Binkley Healing Center

Nutrition Patient Questionnaire

Name ____ Date of Birth ________________

Address ______________________________ City/State/Zip _____________________________

E-mail ____ SS#_________________

Phone - Home __________________ Work ____________________ Cell __________________

Employer ________________________________ Occupation ____________________________

Sex: M F Married _____ Single _____ Divorced _____ Widow(er) _______ # of Children ___________

Spouse ________________________________ Employer _______________________________

In Case of Emergency, who should we contact?

Name______________________ Phone_________________ Relationship _________________

How did you hear about our office? ____

I, the undersigned, clearly understand that all services rendered to me are my responsibility and that payment is expected at the time of service:

Patient's Signature_________________________________ Date ___________________

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: *"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."* A vitamin is not a drug; NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.
Nutritional counseling, advice, and supplement recommendations are provided solely to upgrade the quality of foods in a patient's diet, and to supply nutritional support for the physiological and biomechanical processes of the human body. Nutritional advice and supplementation may also enhance the stabilization of the benefits of chiropractic care.

I have read and understand the above:

Signature ____ Date ____________________

961 East Main Street Ventura CA 93001 (805) 641-9000

PATIENT SYMPTOM SURVEY

Name ____ Date_________

Wt______ Ht______ BP________ Pulse______ O_2______

This is a confidential patient symptom survey. Please check (or X the box) for each condition which is true for you. If you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and should not be marked. However, Insomnia occurring 1-2 times per week is notable and should be marked. Please take your time…

Primary Complaints

090 ▢ General Good Health
091 ▢ Desires Nutritional & Metabolic Analysis
001 ▢ Skin Disorder 692.9
002 ▢ Acne 706.1
003 ▢ Psoriasis 696.1
004 ▢ Urticaria (Hives) 708.9
005 ▢ ADD/ADHD 314.01
006 ▢ Allergies 477.0
007 ▢ Food Allergy 691.8
008 ▢ Sinusitis 461.9
009 ▢ Alzheimer's 333.1
010 ▢ Poor Concentration/ Memory 310.1
011 ▢ Parkinson's Disease 332.0
012 ▢ Anemia 285.9
013 ▢ Arthritic Disorder 716.9
014 ▢ Osteoporosis 733.0
015 ▢ Asthma 493.9
016 ▢ Emphysema 492.8
017 ▢ Cancer
- 018 ▢ Breast 174.9
- 019 ▢ Prostate 185.0
- 020 ▢ Lung 162.9
- 021 ▢ Colon/Rectal 153.9
- 022 ▢ Skin 173.9
- 023 ▢ Leukemia 208.1
- 024 ▢ Lymphoma 202.8
- 025 ▢ Brain Tumor 191.9
- 026 ▢ Other

027 ▢ Anxiety / stress 300.00
028 ▢ Autism 299.0
033 ▢ Edema 782.3
034 ▢ Eczema 692.9
035 ▢ Chronic Fatigue 780.71
036 ▢ Circulatory Disorder 459.90
037 ▢ Heart Disease 429.90
038 ▢ High Cholesterol 272.0

039 ▢ High Blood Pressure 401.9
040 ▢ Low Blood Pressure 458.9
041 ▢ Tachycardia (High Heart Rate) 785.00
042 ▢ Numbness 782.0
043 ▢ Constipation 564.0
044 ▢ Indigestion 536.8
045 ▢ Ulcerative Colitis 556.9
046 ▢ Depression 311.0
047 ▢ Diabetes Mellitus 250.0
- 030 ▢ Diabetes Type I 250.01
- 031 ▢ Diabetes Type II 250.02

029 ▢ Hyperglycemia [high blood sugar] 790.6
048 ▢ Hypoglycemia [low blood sugar] 251.2
049 ▢ Dizziness/Balance Problem 780.4
050 ▢ Ear Infection 386.30
051 ▢ Epstein Barr 075.0
052 ▢ Eye Problems 379.91
- 053 ▢ Cataracts 366.9
- 054 ▢ Glaucoma 365.62
- 055 ▢ Macular Degeneration 362.5

056 ▢ Fever 780.6
057 ▢ Fibromyalgia 729.1
058 ▢ Gallbladder Disorder 575.9
059 ▢ Gout 274.9
060 ▢ Headaches 784.0
061 ▢ Hearing Loss 389.90
062 ▢ Infertility, male 606.9
064 ▢ Liver Disease 571.9
- 065 ▢ Hepatitis 573.3
- 066 ▢ Hepatitis B 573.1
- 067 ▢ Hepatitis C 070.51

