Adult Patient Intake

1. First Name: ____ Last Name: ____ DOB: ____

2. MRN #: ____

PATIENT INTAKE

Welcome to our online intake form. The information you fill in will be sent directly to our office, speeding up your office visit and allowing us to better serve your healthcare needs.

ABOUT YOU

3. **Home Address**

   Address 1 ____ Address 2 ____

   City ____ State ____ Zip Code ____

4. **Contact Information**

   Mobile Phone ____ Home Phone ____

   Primary Email Address ____ Social Security Number ____

5. **Demographic Information**

   Sex:
   - ○ Male ○ Female
   - ○ Choose not to answer

   Marital Status:
   - ○ Single ○ Married ○ Divorced ○ Widowed ○ Other

6. **Spouse's Name:** ____

7. Number of Children: ____

8. **Personal Information**

   Height - Feet: ____ Height - Inches: ____

   Weight (in pounds): ____

9. **Do you have Blue Cross Blue Shield?**

   ○ Yes ○ No

10. **Insurance Policy Information (BCBS only):**

    Insurance Plan Name
    ○ BCBS

    ID/Policy Number: ____ Group Number: ____

Relationship to Patient:
○ Self ○ Spouse ○ Parent ○ Employer ○ Caregiver ○ Other

Insured's First & Last Name: ______________________ Insured's Date of Birth: ______________

11. **Insurance Card Upload**

12. **Emergency Contact Information**

Emergency Contact Name: ______________________ Contact Phone Number: ______________ Relationship to Patient: ______________

13. **Employer Information**

Employment Status:
○ Employed ○ Student ○ Not Employed ○ Retired ○ Unknown

Employer Name: ______________________ Occupation: ______________________

Physical Work Duties: ______________________

14. **Referral Information**

Referring Physician: ______________________ Referring Patient: ______________________

How did you hear about us?
○ Word of mouth ○ Advertisement ○ Social media ○ Direct mail or email campaign ○ Event ○ Internet

Other: ______________________

VISIT PURPOSE

Readiness Assessment & Health Goals

15. **What health goals do you want to achieve by working with us?**

____

16. **When was the last time you felt well?**

____

17. **Did something trigger your change in health?**

____

18. **What makes you feel better?**

____

19. **What activities of daily living that are the most important to you are affected by your condition?**

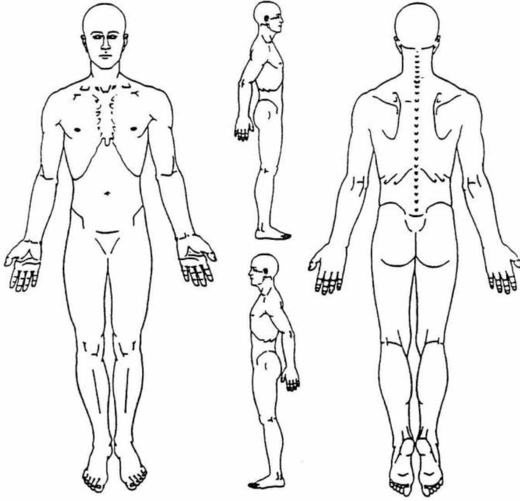
____

20. **What do you feel needs to happen for you to get better?**

____

AREAS OF CONCERN

21. **Please circle areas of concern.**



22. Approximate date this condition began (exact date not required)

What caused this condition?

23. **What term(s) describes your discomfort? Choose all that apply.**

	Yes	No
Aching		
Burning		
Deep		
Dull		
Intolerable		
Sharp		
Shooting		
Stabbing/Throbbing		
Stiffness		
Tightness		
Tingling		
Other		

If other, specify:

24. Rate the severity of your discomfort at its worst, on a scale of 0 – 10 where 0 is no pain and 10 is severe pain

How often do you feel this discomfort?

How has this complaint changed since onset?

