, and that I am responsible for my health choices. I am not here for medical diagnosis or treatment procedures. I understand that it is not Advantage Chiropractic, or Donna Roerick's claim to heal, treat, cure, diagnose allergies, or any other illness or disease and this resource does not replace the advice of a medical professional.

  ______

- I agree to the staff and practitioners of Advantage Chiropractic to communicate with each other regarding my health education. I understand I may agree to Advantage Chiropractic or Donna Roerick to release information or discuss my care by signing the information release form on the next page.

  ____

- Information about traditional uses of supplementation that may create a healthy balance in the body may be discussed. This is not intended to be interpreted as a substitute for a licensed physician's treatment. Nothing said, done, typed, printed, or reproduced by Advantage Chiropractic or Donna Roerick is intended to diagnose, prescribe, treat, or take the place of a licensed physician. ____ __

- Our intent is to provide educational information for the purpose of assisting you with the lifestyle changes and decisions necessary to regain and maintain an environment needed to produce a healthy body. ______

Please turn this page over

I am not on this visit or any subsequent visit acting as an agent for the federal, state, county, local law enforcement agencies or new media on a mission of entrapment or investigation, or for any other reason.

______

Health and Medical Information Release Form (optional)

I, ______________________________, Give permission to Donna Roerick, of Advantage Chiropractic to share private medical information with:

My medical Doctor, ____
Address____Phone___________________

And/or chiropractor,____
Address____Phone_____________________

as well as staff, employees and associates. Also, My medical doctor, his/her staff, employees, and associates have permission to share personal and medical information with Donna Roerick, CNHP.

Signature:____Date:______________________

32 32rd Avenue South, St. Cloud, MN 56301
Phone (320) 251-1080, Fax (320) 656-8991, www.advantagechiro.net

RJL Bioelectrical Impedance Analysis for Body Composition

My signature below indicates that I agree to the following:

(Check off each box before signing this form. Ask questions on any item you do not understand.)

- ❑ I understand that this Body Composition Analysis will give me numerous biomarker values.
- ❑ I understand that I will receive a report to share and discuss with my physician or health care provider.
- ❑ I am NOT pregnant.
- ❑ I do not have a pacemaker, defibrillator, medication pump, or other implanted medical electronic device.
- ❑ I have notified the Technician if I have had a metal joint replacement or metal rod/pin implants of any kind.
- ❑ I have been given contact information if I have any questions at a later date.
- ❑ I release the Technician from any liability of any kind.
- ❑ I have emptied my bladder and/or bowels prior to the test.
- ❑ My cellphone will not be near my body during the Assessment.
- ❑ I have removed any metal jewelry, magnetic objects and therapeutic magnets.
- ❑ I have removed the shoe, sock, or stocking from my right foot and ankle (OR left side, if directed by Technician).

____ ____________________

Signature Date

RJL Bioelectrical Impedance Analysis for Body Composition

First Name	Last Name		Middle Initial
Mailing Address	Date of Birth	Phone	Gender **M F**
City, State, Zip	Email		Age

What target weight would you like to achieve?	Exercise/ Fitness: How many sessions per week?	Exercise/Fitness: Typical activities?	If Female: Date of Last Menstrual Period
	Exercise/Fitness: How many hours per session?		

For Technician Only:

Height	Weight	Resistance	Reactance

Complementary and Alternative Health Care
Client Bill of Rights

The State of Minnesota has not adopted any educational and training standards for unlicensed complementary and alternative health care practitioners. This statement of credentials is for information purposes only.

Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or physical therapist, dietitian, nutritionist, acupuncture practitioner, or any other type of health care provider, the client may seek such services at anytime.

Donna Roerick
Certified Natural Health Practitioner
Advantage Chiropractic
32 32nd Ave. S, St. Cloud, MN 56301

You have the right to express concerns or file complaints with Advantage Chiropractic, 32 32nd Ave S, St. Cloud, MN 56301, (320) 251-1080, through either verbal or written means. Or formally to: Office of Unlicensed Complementary and Alternative Health Care Practice, Health Occupation Program, Suite 400, Metro Square, P.O. Box 64975, St. Paul, MN 55164. (651) 282-6319

(1) Fees at this clinic are available on request.

(2) You have the right to reasonable notice of changes in services or charges.

(3) You have the right to complete and current information concerning my assessment and recommended service that is to be provided.

(4) You may expect courteous and respectful treatment from our staff and to be free from verbal, physical, or sexual abuse by anyone in our office.

(5) Your records and transactions with the practitioners are confidential, unless release of these records is authorized in writing by the client, or otherwise provided by law.

(6) You may choose freely among the providers after treatment has begun. I will be happy to transfer any information you request for use by any other practitioner. At any time during a session you may refuse treatment, unless otherwise provided by law; and you may assert your rights without retaliation.

I acknowledge by my signature that I have read the Complementary and Alternative Health Care Client Bill of Rights.

Signature ____ Date_______________