Swaim CHIROPRACTIC

Patient Name_____ Date_____

Welcome

Address: _____ City/State/Zip:_____

Primary Phone # _____ Birthday _____ / _____ / _____

Email_____

Emergency Contact _____ Phone # _____

Marital Status: Single / Married / Divorced / Widowed Spouses Name: _____

Are you currently pregnant? YES / NO Do you have a history of smoking? Quit / YES / NO

Is Medicare your primary insurance? Yes / No How did you find our office? Friend/family Google Website

Describe your main condition/symptom _____

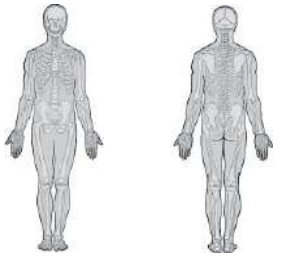
_____

When did this condition/ symptom begin? _____ /_____ / _____

Please rate the following on a scale from 0-10.
0=No discomfort and 10=Extreme Discomfort

Pain_____ Weakness _____ Numbness _____
Stiffness _____ Restriction _____

Please mark on the diagram where your pain is. →



Front Back

Additional information related to the condition

Describe the pain- ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Radiating ☐ Throbbing

If it radiates, where does it radiate to? _____

What is the cause of your symptom? _____

What aggravates it?

☐ Sleeping ☐ Standing ☐ Sitting ☐ Lifting ☐ Time on Computer ☐ Talking on the phone ☐ Walking
☐ Running ☐ Other _____

What relieves it?

☐ Sleep ☐ Standing ☐ Ice ☐ Heat ☐ Stretching ☐ Sitting ☐ Rest ☐ Pain Medication
☐ Other _____

How frequently are you experiencing the pain?

☐ Infrequent ☐ Occasional ☐ Intermittent ☐ Frequent ☐ Constant

Have you ever had the same or similar condition/symptom in the past? ☐ YES ☐ NO

If yes, when? ___ / ___ / ___.

Describe _____

Have you seen other healthcare providers for this current condition/symptom? YES / NO

If yes, who? _____

What medication are you taking?_____

Have you had surgery? YES/ NO What for? _____

Have you been in any auto accidents? _____

Is there anything else about your health that we should know? _____

Systems Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

List your 5 main health complaints in the order of importance:

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

Weight: _____ ❑ Vegetarian ❑ Vegan

Height: _____ ❑ Gluten-free ❑ Dairy-free

Organs Removed:

❑ Gallbladder ❑ Thyroid ❑ Colon ❑ Spleen
❑ Uterus ❑ Ovaries ❑ Breast ❑ Prostate
❑ Tonsils ❑ Appendix ❑ Other: _____

Circle the appropriate number that applies on all questions below. 0 is the least/never to 3 as the most/always

Group 1

1. Acid foods upset 0 1 2 3
2. Get the chills often 0 1 2 3
3. "Lump" in throat 0 1 2 3
4. Dry mouth, eyes, or nose 0 1 2 3
5. Pulse increases after a meal 0 1 2 3
6. Keyed up, difficult to calm down 0 1 2 3
7. Cuts or scratches heal slowly 0 1 2 3
8. Gag easily 0 1 2 3
9. Unable to relax; startle easily 0 1 2 3
10. Clammy or cold hands/feet 0 1 2 3
11. Irritated by strong light 0 1 2 3
12. Urine amount reduced 0 1 2 3
13. Heart pounds after retiring 0 1 2 3
14. "Nervous" stomach 0 1 2 3
15. Forgets to eat meals 0 1 2 3
16. Cold sweats 0 1 2 3
17. Temperature raises easily, fevers 0 1 2 3
18. Skin sensitive or painful if touched 0 1 2 3
19. Eyes lock in fixed stare (few seconds) 0 1 2 3
20. Queasy or sour stomach 0 1 2 3

