APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 1/16

It is a pleasure to welcome you to our family of happy and healthy chiropractic patients.

To help us serve you better, please complete the following information. We look forward to working with you to build better health for your family.

Patient Name_____**Name you go by:**_____

How did you hear about our office?_____

What are your health goals? Please rank them in order of priority.

A) _____

B) _____

C) _____

WELLNESS COMMITMENT

At Health Inc., we are dedicated toward achieving the goal of total lasting health for all of our patients. To better understand your individual health objectives, please check all that apply that are closest to your personal health goal(s):

☐ Restore Health ☐ Increase Wellness ☐ Improve Performance ☐ Temporary relief symptoms

WORK & FAMILY HISTORY

Please Check: ☐ Married ☐ Single ☐ Other DOB_____# of children_____Ages_____

Address (City,State, Zip):_____

Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone: (____)_____

Email Address:_____

Your Occupation:_____Work Duties:_____

Spouse's Health Status:_____

Children's Health Status:_____

Past or present health problems of parents or siblings?:_____

HEALTH HISTORY

Subluxations are a condition of the spine that Chiropractors are trained to detect. Research is now showing that dysfunction within the body can be the result of these subluxations. Often other symptoms are apparent for years before spinal pain is noticed. It is for this reason we ask a wide variety of questions regarding your health. On a daily basis we experience physical, dietary, and environmental stressors that lead to subluxations. Help us identify yours.

Previous Chiropractor:_____Date of last visit & reason:_____

Were spinal maintenance programs given to you to maximize the stability of your spine? ☐No ☐Yes

Are other family members under chiropractic care? ☐No ☐Yes, who?_____

Name of Medical Doctor_____

Are you satisfied with the care you received there? ☐ No ☐ Yes

May we update your medical doctor with your progress in our office? ☐ No ☐ Yes

Who was the last Doctor who created a health development plan for you?_____

Did you follow the Doctor's recommendation? ☐No ☐Yes, for how long?_____

What were your results?_____

What other wellness professionals are currently part of your health care team?_____

☐ Massage ☐Therapist ☐Acupuncturist ☐Naturopath ☐Homeopath ☐Other_____

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 2/16

LIFESTYLE STRESS

The vast majority of our patients have experienced dozens of falls or impacts (auto/work/sports/hobbies) that could either begin or exacerbate subluxations. Help us discover a few of yours.

Current Weight_____Goal Weight_____Car accidents: 5+ 3-4 1-2

Please describe any injuries or treatment: _____

_____

_____

Which sports have you practiced? Check all that apply: ☐Basketball ☐Horseback ☐Martial Arts ☐Soccer ☐Baseball ☐Cheerleading ☐Gymnastics ☐Football ☐Other_____

Have you… ? Check all that apply: ☐Sports Injury ☐Stress/Strain while working ☐ Perform repetitive task (typing/lifting) ☐Sit more than 4 Hours a day ☐Slipped/Fell ☐Fallen down stairs ☐ Drive(4+ hr/day) ☐ Broken a bone (if so, which one):_____ Concussion, if so how many_____

Exercise: ☐1-3 time a week ☐4-7 times a week ☐None

Member of a health club or gym: ☐ YES ☐NO ☐other:_____

LifeStyle Indications

Do you consume any of the following? Check the appropriate answer < meaning "less than" > meaning "greater than"

Alcohol	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Coffee	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Soda	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Sweets	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
White Flour	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Milk/Dairy	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Juice	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____
Meats/Fish	☐ None	☐ < 2 drinks/day	☐ > 2 drinks/day	☐ or Stopped recently M/D/Y_____

Physical Stressors

Briefly state the reason you are seeking chiropractic care:_____

Severity of your main complaint at its worst (circle one):

Low **1 2 3 4 5 6 7 8 9 10** Extreme

Describe your pain (check one): ☐ Constant ☐ Occasional ☐ Dull ☐ Frequent ☐ With Motion ☐ Intermittient ☐ Sharp ☐ Throbbing ☐ Achy ☐ Burning ☐ Numbness

Pain Radiates? ☐ No ☐ Yes, where_____

Worse in: ☐ Mornings ☐ Evenings ☐ When sitting ☐ Standing ☐ Always

Anything not listed above that makes it worse?:_____

Better in?: ☐ Mornings ☐Evenings ☐When sitting ☐Standing ☐ Always

Anything not listed above that makes it better?:_____

Ever had this pain before?: ☐No ☐Yes, when:_____

Was the injury due to an accident: ☐No ☐Yes, when:_____

Type of accident?: ☐ Auto ☐ Home ☐ Fall ☐Other, what happened?:_____

Is your condition getting worst? ☐No ☐Yes, how?:_____

Does it interfere with: ☐ Work ☐Sleep ☐ Daily Routine ☐Exercise

Have you lost time from work? ☐ No ☐ Yes, how long?:_____

Do you have pain and/or difficulty performing any of the following activites:

☐Concentrating ☐ Sleeping ☐ Lifting ☐Work ☐ Recreation ☐Reading ☐Personal Care ☐ Walking ☐ Driving ☐Sitting ☐ Standing

