HOLISTIC HEALTH CHIROPRACTIC & WELLNESS

134 ELDRIDGE RD, SUITE A, SUGAR LAND, TX 77478. ❋ (832) 413-2960

PLEASE PRINT

PERSONAL INFORMATION

NAME____ DATE______________________________

EMAIL____

ADDRESS____CITY_____________ STATE_____ZIP_________

CELL PHONE______________________SOC. SEC. NO._____________________ DATE OF BIRTH_________________

HOME PHONE ______________________MARITAL STATUS____________SEX________AGE____# OF CHILREN_____

OCCUPATION______________________________________EMPLOYER____________________________________

ADDRESS______________________________CITY/ZIP___________________TELEPHONE____________________

NAME OF SPOUSE_________________________________ SPOUSE'S OCCUPATION_-----------____________________

EMPLOYER____

ADDRESS_________________________________CITY/ZIP________________TELEPHONE____________________

EMERGENCY NOTIFICATION

NAME ____

ADDRESS_____________________CITY/ZIP________________TELEPHONE____________________

REFERRED BY____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

Date__________________________ Patient's Signature_______________________________________

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Holistic Health Chiropractic to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date__________________________ Patient's Signature_______________________________________

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT____

HOW DID IT HAPPEN?____

____

TODAYS CONDITION STARTED WHEN?____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION?____

WHAT ACTIVITIES LESSEN YOUR CONDITION?____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY?_____________________________________

IS THIS CONDITION INTERFERING WITH WORK?____________ SLEEP?_________ ROUTINE? ____________________

IS CONDITION GETTING PROGRESSIVELY WORSE?____

OTHER DOCTORS SEEN FOR THIS CONDITION____

TYPE OF TREATMENT_______________________________________RESULTS___________________________

Habits

- ❑ Alcohol: Type___________
  Amount__________________
  Diet: Salt intake___________
  Fat intake________________
  Other____________________
- ❑ Sleep:Difficulty falling asleep__________________
  Continuity disturbances_____
  Early morning awakenings___
  Daytime drowsiness________
  Other____________________
- ❑ Smoking: Packs daily_______
  How long________________
  Interested in stopping?______
- ❑ Exercise routine:____
  ____
  ____
- ❑ Caffeine: Coffee, cups daily__________________
  Other__________________

MEDICATIONS:____

DRUG ALLERGIES:____

Medical History

❑ Ringing In Ear____________________
❑ Ear Infections - *Frequent* __________
❑ Dizziness/Fainting ______________
❑ Failing Vision _________________
❑ Eye Infections _________________
❑ Nose Bleeds____________________
❑ Sinus Trouble __________________
❑ Sore Throats - *Frequent* _________
❑ Hayfever/Allergies ______________
❑ Pneumonia ____________________
❑ Bronchitis/Chronic Cough_________
❑ Asthma/Wheezing ______________
❑ Chest Pain ____________________
❑ High Blood Pressure ____________
❑ Heart Murmur _________________
❑ Swollen Ankles ________________
❑ Leg Pain - *Walking*______________
❑ Varicose Veins/Phlebitis __________
❑ Loss of Appetite ________________
❑ Difficulty Swallowing ____________
❑ Indigestion or Heartburn _________
❑ Persistent Nausea/Vomiting _______
❑ Peptic Ulcers __________________
❑ Abdominal Pain - *Chronic*_________

❑ Gall Bladder Trouble ___________
❑ Jaundice/Hepatitis _____________
❑ Change in Bowel Habits _________
❑ Diarrhea ❑ Constipation _________
❑ Diverticulosis ❑ Crohn's/Colitis ____
❑ Bloody or Tarry Stools _________
❑ Hemorrhoids __________________
❑ Hernia ______________________
❑ Urine Infections - *Frequent* _______
❑ Blood In Urine ________________
Urination-❑ Overnight > than twice
❑ Painful ❑ Loss of Control
❑ Decrease in Force/Flow
❑ Kidney Stones _________________
❑ Venereal Disease_______________
❑ Urethral Discharge _____________
❑ Chronic Fatigue ______________
❑ Weight Loss - *Recent* ____________
❑ Anemia ❑ Bruise Easily __________
❑ Cancer ______________________
❑ Diabetes _____________________
❑ Thyroid Disease ______________
❑ Convulsions/Seizures ___________
❑ Stroke ______________________