068 ▢ Kidney (593.9) / Bladder (596.9)
063 ▢ Prostate Disorder 602.9

069 ▢ Hyperthyroid 242.9
070 ▢ Hypothyroid 244.9
071 ▢ Lupus 710.0
072 ▢ Infertility, female 628.9
073 ▢ Interstitial Cystitis 595.1
074 ▢ Irregular Menstrual Cycle 626.4
075 ▢ Menopausal Symptoms 627.2
076 ▢ Hot Flashes 627.2
077 ▢ Mental Disorder 300.9
078 ▢ Insomnia 780.52
079 ▢ Mouth/Throat/Tongue
080 ▢ Canker Sores 528.2
081 ▢ Overweight 278.0
082 ▢ Underweight 783.2
083 ▢ Sexual Disorder 302.9
084 ▢ Spinal Problems
085 ▢ Obesity 278.0
086 ▢ GERD 530.81
087 ▢ HIV infection 079.53
088 ▢ Crohn's Disease 555.9
089 ▢ Irritable Bowel Syndrome 564.1
092 ▢ Pregnant v22.2
093 ▢ Shingles 053.9
140 ▢ Migraines 346.90
141 ▢ Rheumatoid Arthritis 714.0
142 ▢ Lupus 710.0
143 ▢ Multiple Sclerosis 340.0
144 ▢ ALS Lou Gehrig's disease 335.20
145 ▢ Polymyalgia Rheumatica 725.0
146 ▢ Scleroderma 710.1
171 ▢ Goiter 240.9
178 ▢ Raynaud's Syndrome 433.8
179 ▢ Hemochomatosis 275.0
180 ▢ Thalassemia 282.49
181 ▢ Post stroke/brain aneurism 747.81

Please state your most significant concern…

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____

____

General Health

- 100 ☐ Fingernail base is pink
- 101 ☐ Fingernail base is purple
- 102 ☐ Fingernails have ridges or white spots
- 103 ☐ Fingernails are soft
- 104 ☐ Fingernails are splitting
- 105 ☐ Fingernails peel
- 106 ☐ Pale fingernail beds
- 107 ☐ Blacks out easily
- 108 ☐ Balance problems
- 109 ☐ Difficulty walking
- 110 ☐ Has tattoos
- 111 ☐ Brittle hair
- 112 ☐ Dry hair
- 113 ☐ Thin hair
- 114 ☐ Hair loss
- 115 ☐ Drinks alcoholic beverages daily
- 116 ☐ Drinks less than 8 glasses of water per day
- 117 ☐ Currently on Chemotherapy
- 118 ☐ Currently on radiation treatment
- 148 ☐ Had radiation therapy in the last year
- 149 ☐ Had chemotherapy in the last year
- 119 ☐ Had chemotherapy in the past
- 120 ☐ Has had radiation treatments in the past
- 121 ☐ Gained over 20 lbs in the last 12 months
- 122 ☐ Somewhat Overweight
- 123 ☐ Somewhat Underweight
- 124 ☐ Unexplained weight loss of over 20lbs within the last 4 months
- 125 ☐ Energy level is worse than it was 5 years ago
- 127 ☐ Sleeps less than 6 hours per night
- 128 ☐ Unable to recall dreams the next day
- 129 ☐ Sensitive to chemicals, paint, fumes, cologne
- 130 ☐ Had blood transfusion in the past
- 131 ☐ Had transplant in the past
- 138 ☐ Takes anti-rejection drugs
- 132 ☐ Had a major accident or injury
- 137 ☐ Sleep Apnea
- 139 ☐ Toxic chemical exposure
- 175 ☐ Has been out of the country recently
- 176 ☐ Had childhood vaccines
- 177 ☐ Had a vaccine in the last 12 months
- 147 ☐ Had a flu shot last year
- 182 ☐ Had a pneumonia vaccine last year
- 183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Have a family history of:

- 184 ☐ Cancer
- 185 ☐ Heart Disease
- 186 ☐ Diabetes
- 187 ☐ Alcoholism
- 188 ☐ Depression
- 189 ☐ Obesity

Lifestyle Habits

- 380 ☐ Drinks beverages from a can
- 370 ☐ Drinks alcohol
- 371 ☐ Drinks caffeinated coffee
- 372 ☐ Drinks caffeinated pop/soda
- 373 ☐ Drinks caffeinated tea
- 374 ☐ Drinks decaffeinated coffee
- 375 ☐ Drinks decaffeinated pop/soda
- 376 ☐ Drinks decaffeinated tea
- 377 ☐ Drinks more than 3 cups of coffee per day
- 378 ☐ Drinks more than 3 cups of tea per day
- 388 ☐ Drinks diet pop/soda
- 379 ☐ Drinks 1 or more pop/sodas per day