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 3/16

Do you sleep on your stomach?: ☐ No ☐ Yes ☐ Sometimes

Is there any other injury to your spine, minor or major, that the Doctor should know about?_____

_____

Have you seen another professional for this condition?: ☐ No ☐ Yes, who_____

Results with treatment? ☐ None ☐ Yes,describe:_____

List any past surgeries and dates:_____

_____

_____

Other health problems or complaints that you would like to address?_____

_____

_____

Emotional Stress

What do you do to relieve stress?:_____

Do you have other healthier habits you could share with us?_____

Sleep	Low	1	2	3	4	5	6	7	8	9	10	Extreme
Mindset	Low	1	2	3	4	5	6	7	8	9	10	Extreme
Personal Relationship	Low	1	2	3	4	5	6	7	8	9	10	Extreme
Occupational	Low	1	2	3	4	5	6	7	8	9	10	Extreme
Finances	Low	1	2	3	4	5	6	7	8	9	10	Extreme

Environmental Stress

Prescription and non-prescription you are taking:

☐ Blood Pressure ☐ Anti-Depressant ☐ Tylenol ☐ Asthma ☐ Cold/Allergy
☐ Hormones ☐ Sleep Aids ☐ Blood Thinners ☐ Advil/Ibuprofen ☐ Attention Aids
☐ Anxiety ☐ Muscle Relaxers
☐ Other:_____

Do you take any Vitamins or Herbs ? ☐ No ☐ Yes, are they: ☐ Synthetic ☐ Food Based

Do you smoke?: ☐ No ☐ Yes, for how long?:_____ How much?:_____

Do you?:

☐ Drink Soda ☐ Use vitamins ☐ Drink bottled water ☐ Belong to a health club
☐ Watch more than 5 hours of TV/wk. ☐ Spend 1 or more hours on a computer daily

Sleep Habits

How do you sleep?: ☐ Well ☐ Trouble falling asleep ☐ Trouble staying asleep ☐ Insomnia

How long has this been happening?_____

How many hours do you sleep a night on average?_____

Do night sweats wake you up? ☐ No ☐ Yes, how often?:_____

Do you wake up tired? ☐ No ☐ Yes, how often?:_____

Is your room completely dark when you sleep at night? (no night light, street lamp, TV, etc.) ☐ Yes ☐ No

Do you get at least 30 minutes of outside daylight time, several days each week? ☐ Yes ☐ No

For Cycle-Age Females

Age of onset of menarche (first period)_____ Approximate date of onset:_____

Are you currently using Birth Control?: ☐ No ☐ Yes, what method?:_____

I have used: ☐ Oral ☐ Pill ☐ Injected ☐ Patch ☐ Ring
☐ Emergency ("Day After" pills) for how long?:_____

Have you used an IUD: ☐ Copper ☐ Hormone ☐ Other_____ For how long?:_____

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 4/16

Please describe any problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweat, sweet cravings, fatigue, depression, palpitations, etc.)

_____

_____

Have you used, or are you currently using, bio-identical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? ☐Yes ☐No If so, what hormone(s), dosage, & for how long? (Specify dates of use below)

_____

_____

First day of menstrual period (LMP)_____Have you had a tubal ligation?☐No ☐Yes, method?_____
Any recent change in your cycle or symptoms associated with your cycle? ☐No ☐Yes, details? _____
How many days does menstruation typically last?_____
How many days is your current cycle (counted from the first day of your last period to the first day of your next period)?
☐ < 20 days ☐20-30 days ☐ 30-40 days ☐40-50 days
Is your cycle regular? ☐Yes ☐ Not always ☐No, details? _____
Typical menstrual flow: ☐ Light ☐ Medium ☐Heavy, details:_____
Do you:

- Use: ☐ Pads ☐ Tampons ☐How many on heavy days?
- Pass clots? ☐ No ☐ Yes, how often?
- Spot? ☐ No ☐ Yes, at what point in your cycle?
- Experience cramping? ☐ None ☐ Mild ☐Moderate ☐Severe
- At what point in your cycle? _____
- Experience abnormal vaginal discharge? ☐ No ☐Yes, when? _____
- Experience vaginal itching and/or odor? ☐ No ☐Yes, when?_____
- Experience breast tenderness? ☐None ☐Mild ☐Moderate ☐ Severe
- At what point in your cycle?_____
- Change in breast size?_____☐No ☐Yes
- Experience nipple discharge?_____ ☐No ☐Yes, when?_____

FOR MENOPAUSAL WOMEN

Please fill in or check the appropriate answer.
Your age at the onset of menopause_____Year of onset_____
Have you had a hysterectomy? Complete (ovaries AND uterus)Partial (uterus only)
Date_____Reason _____
List any other GYN-related surgeries:

_____

_____

Describe your transitioning into menopause (symptoms, strong emotions, thoughts, unusual stressors, etc.)