Group 2

21. Joint stiffness on arising 0 1 2 3
22. Muscle, leg, or toe cramps at night 0 1 2 3
23. "Butterfly" stomach, cramps 0 1 2 3
24. Eyes or nose watery 0 1 2 3
25. Eyes blink rapidly 0 1 2 3
26. Eyelids swollen or puffy 0 1 2 3
27. Indigestion soon after meals 0 1 2 3
28. Always feel hungry; "lightheaded" often 0 1 2 3
29. Digestion is rapid 0 1 2 3
30. Occasional nausea or vomiting 0 1 2 3
31. Voice gets hoarse or raspy 0 1 2 3
32. Slow or Irregular breathing pattern 0 1 2 3
33. Pulse skips or feels "irregular" 0 1 2 3
34. Excessive saliva production 0 1 2 3
35. Difficulty swallowing food or pills 0 1 2 3
36. Alternating constipation & diarrhea 0 1 2 3
37. Slow starter in the morning 0 1 2 3
38. Ears get hot or red 0 1 2 3
39. Sweat easily 0 1 2 3
40. Feel cold – hands, feet, all over 0 1 2 3
41. Colds or respiratory infections 0 1 2 3

Group 3

42. Eat when nervous or anxious 0 1 2 3
43. Excessive appetite 0 1 2 3
44. Hungry between meals 0 1 2 3
45. Irritated before meals (hangry) 0 1 2 3
46. Get "shaky" or "jittery" if hungry 0 1 2 3
47. Fatigue after meals (food coma) 0 1 2 3
48. "Lightheaded" if meals delayed 0 1 2 3
49. Can feel heart beat, palpitates 0 1 2 3
50. Afternoon Headaches 0 1 2 3
51. Bloating after eating fiber, starch, sugar 0 1 2 3
52. Insomnia: Cannot stay asleep 0 1 2 3
53. Crave candy or coffee during the day 0 1 2 3
54. Depression, lack of motivation 0 1 2 3
55. Crave sweets or snacks during the day 0 1 2 3

Group 4

56. Hands or feet go to sleep, numbness 0 1 2 3
57. Sigh frequently, "Air hunger" 0 1 2 3
58. Aware of "breathing heavily" 0 1 2 3
59. High-Altitude discomfort 0 1 2 3
60. Feel must open windows in closed rooms 0 1 2 3
61. Easily gets colds or fevers 0 1 2 3
62. Afternoon "yawner" 0 1 2 3
63. Feel "drowsy" 0 1 2 3
64. Ankle or wrist swelling, fluid retention 0 1 2 3
65. Muscle cramps 0 1 2 3
66. Shallow, rapid breathing 0 1 2 3
67. Chest tightness, pressure or pain 0 1 2 3
68. Bruise easily, "black and blue" spots 0 1 2 3
69. Tendency to Anemia 0 1 2 3
70. "Nose bleeds" 0 1 2 3
71. Noises in head, or "ringing in ears" 0 1 2 3
72. Shortness of breath upon exertion 0 1 2 3

Group 5

73. Dizziness 0 1 2 3
74. Dry or flaky skin (scalp, feet, anywhere) 0 1 2 3
75. Burning or itching feet 0 1 2 3
76. Blurred vision 0 1 2 3
77. Unexplained itching skin or rash anywhere 0 1 2 3
78. Excessive falling hair 0 1 2 3
79. Reddened skin, especially palms or feet 0 1 2 3
80. Bitter or metallic taste in mouth in mornings 0 1 2 3
81. Bowel movements painful or difficult 0 1 2 3
82. Worrier, feel insecure 0 1 2 3
83. Tightness/headache over eyes 0 1 2 3
84. Greasy or high-fat foods cause distress 0 1 2 3
85. Stool color is pale, white or light colored 0 1 2 3
86. Perfume/fragrance sensitivity 0 1 2 3
87. Muscle tightness between shoulder blades 0 1 2 3
88. Occasional constipation 0 1 2 3
89. Stools alternate from soft to watery 0 1 2 3
90. History of gallbladder spasms or stones 0 1 2 3
91. Sneezing attacks 0 1 2 3
92. Nightmare-type dreams or terrors 0 1 2 3
93. Bad breath (halitosis) 0 1 2 3
94. Dairy, Milk products cause distress or lactose intolerant 0 1 2 3
95. Sensitive to hot weather 0 1 2 3
96. Itching or burning anus 0 1 2 3
97. Sweet and sour cravings 0 1 2 3