❑ Tremor/Hands Shaking ___________
❑ Muscle Weakness ______________
❑ Numbness/Tingling Sensations ______
❑ Headaches - *Frequent* ___________
❑ Arthritis/Rheumatism _____________
❑ Osteoporosis __________________
❑ Back Pain - *Recurrent* ___________
❑ Bone Fracture/Joint injury ________
❑ Gout _________________________
❑ Foot Pain ❑ Cold Numb Feet ______
❑ Rashes ❑ Hives ________________
❑ Psoriasis ❑ Eczema______________
❑ Nervousness ❑ Depression_________
❑ Memory Loss __________________
❑ Moodiness - *Excessive* __________
❑ Phobias ______________________
❑ Mental Illness__________________
❑ Lactose Intolerance ____________
❑ Prostate Disease _______________
❑ Sexual/Menstrual Dysfunction _____
❑ Frequent Infections ____________
❑ Diphtheria ____________________
❑ Tetanus ______________________
❑ Chicken Pox ❑ Polio ❑ Mumps ❑

Measles ❑ Rubella ❑ Rheumatic Fever
❑ Scarlet Fever ❑ Tuberculosis ❑ Herpes
❑ Other _______________________
❑ Other _______________________

Females - *Please Complete*
Pregnant? ❑ Yes ❑ No
Planning Pregnancy? ❑ Yes ❑ No
Menstrual Flow:
❑ Regular ❑ Irregular ❑ Pain/Cramps
____Days of Flow ____Length of Cycle
Date-1st day of last period_______
❑ Pain/Bleeding during or after sex
Number of:
____Pregnancies ____Abortions
____Miscarriages ____Live Births
Birth Control Method______________
B.C. Pill (Name) _________________
❑ Flushing/Menopause
Date of Last PAP Test ______________
❑ Normal ❑ Abnormal
Date of Last Mammogram
❑ Normal ❑ Abnormal

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS	______	______	______	BLOOD DISEASE	______
	______	______	______	GLAUCOMA	______
	______	______	______	EPILEPSY	______
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN	______	______	______	TUBERCULOSIS	______
	______	______	______	GOUT	______
	______	______	______	HIGH BLOOD PRESSURE	______
				HEART DISEASE	
				BACK PROBLEMS	

Consent to Communicate Via Text/Email

" I, ____________________, hereby consent and state my preference to have my physician, Quang Nguyen DC, and other staff at Holistic Health Chiropractic Clinic to communicate with me by email or standard SMS/text messaging, in addition to or to replace leaving phone messages, regarding various aspects of my health care, which may include, but shall not be limited to, test results, appointments, and billing. I understand that email and standard SMS/text messaging are not confidential methods of communication and may be insecure. I further understand that, because of this, there is a risk that email and standard SMS/text messaging regarding my medical care might be intercepted and read by a third party.

1. I give my permission to leave both **appointment reminders** AND **my private health information** at the following (please fill-in the ones you agree to):

   Phone number________________________________
   Email____
   Text____

OR

2. I give permission to contact me, relative to **appointment reminders only**, by the following methods:

   Phone message at the following number______________________________
   Email messages at the following email address_________________________
   Text messages at the following phone number__________________________

Signature _____________________________ Date: ________________________

SYSTEMS SURVEY FORM

Patient ______________________ Doctor ______________________ Date ______________

Birth Date ___/___/___ Approx Weight ______________ Sex: Male ☐ Female ☐

Pulse: Recumbent ______________ Standing ______________ Vegetarian ☐ Gluten-free ☐

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.

● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1 2 3	**GROUP 1**
1	○ ○ ○	Acid foods upset
2	○ ○ ○	Get chilled often
3	○ ○ ○	"Lump" in throat
4	○ ○ ○	Dry mouth-eyes-nose
5	○ ○ ○	Pulse speeds after meal
6	○ ○ ○	Keyed up - fail to calm
7	○ ○ ○	Gag occasionally
8	○ ○ ○	Unable to relax; startles easily
9	○ ○ ○	Extremities cold, clammy
10	○ ○ ○	Strong light irritates
11	○ ○ ○	Occasionally weak urine flow
12	○ ○ ○	Heart pounds after retiring
13	○ ○ ○	"Nervous" stomach
14	○ ○ ○	Appetite reduced occasionally
15	○ ○ ○	Cold sweats often
16	○ ○ ○	Get heated easily
17	○ ○ ○	Nerve discomfort
18	○ ○ ○	Staring, blinks little
19	○ ○ ○	Sour stomach frequent
		GROUP 2
20	○ ○ ○	Joint stiffness on arising
21	○ ○ ○	Muscle-leg-toe cramps at night
22	○ ○ ○	"Butterfly" stomach, cramps
23	○ ○ ○	Eyes or nose watery
24	○ ○ ○	Eyes blink often
25	○ ○ ○	Eyelids swollen, puffy
26	○ ○ ○	Indigestion soon after meals
27	○ ○ ○	Always seems hungry; feels "lightheaded" often
28	○ ○ ○	Digestion rapid
29	○ ○ ○	Vomit occasionally
30	○ ○ ○	Hoarseness frequent
31	○ ○ ○	Uneven breathing
32	○ ○ ○	Pulse slow
33	○ ○ ○	Gagging reflex slow
34	○ ○ ○	Difficulty swallowing
35	○ ○ ○	Temporary constipation or diarrhea
36	○ ○ ○	"Slow starter"
37	○ ○ ○	Get "chilled"
38	○ ○ ○	Perspire easily
39	○ ○ ○	Sensitive to cold
40	○ ○ ○	Upper respiratory challenges
		GROUP 3
41	○ ○ ○	Eat when nervous
42	○ ○ ○	Excessive appetite
43	○ ○ ○	Hungry between meals
44	○ ○ ○	Irritable before meals
45	○ ○ ○	Get "shaky" if hungry
46	○ ○ ○	Fatigue, eating relieves
47	○ ○ ○	"Lightheaded" if meals delayed
48	○ ○ ○	Heart palpitates if meals missed or delayed
49	○ ○ ○	Fatigue in afternoons
50	○ ○ ○	Overeating sweets upsets
51	○ ○ ○	Awaken after few hours sleep - hard to get back to sleep
52	○ ○ ○	Crave candy or coffee in afternoons
53	○ ○ ○	Moods of "blues" or melancholy
54	○ ○ ○	Craving for sweets or snacks
		GROUP 4
55	○ ○ ○	Hands and feet go to sleep easily, numbness
56	○ ○ ○	Sigh frequently, "air hunger"
57	○ ○ ○	Aware of "breathing heavily"
58	○ ○ ○	High altitude discomfort
59	○ ○ ○	Opens windows in closed rooms
60	○ ○ ○	Immune system challenges
61	○ ○ ○	Afternoon "yawner"
62	○ ○ ○	Get "drowsy" often
63	○ ○ ○	Swollen ankles, worse at night
64	○ ○ ○	Muscle cramps, worse during exercise; get "charley horses"
65	○ ○ ○	Difficulty catching breath, especially during exercise
66	○ ○ ○	Tightness or pressure in chest, worse on exertion
67	○ ○ ○	Skin discolors easily after impact
68	○ ○ ○	Tendency to anemia
69	○ ○ ○	Noises in head, or "ringing in ears"
70	○ ○ ○	Fatigue upon exertion
		GROUP 5
71	○ ○ ○	Dizziness
72	○ ○ ○	Dry skin
73	○ ○ ○	Burning feet
74	○ ○ ○	Blurred vision
75	○ ○ ○	Itching skin and feet
76	○ ○ ○	Hair loss
77	○ ○ ○	Occasional skin rashes
78	○ ○ ○	Bitter, metallic taste in mouth in mornings
79	○ ○ ○	Occasional constipation
80	○ ○ ○	Worrier, feels insecure
81	○ ○ ○	Nausea occasionally after eating
82	○ ○ ○	Greasy foods upset
83	○ ○ ○	Stools light colored
84	○ ○ ○	Skin peels on foot soles
85	○ ○ ○	Discomfort between shoulder blades
86	○ ○ ○	Occasional laxative use
87	○ ○ ○	Stools alternate from soft to watery
88	○ ○ ○	Sneezing attacks
89	○ ○ ○	Dreaming, nightmare type bad dreams
90	○ ○ ○	Bad breath (halitosis)
91	○ ○ ○	Milk products cause upset
92	○ ○ ○	Sensitive to hot weather
93	○ ○ ○	Burning or itching anus
94	○ ○ ○	Crave sweets
		GROUP 6
95	○ ○ ○	Loss of taste for meat
96	○ ○ ○	Lower bowel gas several hours after eating
97	○ ○ ○	Burning stomach sensations, eating relieves
98	○ ○ ○	Coated tongue
99	○ ○ ○	Pass large amounts of foul-smelling gas
100	○ ○ ○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
101	○ ○ ○	Watery or loose stool
102	○ ○ ○	Gas shortly after eating
103	○ ○ ○	Stomach "bloating"