_____

Have you used, or are you currently using, conventional hormone replacement therapy (HRT)?
☐No ☐Yes, for how long?_____What?_____
Have you used, or are you currently using, bio-identical hormone creams/gels/sublingual, troche, oral?
☐No ☐Yes, for how long?_____What?_____Dosage?_____
Have you utilized any alternative, complimentary, or natural remedies in your management of menopause?
☐No ☐Yes, for how long?_____What?_____Dosage?_____
Have you had, or do you have, any vaginal spotting or bleeding since menopause?

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 5/16

☐ No ☐ Yes, when?_____

Where you evaluated and/or treated by a GYN?

☐ No ☐ Yes, treatment?_____

Did you experience cramping?

☐ None ☐ Mild ☐ Moderate ☐ Severe, at what point in your cycle?_____

Please describe your cycle history.

_____

_____

How would you have described your menstruation?

☐ Easy ☐ Uncomfortable ☐ Difficult ☐ Debilitating

What was your typical menstrual flow?

☐ Light ☐ Medium ☐ Heavy

When you were cycling, would you consider your cycle regular?

☐ Yes ☐ No, if no, explain?_____

Please describe any "treatment" ever received for cycle issues._____

_____

NUTRITIONAL ID QUESTIONNAIRE (Circle one answer per question.)

When complete, count the number of A, B, and C answers to discover your Base Nutritional Plan.

1. If you had a full schedule for your morning and had to be at your peak until lunch, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going, which of these breakfast choices would give you the highest sustained energy?
   - A. Eggs, with bacon or sausage, and a small amount of hash browns
   - B. Almost any meal will give me the energy I need
   - C. Something light such as fruit, toast, yogurt or a protein shake would allow me to enjoy peak energy, without any need or desire for a snack
2. What are your thoughts about salt?
   - A. Love it, would add it often if I thought it was good for me, and love vehicles for salt such as chips, pretzels, etc.
   - B. I could take it or leave it
   - C. I don't like it – I often find foods too salty
3. If you have ever been on a juice or water fast for any length of time how did you react?
   - A. I reacted terribly; low energy, anxious, and starving
   - B. I could fast if necessary
   - C. I thrived when fasting and could do this regularly
4. At Thanksgiving dinner, when the turkey plate is being passed around, which would you prefer?
   - A. I would reach for a thigh or a leg – I prefer the taste
   - B. Either light or dark meat would be pleasurable
   - C. I prefer white meat and am sometimes repulsed by fattier dark meat
5. If you had a full schedule for your afternoon and had to be at your peak until after dinner, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going; which of these lunch choices would give you the highest sustained energy?
   - A. I would prefer a burger with cheese and maybe a small spinach salad with dressing to provide the energy needed for my afternoon
   - B. Almost any meal will give me the energy I need
   - C. My energy would excel if I consumed a large salad with either some cheese or a small chicken breast as a protein

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 6/16

6. You are given the choice of a lighter fish such as tilapia or a heavier fish such as salmon at your local seafood.
   A. I would generally choose salmon over a lighter fish
   B. Either would work for me depending on the day
   C. I would prefer the lighter tilapia over heavier seafood such as salmon
7. If you are out for a celebratory dinner and you are going to eat dessert with no guilt attached; which would you choose?
   A. I would prefer a piece of cheesecake
   B. Either cheesecake or a dish or mixed berries would work for me
   C. I would prefer something lighter such as a dish of mixed berries
8. How do you feel about eating dessert?
   A. I love it and would eat it often if I could get away with it
   B. I can take it or leave it
   C. I really do not like dessert except on rare occasions
9. If I would consume sweets on their own such as candies, cookies or cakes I would feel....
   A. That this would create some negative feeling and possibly cravings for more sweets
   B. That this would not create significant challenges for me but I may not be at my best
   C. That it would not have any negative effects and may actually satisfy my appetite
10. If you had a full schedule for your evening and had to be at your peak until bedtime, knowing that you would have no opportunity to snack or reach for a stimulant such as caffeine to keep you going; which of these dinner choices would give you the highest sustained energy?
   A. A small filet or broiled salmon with green beans or asparagus covered in butter or olive oil
   B. Almost any meal will give me the energy I need
   C. It would be best if I ate a light protein such as orange roughy or chicken breast with a large salad or vegetables such as broccoli or zucchini, with a small amount of butter or olive oil
11. I experience the most significant weight gain when....
   A. I over consume grains, breads and pastas
   B. I typically gain weight whenever I eat too much food of any kind- I see no noticeable difference based on fat or grain products
   C. I over consume fat
12. If you consumed a cup of caffeinated coffee on an empty stomach; how would you feel?
   A. This would make me feel anxious, jittery and / or hungry
   B. I could take it or leave it
   C. I do well on coffee as long as I do not drink too much
13. If I skip a meal I will feel...
   A. Anxious, jittery, and weak, depressed or have other negative symptoms
   B. I would simply have normal hunger pangs
   C. That this would not bother me and I may often forget to eat

Scoring:

For every A chosen, add 1 point.
For every B chosen, add 0 points.
For every C chosen, subtract 1 point.