I had 4 alcoholic drinks in one day:

- 172 ☐ never
- 173 ☐ more than 3 months ago
- 174 ☐ less than 3 months ago

- 381 ☐ Has more than 5 alcoholic drinks per week
- 391 ☐ Craves sugar / starches
- 382 ☐ Currently smokes
- 383 ☐ Quit smoking in the last 5 years
- 384 ☐ Smoked for more than 5 years
- 385 ☐ Smokes more than 1 pack per day
- 126 ☐ Rarely exercises
- 133 ☐ Regularly exercises
- 386 ☐ Takes Vitamins
- 134 ☐ Vegetarian
- 135 ☐ Eats no red meat
- 136 ☐ Eats no meat, no dairy
- 387 ☐ Frequent use of artificial sweeteners
- 389 ☐ Anorexia
- 390 ☐ Bulimic

Surgeries

- 700 ▢ Tonsillectomy and/or Adenoids
- 701 ▢ Appendix
- 702 ▢ Gallbladder
- 703 ▢ Thyroid
- 715 ▢ Radiated thyroid
- 708 ▢ Cancer
- 704 ▢ Hysterectomy, complete
- 705 ▢ Hysterectomy, partial
- 706 ▢ Tubal ligation
- 707 ▢ Breast implants
- 709 ▢ Coronary by-pass
- 710 ▢ Spinal surgery
- 711 ▢ Extremity surgery
- 712 ▢ Hip replacement
- 713 ▢ Knee replacement
- 714 ▢ Splenectomy
- 716 ▢ Cataract surgery
- 717 ▢ Hemorroidectomy

Gastrointestinal

- 265 ▢ 4-5 bowel movements per week
- 266 ▢ 3 or less bowel movements per week
- 267 ▢ 6 or more bowel movements per week
- 268 ▢ Black tarry stools
- 269 ▢ Pale or yellow colored stool
- 270 ▢ Blood stools
- 271 ▢ Constipation
- 272 ▢ Hemorrhoids
- 273 ▢ Loose bowel movements
- 274 ▢ Frequent diarrhea
- 275 ▢ Frequent nausea
- 276 ▢ Frequent vomiting
- 277 ▢ Abdominal gas
- 278 ▢ Belching and burping after eating
- 279 ▢ Bloated after eating
- 280 ▢ Severe abdominal pains
- 281 ▢ Stomach ulcers
- 282 ▢ Uses digestive aids
- 283 ▢ Uses laxatives
- 284 ▢ Immediate indigestion upon eating
- 285 ▢ Indigestion in 2 hours or more after meals
- 286 ▢ Indigestion within 1 hour after meals
- 287 ▢ Difficulty swallowing
- 288 ▢ Eating relieves fatigue
- 289 ▢ Eats when nervous
- 290 ▢ Excessive hunger
- 291 ▢ Poor appetite
- 292 ▢ Experiences fainting spells when hungry
- 293 ▢ Feels shaky when hungry
- 294 ▢ Frequently drowsy after eating a meal
- 295 ▢ Gall bladder disease
- 296 ▢ Has had intestinal worms
- 297 ▢ Reflux/Hiatal hernia
- 298 ▢ Liver disease
- 299 ▢ Irritable Bowel Syndrome
- 300 ▢ Diverticulitis
- 301 ▢ Diverticulosis

Respiratory

- 485 ▢ Catches severe colds
- 486 ▢ Chronic chest condition
- 487 ▢ Chronic cough
- 488 ▢ Constant runny nose
- 489 ▢ COPD
- 490 ▢ Difficulty breathing
- 491 ▢ Frequent colds
- 492 ▢ Frequent nose bleeds
- 493 ▢ Frequent sinus infections
- 494 ▢ Frequent stuffy nose
- 495 ▢ Hay fever
- 496 ▢ Nasal polyps
- 497 ▢ Night sweats
- 498 ▢ Post nasal drip
- 499 ▢ Sneezing spells
- 500 ▢ Spits up blood
- 501 ▢ Spits up phlegm
- 502 ▢ Wheezes

Mouth and Throat

- 400 ▢ Bad breath
- 401 ▢ Bitter taste in the mouth in the morning
- 402 ▢ Dry mouth
- 403 ▢ Excessive saliva
- 404 ▢ Sores or cracks in the corners of the mouth
- 405 ▢ Glands often swell
- 406 ▢ Frequent canker sores
- 407 ▢ Frequent fever blisters
- 408 ▢ Frequent sore throats
- 409 ▢ Frequently has a sore tongue
- 410 ▢ Sore gums
- 411 ▢ Swollen gums
- 412 ▢ Swollen tongue
- 413 ▢ Tongue burns
- 414 ▢ Tongue has grooves or fissures
- 415 ▢ Tongue is coated
- 416 ▢ Gums bleed when brushing teeth
- 417 ▢ Toothaches
- 418 ▢ Amalgam dental fillings
- 420 ▢ Other dental fillings (gold, composite, etc)
- 419 ▢ Has had root canal(s)