Group 6

98. Loss of interest to eat meat 0 1 2 3
99. Use antacids 0 1 2 3
100. Burning stomach relieved by eating 0 1 2 3
101. White coating on tongue 0 1 2 3
102. Pass large amounts of foul-smelling gas 0 1 2 3
103. Bloating lasts hours after eating 0 1 2 3
104. Unpredictable urgency to defecate 0 1 2 3
105. Pass large amounts of gas: No odor 0 1 2 3
106. Heartburn when lying down 0 1 2 3

Group 7A

107. Insomnia: Hard to fall asleep 0 1 2 3
108. Nervousness, feel on edge 0 1 2 3
109. Difficult to gain weight 0 1 2 3
110. Intolerance to heat 0 1 2 3
111. Highly emotional 0 1 2 3
112. Face or skin flushes easily 0 1 2 3
113. Night sweats 0 1 2 3
114. Thin, moist skin 0 1 2 3
115. Inward trembling 0 1 2 3
116. Can hear heartbeat on pillow 0 1 2 3
117. Increased appetite but can't gain weight 0 1 2 3
118. Increased or rapid pulse at rest 0 1 2 3
119. Eyelids or face twitch 0 1 2 3
120. Irritable and restless 0 1 2 3
121. Difficulty working under pressure 0 1 2 3

Group 7B

122. Increase in weight 0 1 2 3
123. Decrease in appetite 0 1 2 3
124. Fatigue easily 0 1 2 3
125. Ringing in ears (Pitch: ❑ High ❑Low) 0 1 2 3
126. Sleepy during day 0 1 2 3
127. Sensitive to cold 0 1 2 3
128. Dry or scaly skin 0 1 2 3
129. Use laxatives 0 1 2 3
130. Mental sluggishness 0 1 2 3
131. Hair coarse or falling out 0 1 2 3
132. Headaches in mornings, wear off during the day 0 1 2 3
133. Slow pulse, below 65 0 1 2 3
134. Frequent urination 0 1 2 3
135. Impaired or loss of hearing 0 1 2 3
136. Reduced initiative or motivation 0 1 2 3

Group 7C

137. Failing memory 0 1 2 3
138. Low blood pressure 0 1 2 3
139. Increased sex drive 0 1 2 3
140. "Splitting or rending" headache near the temple 0 1 2 3
141. Cannot handle sugar well 0 1 2 3

Group 7D

142. Thirsty all the time 0 1 2 3
143. Bloating of abdomen 0 1 2 3
144. Weight gain around hips or waist 0 1 2 3
145. Sex drive reduced or lacking 0 1 2 3
146. Tendency to ulcers, colitis 0 1 2 3
147. Can eat and burn sugar easily 0 1 2 3
148. Increased urine output 0 1 2 3
149. Sexual dysfunction 0 1 2 3

Group 7E

150. Feel off balance, vertigo 0 1 2 3
151. Headaches that go away with caffeine 0 1 2 3
152. Hot flashes 0 1 2 3
153. Increased blood pressure 0 1 2 3
154. Thinning skin on arms or hands 0 1 2 3
155. Urine smells sweet or fruity 0 1 2 3
156. Over aggressive tendencies 0 1 2 3