Number of A answers = _____
Number of B answers = _____
Number of C answers =_____
Your score =_____

If your score is between:

6 thru 14, you would begin your Base Nutritional Plan as a Protein Type
-5 thru 5, you would begin your Base Nutritional Plan as a Mixed Type
-14 thru -6, you would begin your Base Nutritional Plan as a Veggie Type

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 7/16

GLUTEN QUESTIONAIRE

Gluten intolerance has been found to be most common among people of Irish, English, Scottish, and Scandinavian, and Eastern European. Often times, it is assumed that gluten intolerance is a food allergy, but it is not. It is actually an autoimmune process, which affects an alarming percentage of the population. The most significant symptoms are weight gain, fatigue, and depression. The following test is a diagnostic tool to help you understand the symptoms and signs that are likely to go along with gluten intolerance.

1. Do any of the following apply to you? Check what applies to you.

- ☐ Overly sensitive to physical & emotional pain, cry easily
- ☐ Muscle or joint pain or stiffness of unknown cause
- ☐ Difficulty relaxing, feeling tense frequently
- ☐ Tendency to over-consume alcohol
- ☐ Tendency to overeat sweets, bread, carbs
- ☐ Cravings for sweets, bread, carbs
- ☐ Female hormone imbalance (PMS, menopausal symptoms)
- ☐ Weight gain
- ☐ Difficulty gaining weight
- ☐ Unexplained fatigue
- ☐ Eat when upset/eat to relax
- ☐ Migraine-like headache
- ☐ Abdominal pain/cramping
- ☐ "Love" specific foods
- ☐ Food allergies/sensitivities
- ☐ Difficulty digesting dairy products
- ☐ Unexplained digestive problems
- ☐ Intestinal gas
- ☐ Constipation/diarrhea of unknown cause
- ☐ Abdominal bloating or distention
- ☐ Unexplained skin problems/rashes

2. Have you suffered from any of the following conditions?

- ☐ Allergies
- ☐ Irritable Bowl Syndrome
- ☐ Bulimia
- ☐ Iron deficiency/anemia
- ☐ Osteoporosis/bone loss
- ☐ Anorexia
- ☐ Ulcerative colitis
- ☐ Candida
- ☐ Lactose intolerance
- ☐ Depression
- ☐ Rosacea
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Chronic fatigue
- ☐ Crohn's Disease

Scoring:

Count the number of checked ("yes") responses =_____

If your score is 4 or less, your potential for gluten intolerance is: Not likely

If your score is between 5 through 8, your potential for gluten intolerance is: Suspected

If your score is 9 or more, your potential for gluten intolerance is: Very likely

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 8/16

Mood Swings (Please check one per question)

Anxiety/Nervousness/Irritable	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Overly reactive/Short fuse/Anger	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Low mood/Depression	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Low blood sugar/High blood sugar	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Lowered self-esteem/self-image	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Care for others before yourself Sadness/Crying	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Trouble Concentrating	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Memory difficulties	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Fatigue/Anemia	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Increased Appetite/Constant hunger	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Sweet cravings/Carbs/Chocolate	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Caffeine/Stimulant cravings	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Salt cravings	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Headaches/Migraines	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Muscle Pain/Joint Aches/Backache	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Weight gain/Trouble Losing Weight	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Weight loss	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Water Retention	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Bloating/Belching/Gas	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Stomach Burning/Nausea/Indigestion	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Constipation	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Light colored stool	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Loose stool/Diarrhea/IBS	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Acne/Rashes/Brown Spots	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Excessive facial hair/body hair	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Body/Head hair loss	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Infertility	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Lowered libido/Heightened libido	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Hot flashes/Night Sweats	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Palpitations	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Breast tenderness/Breast cysts	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Nipple discharge	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Vaginal infections/Yeast infections	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Urinary Frequency/Incontinence/Infections	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Dry eyes/Dry skin/Overall dryness	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Changes to Labia/Clitoral tissue	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe
Vaginal changes (dryness, tearing, decreasing size))	☐Ongoing	☐Worse w/ Period	☐Mild	☐Moderate	☐Severe

Other:

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 9/16

SYMPTOM SURVEY

Only check symptoms that apply.

Mild = occurs rarely. Moderate = occurs several times a month. Severe = constant.

A

Acid foods upset	☐ Mild	☐ Moderate	☐ Severe
Get chilled	☐ Mild	☐ Moderate	☐ Severe
Lump in throat	☐ Mild	☐ Moderate	☐ Severe
Dry mouth/eyes/nose	☐ Mild	☐ Moderate	☐ Severe
Pulse speeds after meals	☐ Mild	☐ Moderate	☐ Severe
Keyed up – fail to calm	☐ Mild	☐ Moderate	☐ Severe
Cuts heal slowly	☐ Mild	☐ Moderate	☐ Severe
Gag easily	☐ Mild	☐ Moderate	☐ Severe
Unable to relax, startles easily	☐ Mild	☐ Moderate	☐ Severe
Extremities cold, clammy	☐ Mild	☐ Moderate	☐ Severe
Strong light irritates	☐ Mild	☐ Moderate	☐ Severe
Urine amount reduced	☐ Mild	☐ Moderate	☐ Severe
Heart pounds after retiring	☐ Mild	☐ Moderate	☐ Severe
Nervous stomach	☐ Mild	☐ Moderate	☐ Severe
Appetite reduced	☐ Mild	☐ Moderate	☐ Severe
Cold sweats often	☐ Mild	☐ Moderate	☐ Severe
Fever easily raised	☐ Mild	☐ Moderate	☐ Severe
Neuralgia-like pains	☐ Mild	☐ Moderate	☐ Severe
Staring blinks little	☐ Mild	☐ Moderate	☐ Severe
Sour stomach frequent	☐ Mild	☐ Moderate	☐ Severe