25. What aggravates this condition? Choose all that apply.

	Yes	No
Almost any movement		
Athletic activity and/or exercise		
Bending		
Carrying or lifting		
Changing positions		
Coughing and/or sneezing		
Daily child or pet care		
Getting out of bed, chair or car		
Household chores (cleaning, cooking, etc.)		
Looking over shoulder		
Lying down, getting and staying asleep		
Pulling, pushing or reaching		
Raising arm(s) above shoulder(s)		
Self care (dressing, bathing, etc.)		
Sitting in car or chair		
Squatting or bending		
Standing		
Stress		
Walking or running		
Working at a desk/computer		
Yardwork		
Unknown		
Other		

If other,specify:

26. What improves this condition or gives you relief? Choose all that apply.

	Yes	No
Nothing		
Chiropractic adjustment		
Prescription medications		
Cold packs		
Redirecting attention		
Exercise		
Rest		
Heat packs		
Stretching		
Massage		
Work		
Over-the-counter medications		
Physical therapy		
Other		

If other, specify:

27. Have other health care provider(s) performed tests related to this condition?

○ Yes ○ No

If Yes, specify:

28. What treatment, if any, have you received since the injury? Choose all that apply.

	Yes	No
Chiropractic care		
Massage		
Medical injection treatment		
Surgical treatment		
Over-the-counter medications		
Prescribed medications		
Natural or holistic treatment		
Acupuncture		
Physical therapy		
None		
Other		

If other, specify:

29. Have you ever had any previous episodes of this condition?

○ Yes ○ No

If Yes, specify:

CURRENT HEALTH

30. Are you currently taking any medications?

○ Yes ○ No

31. Please list regularly used prescription and over-the-counter medications taken, as well as the Dosage and Frequency for each medication (e.g. 5 mg once daily)

	Medication Name	Dosage/Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

32. Medication Allergies

	Medication Name	Reaction	Onset Date	Additional Comments
1.				
2.				
3.				
4.				
5.				
6.				
7.				

33. Have you taken any of these regularly or for a long period of time?

	Yes	No
Tylenol (Acetaminophen)		
NSAIDs (Advil, Aleve, Ibuprofen, etc.) Motrin, Aspirin		
Acid Blocking Drugs (Zantac, Prilosec, Nexium, etc.)		

34. How many times have you taken antibiotics?

	<5	>5
Childhood		
Teen		
Adult		

35. Have you ever taken long term antibiotics?

○ Yes ○ No

If yes, please explain:

____

36. How often have you taken oral steroids (Cortisone, Prednisone, etc.)

	<5	>5
Childhood		
Teen		
Adult		

Supplements

37. Please list regularly used supplements as well as dosage and frequency for each

	Supplement	Dosage / Frequency
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

Patients Birth/Childhood History

38. You were born:

- ○ Term
- ○ Premature
- ○ Unsure

39. Were there any pregnancy or birth complications?

- ○ Yes
- ○ No

If yes, explain:

____

40. You were:

	Yes
Breastfed	
Formula	
Unsure	

How long?

____

41. As a child, were there any foods that were avoided be because they gave you symptoms?

- ○ Yes
- ○ No

42. If yes, what foods and what symptoms? (Ex: Milk- gas and diarrhea)

____

43. Did you eat a lot of sugar or candy as a child?

- ○ Yes
- ○ No

44.

	Yes	No
Have you had any surgical procedures?		
Are there any past illnesses or conditions we should be aware of?		
Do you have a past history of accidents or trauma?		

If yes, please explain:

____

Dental History

45. Check if you have any of the following; provide number if applicable:

- ☐ Silver Mercury Fillings ____________
- ☐ Gold Fillings ____________
- ☐ Root Canals ____________
- ☐ Implants ____________
- ☐ Caps/Crowns ____________
- ☐ Tooth Pain ____________
- ☐ Bleeding gums ____________
- ☐ Gingivitis ____________
- ☐ Problem Chewing ____________
- ☐ Other ____________

46. **Have you had any mercury fillings removed?**

- ○ Yes
- ○ No

If yes, when?

____

47. **Do you brush regularly?**

- ○ Yes
- ○ No

Environmental / Detoxification History

48. **Do any of these significantly affect you?**

- ☐ Cigarette Smoke
- ☐ Perfume / Cologne
- ☐ Auto Exhaust Fumes
- ☐ Other

49. **In your work or home environment are you regularly exposed to: (Check all that apply)**

- ☐ Mold
- ☐ Water leaks
- ☐ Renovations
- ☐ Chemicals
- ☐ Electromagnetic Radiation
- ☐ Damp Environments
- ☐ Carpets or Rugs
- ☐ Old Paint
- ☐ Stagnant / Stuffy Air
- ☐ Smokers
- ☐ Pesticides
- ☐ Herbicides
- ☐ Airplane Travel
- ☐ Cleaning Chemicals
- ☐ Harsh Chemicals
- ☐ Heavy Metals
- ☐ Other

50. **Have you had a significant exposure to any harmful chemicals?**

- ○ Yes
- ○ No

If yes, list chemical name, length of exposure, and date:

____

51. **Do you have any pets or farm animals?**

- ☐ Yes
- ☐ No

52. **If yes, do they live:**

	Answer
Inside	
Outside	
Both Inside & Outside?	