#	1 2 3	GROUP 7A
104	O O O	Difficulty sleeping
105	O O O	On edge
106	O O O	Can't gain weight
107	O O O	Intolerance to heat
108	O O O	Highly emotional
109	O O O	Flush easily
110	O O O	Night sweats
111	O O O	Thin, moist skin
112	O O O	Inward trembling
113	O O O	Heart races
114	O O O	Increased appetite without weight gain
115	O O O	Pulse fast at rest
116	O O O	Eyelids and face twitch
117	O O O	Irritable and restless
118	O O O	Can't work under pressure
		GROUP 7B
119	O O O	Increase in weight
120	O O O	Decrease in appetite
121	O O O	Fatigue easily
122	O O O	Ringing in ears
123	O O O	Sleepy during day
124	O O O	Sensitive to cold
125	O O O	Dry or scaly skin
126	O O O	Temporary constipation
127	O O O	Mental sluggishness
128	O O O	Hair coarse, falls out
129	O O O	Tension in head upon arising wears off during day
130	O O O	Slow pulse, below 65
131	O O O	Changing urinary function
132	O O O	Sounds appear diminished
133	O O O	Reduced initiative
		GROUP 7C
134	O O O	Failing memory with age
135	O O O	Increased sex drive
136	O O O	Episodes of tension in head
137	O O O	Decreased sugar tolerance
		GROUP 7D
138	O O O	Abnormal thirst
139	O O O	Bloating of abdomen
140	O O O	Weight gain around hips or waist
141	O O O	Sex drive reduced or lacking
142	O O O	Tendency for stomach issues
143	O O O	Immune system challenges
144	O O O	Menstrual disorders
		GROUP 7E
145	O O O	Dizziness
146	O O O	Headaches
147	O O O	Hot flashes
148	O O O	Hair growth on face or body (female)
149	O O O	Sugar in urine (not diabetes)
150	O O O	Masculine tendencies (female)
		GROUP 7F
151	O O O	Weakness, dizziness
152	O O O	Tired throughout day
153	O O O	Nails weak, ridged
154	O O O	Sensitive skin
155	O O O	Stiff joints
156	O O O	Perspiration increase
157	O O O	Bowel discomfort
158	O O O	Poor circulation
159	O O O	Swollen ankles
160	O O O	Crave salt
161	O O O	Areas of skin darkening
162	O O O	Upper respiratory sensitivity
163	O O O	Tiredness
164	O O O	Breathing challenges

#	1 2 3	GROUP 8
165	O O O	Muscle weakness
166	O O O	Lack of Stamina
167	O O O	Drowsiness after eating
168	O O O	Muscular soreness
169	O O O	Heart races
170	O O O	Hyperirritable
171	O O O	Feeling of a band around your head
172	O O O	Melancholia (feeling of sadness)
173	O O O	Swelling of ankles
174	O O O	Change in urinary function
175	O O O	Tendency to consume sweets or carbohydrates
176	O O O	Muscle spasms
177	O O O	Blurred vision
178	O O O	Involuntary muscle action
179	O O O	Numbness
180	O O O	Night sweats
181	O O O	Rapid digestion
182	O O O	Sensitivity to noise
183	O O O	Redness of palms of hands and bottom of feet
184	O O O	Visible veins on chest and abdomen
185	O O O	Hemorrhoids
186	O O O	Apprehension (feeling that something bad will happen)
187	O O O	Nervousness causing loss of appetite
188	O O O	Nervousness with indigestion
189	O O O	Gastritis
190	O O O	Forgetfulness
191	O O O	Thinning hair
		FEMALE ONLY
192	O O O	Very easily fatigued
193	O O O	Premenstrual tension
194	O O O	Menses more painful than usual
195	O O O	Depressed feelings before menstruation
196	O O O	Painful breasts during menses
197	O O O	Menstruate too frequently
198	O	Hysterectomy / ovaries removed
199	O O O	Menopausal hot flashes
200	O O O	Menses scanty or missed
201	O O O	Acne, worse at menses
		MALE ONLY
202	O O O	Less involved in exercise/social activities
203	O O O	Difficult to postpone urination
204	O O O	Weak urinary stream
205	O O O	Feeling of “blues” or melancholy
206	O O O	Feeling of incomplete bowel evacuation
207	O O O	Lack of energy
208	O O O	Muscles in arms and legs seem softer/smaller
209	O O O	Tire too easily
210	O O O	Avoids activity
211	O O O	Leg nervousness at night
212	O O O	Diminished sex drive

List the five main complaints you have in the order of their importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.