B

Joint stiffness after arising	☐ Mild	☐ Moderate	☐ Severe
Muscle/leg/toe cramps at night	☐ Mild	☐ Moderate	☐ Severe
Butterfly stomach cramps	☐ Mild	☐ Moderate	☐ Severe
Watery eyes/nose	☐ Mild	☐ Moderate	☐ Severe
Eyes blink often	☐ Mild	☐ Moderate	☐ Severe
Eyelids swollen, puffy	☐ Mild	☐ Moderate	☐ Severe
Indigestion soon after meals	☐ Mild	☐ Moderate	☐ Severe
Always hungry; “Lightheaded” often	☐ Mild	☐ Moderate	☐ Severe
Digestion rapid	☐ Mild	☐ Moderate	☐ Severe
Vomiting frequent	☐ Mild	☐ Moderate	☐ Severe
Hoarseness frequent	☐ Mild	☐ Moderate	☐ Severe
Breathing irregular	☐ Mild	☐ Moderate	☐ Severe
Pulse slow; feels “irregular”	☐ Mild	☐ Moderate	☐ Severe
Gagging reflex slow	☐ Mild	☐ Moderate	☐ Severe
Difficulty swallowing	☐ Mild	☐ Moderate	☐ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 10/16

Constipation/diarrhea alternating	☐ Mild	☐ Moderate	☐ Severe
"Slow starter"	☐ Mild	☐ Moderate	☐ Severe
Gets "chilled" infrequently	☐ Mild	☐ Moderate	☐ Severe
Perspire easily	☐ Mild	☐ Moderate	☐ Severe
Circulation poor, sensitive to cold	☐ Mild	☐ Moderate	☐ Severe
Subject to colds, asthma, and bronchitis	☐ Mild	☐ Moderate	☐ Severe
C			
Eat when nervous	☐ Mild	☐ Moderate	☐ Severe
Excessive appetite	☐ Mild	☐ Moderate	☐ Severe
Hungry between meals	☐ Mild	☐ Moderate	☐ Severe
Irritable before meals	☐ Mild	☐ Moderate	☐ Severe
Get "shaky" if hungry	☐ Mild	☐ Moderate	☐ Severe
Fatigue, eating relieves	☐ Mild	☐ Moderate	☐ Severe
"Lightheaded" if meals delayed	☐ Mild	☐ Moderate	☐ Severe
Heart palpitates if meals delayed	☐ Mild	☐ Moderate	☐ Severe
Afternoon headaches	☐ Mild	☐ Moderate	☐ Severe
Overeating sweets upsets	☐ Mild	☐ Moderate	☐ Severe
Sleeping few hrs; difficulty falling asleep	☐ Mild	☐ Moderate	☐ Severe
Crave candy or coffee in afternoons	☐ Mild	☐ Moderate	☐ Severe
Depression moods: "blues"/melancholy	☐ Mild	☐ Moderate	☐ Severe
Abnormal craving for sweets/snacks	☐ Mild	☐ Moderate	☐ Severe
D			
Hands/feet go to sleep, numbness	☐ Mild	☐ Moderate	☐ Severe
Sigh frequently, "air hunger"	☐ Mild	☐ Moderate	☐ Severe
Aware of "breathing heavily"	☐ Mild	☐ Moderate	☐ Severe
High altitude discomfort	☐ Mild	☐ Moderate	☐ Severe
Opens windows in closed room	☐ Mild	☐ Moderate	☐ Severe
Susceptible to colds and fevers	☐ Mild	☐ Moderate	☐ Severe
Afternoon "yawner"	☐ Mild	☐ Moderate	☐ Severe
Get "drowsy" often	☐ Mild	☐ Moderate	☐ Severe
Swollen ankles worse at night	☐ Mild	☐ Moderate	☐ Severe
Muscle cramps worse in exercise	☐ Mild	☐ Moderate	☐ Severe
Shortness of breathe worse on exertion	☐ Mild	☐ Moderate	☐ Severe
Dull pain in chest/left arm, worse on exertion	☐ Mild	☐ Moderate	☐ Severe
Bruise easily; "black and blue" spots	☐ Mild	☐ Moderate	☐ Severe
Tendency to anemia	☐ Mild	☐ Moderate	☐ Severe
"Nose bleeds" frequent	☐ Mild	☐ Moderate	☐ Severe
Noises in head or "ringing in ears"	☐ Mild	☐ Moderate	☐ Severe
Breastbone "tightness" on exertion	☐ Mild	☐ Moderate	☐ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 11/16