Women's History (Skip if Male)

Obstetric History (check and provide a number to all that apply)

53.
- ☐ Pregnancies ____________
- ☐ Vaginal Deliveries ____________
- ☐ Miscarriages ____________
- ☐ Cesarean ____________
- ☐ Abortions ____________
- ☐ Term Births ____________
- ☐ Living Children ____________
- ☐ Premature Birth ____________

54. Did you develop any problems in or after pregnancy? (Toxemia, Diabetes, Postpartum Depression, Breast-feeding Issues)

- ○ Yes
- ○ No

If yes, please explain:

____

Menstrual History (Skip if Male)

55.
- ☐ Age of First Cycle ____________
- ☐ Date of Last Cycle ____________
- ☐ Length of Cycle ____________
- ☐ Time Between Cycles ____________

56. Other problems with your cycle?

- ○ Yes
- ○ No

If yes, describe:

____

57. Use of hormonal birth control?

- ○ Birth Control Pills
- ○ Birth Control Patch
- ○ Nuva Ring
- ○ Other

58. Other forms of contraception?

- ○ Yes
- ○ No

59.
- ○ Condoms
- ○ Diaphrahm
- ○ IUD
- ○ Partner Vasectomy

60. Are you in menopause?

- ○ Yes
- ○ No

61. Do you currently have symptomatic problems with menopause? (Check all that apply)

- ☐ Hot Flashes
- ☐ Mood Swings
- ☐ Headaches
- ☐ Joint Pain
- ☐ Concentration / Memory Loss
- ☐ Vaginal Dryness
- ☐ Weight Gain
- ☐ Decreased Libido
- ☐ Urine Control Loss
- ☐ Palpitations

62. Are you on hormone therapy?

- ○ Yes
- ○ No

If yes, for how long & for what reason?

____

Other Gynecological Symptoms (Check all that apply)

63.
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic Breasts
- ☐ Pelvic Inflammatory Disease
- ☐ Ovarian Cysts
- ☐ Fibroids
- ☐ Reproductive Cancer
- ☐ Sexually Transmitted Diseases
- ☐ Other

STD (describe):

Men's History (Skip if Female)

64. Check if Applicable

- ☐ Testicular Mass
- ☐ Testicular Pain
- ☐ Prostate Infection
- ☐ Change in Libido
- ☐ Impotence
- ☐ Premature Ejaculation
- ☐ Difficulty Obtaining Erection
- ☐ Loss of Urine Control
- ☐ Urinary Stream Issues
- ☐ Vasectomy
- ☐ Prostate Enlargement
- ☐ Difficulty Maintaining Erection
- ☐ Nocturia (unrination at night)
- ☐ Sexually Transmitted Disease (describe):
- ☐ Other

STD describe:

Lifestyle Review

65. How many hours of sleep do you get on average?

66.

	Yes	No
Problems falling asleep?		
Problems with insomnia?		
Staying asleep?		
Do you snore?		
Do you feel rested upon awakening?		
Do you use sleeping aids?		

If yes, please explain:

---

67. Personal Social Habits

	Yes	No
Smoke or use tobacco products		
Drink alcohol		
Drink caffeine		
Use recreational drugs		
Other, to be discussed with doctor		

68. Present Exercise Habits

	Yes	No
No current exercise		
Exercise daily		
Exercise 3+ times per week		
Cannot return to exercise due to current condition		

69. Do you have any intolerances to the following?

- ☐ Gluten (Wheat)
- ☐ All Dairy Products
- ☐ Lactose
- ☐ Corn
- ☐ Eggs
- ☐ Fatty Foods
- ☐ Yeast

70. Any known food allergies or sensitivities?

____

71. Are there any foods that you crave or binge on?

- ☐ Yes
- ☐ No

If yes, please explain?

____

72. Do you adversely react to: (Check all that apply)

- ☐ Monosodium glutamate (MSG
- ☐ Chocolate
- ☐ Artificial sweeteners
- ☐ Garlic/onion
- ☐ Cheese
- ☐ Citrus foods
- ☐ Preservatives
- ☐ Food colorings
- ☐ Other

73. Do you drink caffeinated beverages?

- ○ Yes
- ○ No

74. Coffee (cups per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

75. Tea (cups per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

76. Caffeinated sodas - diet or regular (cans per day)

- ○ 1
- ○ 2-4
- ○ >4
- ○ None

77. Do you have adverse reactions to caffeine?

- ☐ Yes
- ☐ No

If yes, please explain:

____

Smoking

78. Do you smoke currently?

- Yes
- No

If yes, packs per day and number of years?