Endocrine

- 245 ☐ Coarse hair
- 246 ☐ Coarse skin
- 247 ☐ Diabetic
- 248 ☐ Excessive thirst
- 249 ☐ Frequently feels cold
- 250 ☐ Frequently feels hot
- 251 ☐ Gets lightheaded when standing quickly
- 252 ☐ Heals slowly
- 253 ☐ Unusually jumpy or nervous
- 254 ☐ Unusually tired most of the time

Cardiovascular

- 190 ☐ Cold feet
- 191 ☐ Cold hands
- 192 ☐ Experiences shortness of breath while sitting still
- 193 ☐ Heart skips beats
- 194 ☐ Tendency of High blood pressure
- 195 ☐ Leg cramps during bedtime
- 196 ☐ Leg cramps during daytime
- 197 ☐ Low blood pressure at times
- 198 ☐ Pain in leg/hips when walking
- 199 ☐ Frequent swollen ankles
- 200 ☐ Pains in the heart or chest
- 201 ☐ Spells of rapid heart rate
- 202 ☐ Troubled with blood clots
- 203 ☐ Unusually slow pulse rate
- 204 ☐ Varicose veins
- 205 ☐ Heart palpitations

Skin

- 520 ☐ Bruises easily
- 521 ☐ Excessive perspiration
- 522 ☐ Frequent goose bumps
- 523 ☐ Has acne
- 524 ☐ Has Psoriasis
- 525 ☐ Hives
- 526 ☐ Itchy skin
- 527 ☐ Problems with Eczema
- 528 ☐ Has moles which are changing in size and/or color
- 530 ☐ Skin is rough, especially on the back of the arms
- 529 ☐ Skin eruptions
- 531 ☐ Skin is tender
- 532 ☐ Sores that heal slowly
- 533 ☐ Troubled with boils
- 534 ☐ Dry skin

Ears

- 220 ☐ Discharge from ears
- 221 ☐ Hard of hearing
- 222 ☐ Punctured ear drum
- 223 ☐ Recurrent ear infection
- 224 ☐ Ringing or noises in the ears
- 225 ☐ Tinnitus

Eyes

- 320 ☐ Bloodshot eyes
- 321 ☐ Blurred vision
- 322 ☐ Cross eyes
- 323 ☐ Eye pain
- 324 ☐ Eyes feel gritty
- 325 ☐ Eyes watery
- 326 ☐ Mild Glaucoma
- 327 ☐ Far sighted
- 328 ☐ Developing cataracts
- 329 ☐ Mild Macular degeneration
- 330 ☐ Itchy eyes
- 331 ☐ Near sighted
- 332 ☐ Dry Eyes

Feet

- 350 ☐ Corns
- 351 ☐ Frequent foot cramps
- 352 ☐ Heel spurs
- 353 ☐ Painful feet
- 354 ☐ Plantar warts
- 355 ☐ Swelling in the feet and/or ankles
- 356 ☐ Plantar fascitis
- 357 ☐ Fungal Infectio

Neuromuscular

- 440 ☐ Bites nails
- 441 ☐ Frequent muscle soreness
- 442 ☐ Muscle spasms
- 443 ☐ Muscle weakness
- 444 ☐ Tremors
- 445 ☐ Frequent headaches
- 446 ☐ Often dizzy
- 447 ☐ Frequently feels faint
- 448 ☐ Has Epilepsy
- 449 ☐ Has motion sickness
- 450 ☐ Has Osteoarthritis
- 451 ☐ Has Rheumatism
- 452 ☐ Rheumatoid Arthritis
- 453 ☐ Joint stiffness in the morning
- 454 ☐ Swollen joints
- 455 ☐ Leg pain at rest
- 456 ☐ Spinal curvature
- 457 ☐ Low back pain
- 458 ☐ Neck pain
- 459 ☐ Pain between the shoulders
- 460 ☐ Shoulder/arm pain
- 461 ☐ Numbness/tingling in the body
- 462 ☐ Sleep walks
- 463 ☐ Stutters or stammers
- 464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when others are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are <u>currently taking</u> including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken <u>within the last year</u> including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement you are taking.

<u>VITAMIN/HOW MUCH/BRAND</u>