E			
Dizziness	☐ Mild	☐ Moderate	☐ Severe
Dry skin	☐ Mild	☐ Moderate	☐ Severe
Burning feet	☐ Mild	☐ Moderate	☐ Severe
Blurred vision	☐ Mild	☐ Moderate	☐ Severe
Itching skin and feet	☐ Mild	☐ Moderate	☐ Severe
Excessive falling hair	☐ Mild	☐ Moderate	☐ Severe
Frequent skin rashes	☐ Mild	☐ Moderate	☐ Severe
Bitter/metallic taste in mouth in mornings	☐ Mild	☐ Moderate	☐ Severe
Bowel movements painful or difficult	☐ Mild	☐ Moderate	☐ Severe
Worrier, feels insecure	☐ Mild	☐ Moderate	☐ Severe
Feeling queasy; headache over eyes	☐ Mild	☐ Moderate	☐ Severe
Greasy foods upset	☐ Mild	☐ Moderate	☐ Severe
Stools light-colored	☐ Mild	☐ Moderate	☐ Severe
Skin peels on foot soles	☐ Mild	☐ Moderate	☐ Severe
Pain between shoulder blades	☐ Mild	☐ Moderate	☐ Severe
Use laxatives	☐ Mild	☐ Moderate	☐ Severe
Stools alternate from soft to watery	☐ Mild	☐ Moderate	☐ Severe
History of gallbladder attacks or gallstones	☐ Mild	☐ Moderate	☐ Severe
Sneezing attacks	☐ Mild	☐ Moderate	☐ Severe
Dreaming, nightmare type bad dreams	☐ Mild	☐ Moderate	☐ Severe
Bad breath (halitosis)	☐ Mild	☐ Moderate	☐ Severe
Milk products cause distress	☐ Mild	☐ Moderate	☐ Severe
Sensitive to hot weather	☐ Mild	☐ Moderate	☐ Severe
Burning or itching anus	☐ Mild	☐ Moderate	☐ Severe
Crave sweets	☐ Mild	☐ Moderate	☐ Severe
F			
Loss of taste for meat	☐ Mild	☐ Moderate	☐ Severe
Lower bowel gas several hrs after eating	☐ Mild	☐ Moderate	☐ Severe
Burning stomach sensations, eating relieves	☐ Mild	☐ Moderate	☐ Severe
Coated tongue	☐ Mild	☐ Moderate	☐ Severe
Pass large amounts of foul-smelling gas	☐ Mild	☐ Moderate	☐ Severe
Indigestion 1/2-1 hr after eating; up to 3-4hrs	☐ Mild	☐ Moderate	☐ Severe
Mucous colitis or “irritable bowel”	☐ Mild	☐ Moderate	☐ Severe
Gas shortly after eating	☐ Mild	☐ Moderate	☐ Severe
Stomach “bloating” after eating	☐ Mild	☐ Moderate	☐ Severe
G			
1			
Insomnia Nervousness	☐ Mild	☐ Moderate	☐ Severe
Can’t gain weight	☐ Mild	☐ Moderate	☐ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 12/16

Intolerance to heat	☐ Mild	☐ Moderate	☐ Severe
Highly emotional	☐ Mild	☐ Moderate	☐ Severe
Flush easily	☐ Mild	☐ Moderate	☐ Severe
Night sweats	☐ Mild	☐ Moderate	☐ Severe
Thin, moist skin	☐ Mild	☐ Moderate	☐ Severe
Inward trembling	☐ Mild	☐ Moderate	☐ Severe
Heart palpitates	☐ Mild	☐ Moderate	☐ Severe
Increased appetite without weight gain	☐ Mild	☐ Moderate	☐ Severe
Pulse fast at rest	☐ Mild	☐ Moderate	☐ Severe
Eyelids and face twitch	☐ Mild	☐ Moderate	☐ Severe
Irritable and restless	☐ Mild	☐ Moderate	☐ Severe
Can't work under pressure	☐ Mild	☐ Moderate	☐ Severe
2			
Increase in weight	☐ Mild	☐ Moderate	☐ Severe
Decrease in appetite	☐ Mild	☐ Moderate	☐ Severe
Fatigue easily	☐ Mild	☐ Moderate	☐ Severe
Ringing in ears	☐ Mild	☐ Moderate	☐ Severe
Sleepy during day	☐ Mild	☐ Moderate	☐ Severe
Sensitive to cold	☐ Mild	☐ Moderate	☐ Severe
Dry or scaly skin	☐ Mild	☐ Moderate	☐ Severe
Constipation	☐ Mild	☐ Moderate	☐ Severe
Mental sluggishness	☐ Mild	☐ Moderate	☐ Severe
Hair coarse falls out	☐ Mild	☐ Moderate	☐ Severe
Headaches upon arising wear off during day	☐ Mild	☐ Moderate	☐ Severe
Slow pulse, below 65	☐ Mild	☐ Moderate	☐ Severe
Frequency of urination	☐ Mild	☐ Moderate	☐ Severe
Impaired hearing	☐ Mild	☐ Moderate	☐ Severe
Reduced initiative	☐ Mild	☐ Moderate	☐ Severe
3			
Failing memory	☐ Mild	☐ Moderate	☐ Severe
Low blood pressure	☐ Mild	☐ Moderate	☐ Severe
Increased sex drive	☐ Mild	☐ Moderate	☐ Severe
Headaches, "splitting or rendering" type	☐ Mild	☐ Moderate	☐ Severe
Decreased sugar tolerance	☐ Mild	☐ Moderate	☐ Severe
4			
Abnormal thirst	☐ Mild	☐ Moderate	☐ Severe
Bloating of abdomen	☐ Mild	☐ Moderate	☐ Severe
Weight gain around hips or waist	☐ Mild	☐ Moderate	☐ Severe
Sex drive reduced or lacking	☐ Mild	☐ Moderate	☐ Severe
Tendency to ulcers, colitis	☐ Mild	☐ Moderate	☐ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 13/16