___

79. Have you attempted to quit?

- Yes
- No

If yes, what methods?

___

80. Are you regularly exposed to second hand smoke?

- Yes
- No

Alcohol

81. How many alcoholic beverages do you drink a week? (1 drink = 5oz wine, 12oz beer, 1.5oz spirits)

- 1-3
- 4-6
- 7-10
- >10
- None

82. Have you had an alcohol problem?

- Yes
- No

If yes, when?

___

Other Substances

83. Do you currently use recreational drugs?

- Yes
- No

If yes, what type?

___

Stress

84. Do you feel like you have an excessive amount of stress in your life?

- Yes
- No

85. Do you feel you can easily handle the stress in your life?

- Yes
- No

86. How much stress do each of the following cause on a daily basis? (rate on a scale 1-10, 10 being highest)

Work

___

Family

___

Social

___

Finance

Health

Other

87. Do you use relaxation techniques?

- ○ Yes
- ○ No

88. If yes, which techniques?

- ☐ Meditation
- ☐ Breathing
- ☐ Tai Chai
- ☐ Yoga
- ☐ Prayer
- ☐ Other
- ☐ None

If other:

89. Have you ever sought counseling?

- ○ Yes
- ○ No

90. Are you currently in therapy?

- ○ Yes
- ○ No

91. Have you ever been abused, a victim of crime, or experienced a significant trauma?

- ○ Yes
- ○ No

92. What are your hobbies or leisure activities?

Family History

93. Is there anyone in your immediate family who has experienced the following? If yes, please select and indicate who.

	Mother	Father	Brother(s)	Sister(s)	Child 1	Child 2	Child 3	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother	Other
Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Autoimmune Disease												
Arthritis												
Kidney Disease												
Thyroid Problems												
Seizures/Epilepsy												
Psychiatric Disorders												
Anxiety												
Depression												
Asthma												
Allergies												
Eczema												
ADHD												
Autism												
Irritable Bowel Syndrome												
Dementia												
Substance Abuse												
Genetic Disorders												
Other												

Health History

Personal Medical History (Check if you have had any of the following:)

94. Gastrointestinal

- ☐ Irritable Bowel Syndrome
- ☐ GERD (reflux)
- ☐ Crohn's Disease/Ulcerative Colitis
- ☐ Peptic Ulcer Disease
- ☐ Celiac Disease
- ☐ Gallstones
- ☐ SIBO
- ☐ Other
- ☐ None

If other, please explain or specify:

____

95. Respiratory

- ☐ Bronchititis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinusitis
- ☐ Sleep Apnea
- ☐ Other
- ☐ None

If other, please specify:

---

96. Urinary / Genital

- ☐ Kidney Stones
- ☐ Gout
- ☐ Interstitial Cystitis
- ☐ Frequent Yeast Infections
- ☐ Urinary Tract Infections
- ☐ Sexual Disfunction
- ☐ Sexually Transmitted Diseases
- ☐ Other
- ☐ None

If other, please specify:

---

97. Musculoskeletal

- ☐ Fibromyalgia
- ☐ Osteoarthritis
- ☐ Chronic Pain
- ☐ Other
- ☐ None

If other, please specify:

---

98. Skin

- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Skin Cancer
- ☐ Other
- ☐ None

If other, please specify:

---

99. Cardiovascular

- ☐ Angina
- ☐ Heart Attack
- ☐ Heart Failure
- ☐ Hypertension (High Blood Pressure)
- ☐ Stroke
- ☐ High Blood Fats (Cholesterol, Triglycerides)
- ☐ Rheumatic Fever
- ☐ Arrythmia (Irregular Heart Rate)
- ☐ Murmur
- ☐ Mitral Valve Prolapse
- ☐ Other
- ☐ None

If other, please specify:

---

100. Endocrine / Metabolic

- ☐ Diabetes
- ☐ Hypothyroidism (Low Thyroid)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Polycystic Ovarian Syndome
- ☐ Infertility
- ☐ Metabolic Syndrome / Insulin Resistance
- ☐ Eating Disorder
- ☐ Hypoglycemia
- ☐ Other
- ☐ None

If other, please specify:

---

101. Inflammatory / Immune

- ☐ Rheumatoid Arthritis
- ☐ Chronic Fatigue Syndrome
- ☐ Food Allergies
- ☐ Environmental Allergies
- ☐ Multiple Chemical Senitivities
- ☐ Autoimmune Disease
- ☐ Immune Deficiency
- ☐ Mononucleosis
- ☐ Hepatitis
- ☐ Other
- ☐ None

If other, please specify:

___

102. Neurological / Emotional

- ☐ Epilepsy / Seizures
- ☐ ADD / ADHD
- ☐ Headaches
- ☐ Migraines
- ☐ Depression
- ☐ Anxiety
- ☐ Autism
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Dementia
- ☐ Other
- ☐ None

If other, please specify:

___

103. Cancer

- ☐ Lung
- ☐ Breast
- ☐ Colon
- ☐ Ovarian
- ☐ Skin
- ☐ Other
- ☐ None

If other, please specify:

___

104. Injuries

	Date	Additional Information
Concussion / Head Injury		
Other		

If other, please specify:

___

105. Surgeries

Surgeries	Date	Additional Information
Surgery		
Surgery		
Surgery		

106. Hospitalizations

	Date	Additional Information
Hospitalizations		
Hospitalizations		
Hospitalizations		

Symptom Review

107. General

- Cold Hands and Feet
- Cold Intolerance
- Day Time Sleepiness
- Difficulty Falling Asleep
- Early Waking
- Fatigue
- Fever
- Flushing
- Nightmares
- Can't Remember Dreams
- Low Body Temperature
- None

108. Head, Eyes, And Ears

- Conjunctivitis
- Distorted Sense of Smelll
- Distorted Taste
- Ear Fullness
- Ear Ringing / Buzzing
- Eye Crusting
- Eye Pain
- Eyelid Margin Redness
- Headache
- Hearing Loss
- Hearing Problems
- Migraines
- Loud Noise Sensitivity
- Vision Problems
- None

109. Musculoskeletal

- Back Muscle Spasms
- Calf Cramps
- Chest Tightness
- Foot Cramps
- Joint Deformity
- Joint Pain
- Joint Redness
- Joint Stiffness
- Muscle Pain
- Muscle Spasms
- Muscle Twitches (around eyes)
- Muscle Twitches (arms or legs)
- Muscle Weakness
- Neck Muscle Spasms
- Tendinitis
- Tension Headache
- TMJ Problems
- None

110. Mood / Nerves

- Agoraphobia
- Anxiety
- Auditory Hallucinations
- Blackouts
- Depression
- Difficulty Concentration
- Difficulty With Balance
- Difficulty With Thinking
- Difficulty With Judgement
- Difficulty With Speech
- Difficulty with Memory
- Dizziness
- Fainting
- Fearfulness
- Lightheadedness
- Irritability
- Numbness
- Other Phobias
- Panic Attacks
- Paranoia
- Seizures
- Suicidal Thoughts
- Tingling
- Tremor / Trembling
- Visual Hallucinations
- None

111. Cardivascular

- Angina / Chest Pain ______________
- Breathlessness ______________
- Heart Attack ______________
- Heart Murmur ______________
- High Blood Pressure ______________
- Irregular Pulse ______________
- Mitral Valve Prolapse ______________
- Palpitations ______________
- Phlebitis ______________
- Swollen Ankles / Feet ______________
- Varicose Veins ______________
- None ______________

112. Urinary

- Bed Wetting
- Hesitancy
- Infection
- Kidney Disease
- Kidney Stones
- Leaking / Incontinence
- Pain / Burning
- Urgency
- None

113. Digestion

- [ ] Anal Spasms
- [ ] Bad Teeth
- [ ] Bleeding Gums
- [ ] Bloating
- [ ] Blood in Stool
- [ ] Burping
- [ ] Canker Sores
- [ ] Cold Sores
- [ ] Consipation
- [ ] Cracking at Corner of Lips
- [ ] Poor Chewing with Dentrues
- [ ] Diarrhea
- [ ] Difficulty Swallowing
- [ ] Dry Mouth
- [ ] Flatuence
- [ ] Fissures
- [ ] Reflux
- [ ] Heartburn
- [ ] Hemorrhoids
- [ ] Liver Disease / Jaundice
- [ ] Lower Abdominal Pain
- [ ] Mucus in Stool
- [ ] Nausea
- [ ] Periodontal Disease
- [ ] Sore Tongue
- [ ] Strong Stool Oder
- [ ] Undigested Food in Stool
- [ ] Upper Abdominal Pain
- [ ] Vomiting
- [ ] None