Group 7F

157. Dizzy after standing up quickly 0 1 2 3
158. Chronic fatigue 0 1 2 3
159. Headaches w/ exertion, stress 0 1 2 3
160. Weak nails or have ridges 0 1 2 3
161. Tendency to hives 0 1 2 3
162. Joint pain and stiffness 0 1 2 3
163. Perspiration increase 0 1 2 3
164. Bowel inflammation 0 1 2 3
165. Poor circulation 0 1 2 3
166. Swelling of ankles (❑ Left ❑ Right) 0 1 2 3
167. Crave salt 0 1 2 3
168. Brown spots or bronzing of skin 0 1 2 3
169. Allergies 0 1 2 3
170. Weakness after colds, influenza 0 1 2 3
171. Exhaustion - muscular and nervous 0 1 2 3
172. Respiratory or breathing challenges 0 1 2 3

Group 8 | B Complex

173. Muscle weakness 0 1 2 3
174. Lack of Stamina 0 1 2 3
175. Drowsiness after eating 0 1 2 3
176. Muscular soreness 0 1 2 3
177. Rapid heart beat 0 1 2 3
178. Hyper-irritable 0 1 2 3
179. Feeling of a band around the head 0 1 2 3
180. Melancholia (feeling of sadness) 0 1 2 3
181. Difficult to concentrate 0 1 2 3
182. Diminished urination 0 1 2 3
183. Tendency to consume sweets or carbohydrates 0 1 2 3

Group 8 | G Complex

184. Muscle spasms, twitches 0 1 2 3
185. Anxiety 0 1 2 3
186. Loss of muscular control 0 1 2 3
187. Numbness 0 1 2 3
188. Night sweats 0 1 2 3
189. Rapid digestion 0 1 2 3
190. Sensitivity to noise 0 1 2 3
191. Cracking of skin, hands or bottom of feet 0 1 2 3
192. Visible veins on chest and abdomen 0 1 2 3
193. Hemorrhoids or spider veins 0 1 2 3
194. Apprehension (feeling that something bad will happen) 0 1 2 3
195. Nervousness causing loss of appetite 0 1 2 3
196. Nervousness with indigestion 0 1 2 3
197. Gastritis 0 1 2 3
198. Forgetfulness 0 1 2 3
199. Thinning hair 0 1 2 3

FEMALE ONLY

200. Very easily fatigued 0 1 2 3
201. Premenstrual tension 0 1 2 3
202. Painful menses or ovulation 0 1 2 3
203. Depressed feelings before menstruation 0 1 2 3
204. Menstruation excessive and prolonged 0 1 2 3
205. Painful breasts 0 1 2 3
206. Menstruate too frequently 0 1 2 3
207. Vaginal discharge 0 1 2 3
208. Hair growth on face (upper lip, chin) areola, abdomen 0 1 2 3
209. Hot flashes 0 1 2 3
210. Menses scanty or missed 0 1 2 3
211. Acne, worse at menses 0 1 2 3
212. Raised bumps on skin of arm 0 1 2 3

MALE ONLY

213. Prostate challenges 0 1 2 3
214. Urination difficult or dribbling 0 1 2 3
215. Frequent night urination 0 1 2 3
216. Depression, melancholy 0 1 2 3
217. Pain on inside of legs or heels 0 1 2 3
218. Feeling of incomplete bowel evacuation 0 1 2 3
219. Lack of energy 0 1 2 3
220. Migrating aches or pain 0 1 2 3
221. Tire too easily 0 1 2 3
222. Avoid social activity 0 1 2 3
223. Restless legs at night 0 1 2 3
224. Diminished sex drive 0 1 2 3

OFFICE USE ONLY

❑ Food Diary
❑ Tongue
❑ Fingernails

Zinc Test Results: _____

Postural Hypotension:

Recumbent: _____/_____ Pulse: ____

Standing: _____/_____ Pulse: ____

SpO_2: _____%

Calcium Cuff Test:

Before: _____ After: _____

The Nutritional Exam:

❑ HCL ❑ Ascending
❑ Enzyme ❑ Transverse
❑ Murphy's Sign ❑ Descending

Notes:

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.