Increased sugar tolerance	☐ Mild	☐ Moderate	☐ Severe
Women: menstrual disorders	☐ Mild	☐ Moderate	☐ Severe
Young girls: lack of menstrual function	☐ Mild	☐ Moderate	☐ Severe
5			
Dizziness	☐ Mild	☐ Moderate	☐ Severe
Headaches	☐ Mild	☐ Moderate	☐ Severe
Hot flashes	☐ Mild	☐ Moderate	☐ Severe
Increased blood pressure	☐ Mild	☐ Moderate	☐ Severe
Hair growth on face or body	☐ Mild	☐ Moderate	☐ Severe
Sugar in urine (not diabetes)	☐ Mild	☐ Moderate	☐ Severe
Masculine tendencies	☐ Mild	☐ Moderate	☐ Severe
6			
Weakness, dizziness	☐ Mild	☐ Moderate	☐ Severe
Chronic fatigue	☐ Mild	☐ Moderate	☐ Severe
Low blood pressure	☐ Mild	☐ Moderate	☐ Severe
Nails, weak, ridged	☐ Mild	☐ Moderate	☐ Severe
Tendency to hives	☐ Mild	☐ Moderate	☐ Severe
Arthritic tendencies	☐ Mild	☐ Moderate	☐ Severe
Perspiration increase	☐ Mild	☐ Moderate	☐ Severe
Bowel disorders	☐ Mild	☐ Moderate	☐ Severe
Poor circulation	☐ Mild	☐ Moderate	☐ Severe
Swollen ankles	☐ Mild	☐ Moderate	☐ Severe
Crave salt	☐ Mild	☐ Moderate	☐ Severe
Brown spots or bronzing of skin	☐ Mild	☐ Moderate	☐ Severe
Allergies - tendency to asthma	☐ Mild	☐ Moderate	☐ Severe
Weakness after colds, influenza	☐ Mild	☐ Moderate	☐ Severe
Exhaustion - muscular and nervous	☐ Mild	☐ Moderate	☐ Severe
Respiratory disorders	☐ Mild	☐ Moderate	☐ Severe
H			
Apprehension	☐ Mild	☐ Moderate	☐ Severe
Irritability	☐ Mild	☐ Moderate	☐ Severe
Morbid fears	☐ Mild	☐ Moderate	☐ Severe
Never seems to get well	☐ Mild	☐ Moderate	☐ Severe
Forgetfulness	☐ Mild	☐ Moderate	☐ Severe
Indigestion	☐ Mild	☐ Moderate	☐ Severe
Poor appetite	☐ Mild	☐ Moderate	☐ Severe
Craving for sweets	☐ Mild	☐ Moderate	☐ Severe
Muscular soreness	☐ Mild	☐ Moderate	☐ Severe
Depression; feelings of dread	☐ Mild	☐ Moderate	☐ Severe
Noise sensitivity	☐ Mild	☐ Moderate	☐ Severe

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 14/16

Acoustic hallucinations	☐ Mild	☐ Moderate	☐ Severe
Tendency to cry without reason	☐ Mild	☐ Moderate	☐ Severe
Hair is coarse and/or thinning	☐ Mild	☐ Moderate	☐ Severe
Weakness	☐ Mild	☐ Moderate	☐ Severe
Fatigue	☐ Mild	☐ Moderate	☐ Severe
Skin sensitive to touch	☐ Mild	☐ Moderate	☐ Severe
Tendency toward hives	☐ Mild	☐ Moderate	☐ Severe
Nervousness	☐ Mild	☐ Moderate	☐ Severe
Headache	☐ Mild	☐ Moderate	☐ Severe
Insomnia	☐ Mild	☐ Moderate	☐ Severe
Anxiety	☐ Mild	☐ Moderate	☐ Severe
Anorexia	☐ Mild	☐ Moderate	☐ Severe
Inability to concentrate; confusion	☐ Mild	☐ Moderate	☐ Severe
Frequent stuffy nose; sinus infections	☐ Mild	☐ Moderate	☐ Severe
Allergy to some foods	☐ Mild	☐ Moderate	☐ Severe
Loose joints	☐ Mild	☐ Moderate	☐ Severe
Very easily fatigued	☐ Mild	☐ Moderate	☐ Severe
Premenstrual tension	☐ Mild	☐ Moderate	☐ Severe
Painful menses	☐ Mild	☐ Moderate	☐ Severe
Depressed feelings before menstruation	☐ Mild	☐ Moderate	☐ Severe
Menstruation excessive and prolonged	☐ Mild	☐ Moderate	☐ Severe
Painful breasts	☐ Mild	☐ Moderate	☐ Severe
Menstruate too frequently	☐ Mild	☐ Moderate	☐ Severe
Vaginal discharge	☐ Mild	☐ Moderate	☐ Severe
Hysterectomy/ovaries removed	☐ Mild	☐ Moderate	☐ Severe
Menopausal hot flashes	☐ Mild	☐ Moderate	☐ Severe
Menses scanty or missed	☐ Mild	☐ Moderate	☐ Severe
Acne, worse at menses	☐ Mild	☐ Moderate	☐ Severe
Depression of long standing	☐ Mild	☐ Moderate	☐ Severe