114. Eating

- [ ] Binge Eating
- [ ] Bulimia
- [ ] Can't Gain Weight
- [ ] Can't Lose Weight
- [ ] Carbohydrate Craving
- [ ] Carbohydrate Intolerance
- [ ] Poor Appetite
- [ ] Salt Cravings
- [ ] Frequent Dieting
- [ ] Sweet Cravings
- [ ] Caffeine Dependency
- [ ] None

115. Respiratory

- [ ] Bad Breath
- [ ] Bad Odor In Nose
- [ ] Dry Cough
- [ ] Productive Cough
- [ ] Hay Fever
- [ ] Hoarseness
- [ ] Nasal Stuffiness
- [ ] Nose Bleeds
- [ ] Post Nasal Drip
- [ ] Sinus Fullness
- [ ] Sinus Infection
- [ ] Snoring
- [ ] Sore Throat
- [ ] Wheezing
- [ ] Winter Stuffiness
- [ ] None

116. Nails

- [ ] Biten
- [ ] Briddle
- [ ] Curve Up
- [ ] Frayed
- [ ] Finger Fungus
- [ ] Toe Fungus
- [ ] Pitting
- [ ] Ragged Cuticles
- [ ] Ridges
- [ ] Soft
- [ ] Thickening of Finger Nails
- [ ] Thickening of Toe Nails
- [ ] White Spots / Lines
- [ ] None

117. Lymph Nodes

- [ ] Enlarged
- [ ] Tender
- [ ] None

118. Skin Problems

- [ ] Acne
- [ ] Athletes Foot
- [ ] Bumps on Back of Upper Arms
- [ ] Cellulite
- [ ] Dark Circles Under Eyes
- [ ] Easy Bruising
- [ ] Eczema
- [ ] Herpes / Genital
- [ ] Hives
- [ ] Jockitch
- [ ] Lackluster Skin
- [ ] Moles with Color / Size Change
- [ ] Oily Skin
- [ ] Psoriasis
- [ ] Rash
- [ ] Red Face
- [ ] Sensitive to Bites
- [ ] Sensitive to Poison Ivy
- [ ] Shingles
- [ ] Skin Cancer
- [ ] Strong Body Odor
- [ ] Vitiligo
- [ ] None

119. Male Reproductive (Skip if Female)

- ☐ Discharge from Penis
- ☐ Ejaculation Problem
- ☐ Genital Pain
- ☐ Impotence
- ☐ Infection
- ☐ Lumps in Testicles
- ☐ Poor Libido (Low sex drive)
- ☐ None

120. Female Reproductive (Skip if Male)

- ☐ Breast Cysts
- ☐ Breast Lumps
- ☐ Breast Tenderness
- ☐ Ovarian Cyst
- ☐ Poor Libido (Low sex drive)
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Infertility
- ☐ Vaginal Discharge
- ☐ Vaginal Odor
- ☐ Vaginal Itch
- ☐ Vaginal Pain
- ☐ None

121. Premenstrual: (Skip if Male)

- ☐ Bloating
- ☐ Breast Tenderness
- ☐ Carbohydrate Craving
- ☐ Chocolate Craving
- ☐ Constipation
- ☐ Decreased Sleep
- ☐ Diarrhea
- ☐ Fatigue
- ☐ Increased Sleep
- ☐ Irritability
- ☐ None

Readiness Assessment and Health Goals

122. Rate on a scale 1 (not willing) to 5 (very willing): In order to improve your health, how willing are you to:

	1	2	3	4	5
Significantly Modify your Diet					
Take Several Nutritional Supplements Each Day					
Modify your Lifestyle (e.g., Work demands, sleep habits)					
Practice a Relaxation Technique					
Engage in Regular Exercise					

123. Rate on a scale 1 (very unsupportive) to 5 (very supportive):

	1	2	3	4	5
At the present time, how supportive do you think the people in your household will be to your implementing the above changes?					

____

Signature

124. Primary Insurance

Primary Insurance Company ________ Member ID / Policy # ________ Group Number ________

Client Relationship to Insured
○ Self ○ Spouse ○ Child ○ Other

Insured Name ________ Insured Phone # ________ Insured Date of Birth ________ Insured Gender ○ Female ○ Male

Insured Street Address ________ Insured City ________ Insured State ________ Zip Code ________