Symptom Survey Grading:

A: Sympathetic Dominance _____

B: Parasympathetic Dominance_____

C: Sugar Handling _____

D: Cardiovascular_____

E: Liver_____

F: Digestion _____

G: Endocrine

1. Hyperthyroid____ 2. Hyperpituary____ 3. Hyperadrenal____ 4. Hypothyroid_____ 5.Hypopituary_____6. Hypoadrenal_____

H: B Complex_____

I: Female _____

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 15/16

RELEASE AND WAIVER

We require a 24 hour notice to cancel a nutrition appointment.

Arriving 5-10 minutes before your scheduled appointment time will allow you to be in the room and ready for testing at your appointment time.

Please note that, your appointment time is the time you should be in the room ready and waiting for the doctor

I understand that Dermatome Compression Analysis is a health assessment system and it is used to assist the practitioner help the patient improve his/her physical state through nutritional and life style recommendations. I also, understand that it is to assist the practitioner in establishing and monitoring patient nutritional programs and progress. I understand that Dermatome Compression Analysis and procedures do not diagnose or treat any disease or physical illness. I understand that Dermatome Compression Analysis evaluation does not replace standard laboratory or other clinical diagnostic tools or procedures, and in themselves do not treat anything.

I specifically authorize Dr. Bob Apol to create health analysis and to develop a natural, complementary health improvement program for me, which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease. I understand that this is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health. I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success. I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

I understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable. *To agree to arbitration for any disputes*. Understand that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision. To wave the right of notice or exemption within the state of Alabama or any other state in regard to personal property, allows one and one half (1.5 %) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Patient Name (please print):_____Patient Signature:_____Date (M/D/Y):_____
Witness Name (please print):_____Witness Signature:_____Date (M/D/Y):_____

APOL CHIROPRACTIC

500 SOUTHLAND DRIVE
SUITE 149
HOOVER AL 35226
205-538-7410

FEMALE WELLNESS FORM 16/16

REGARDING PAYMENT AND AUTHORIZATION TO TREAT

I understand and agree that the health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore I understand that the Doctor's office will prepare any necessary reports and forms to assist me in making a collection from the insurance company and that any amount authorized to be paid directly to the Doctor's office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment. I also understand that if I terminate, any fees for professional services rendered to me will be immediately due and payable.
I hereby authorize any Doctor to treat my condition, as he or she deems appropriate.

The patient also agrees that he/she is responsible for all bills incurred at this office and agrees to pay minimal charges for all services and products rendered and agrees to arbitration for any disputes. Patient understands that the office may choose the arbitrator and both parties agree to abide by the arbitrator's decision and waive the right of notice or exemption within the state of Alabama or any other state in regard to personal property, allows one and one half (1.5%) per month to any balance owed. In the event of default to also pay reasonable collection charges, attorney fees and court cost.

Signature:_____Date (M/D/Y):_____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS
I, (_____) consent the use and disclosure of my Protected Health Information to Dr. Bob Apol LLC for the purpose of providing treatment to me, for the purposes relating to the payment of services rendered to me, and for the practice's general healthcare operations purposes. Healthcare operations shall include, but is not limited to, quality assessment activities, credentialing, business management, and other general operation activities. I understand that the practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.
For purposes of this consent, "Protected Health Information," means any information including my demographic information, created or received by the practice, that relates to my past, present, or future physical or mental health or condition, the provision of health care to me; or the past, present, or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.
I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment, or healthcare operations of the practice, but the practice is not required to agree to these restrictions. However, if the practice agrees to a restriction that I request, the restriction is binding on the practice.
I understand that I have a right to review the practice's Notice of Privacy Practices prior to signing this document. The Notices of Privacy Practice describes my rights and the practice's duties regarding the types of uses and disclosures of my Protected Health Information. I have the right to revoke this consent, in writing, at any time, except to the extent that the physician or practice has acted in reliance on this consent.

Patient Name or Representative: _____Patient Signature or Representative:_____
Description of Representative's Authority:_____Date (M/D/Y):_____