

Patient Name _____ Date _____

Main Physical Complaint _____

- 1) Please rate your current stress level from 1-10.
(low) 1 2 3 4 5 6 7 8 9 10 (high)
- 2) What hours do you generally sleep? _____
- 3) Nap in the daytime? Yes No
- 4) Do you have trouble falling asleep? Yes No
- 5) List any sleep aids you use. _____
- 6) Do you have trouble staying asleep? Yes No
- 7) Do you wake feeling rested? Yes No
- 8) Please rate your energy level from 1-10
(low) 1 2 3 4 5 6 7 8 9 10 (high)
- 9) Do you have an energy dip in the afternoon? Yes No
- 10) How much water do you drink each day? _____
- 11) What kind of water do you drink? _____
- 12) How many cups of coffee do you drink daily? _____
- 13) Decaf? Yes No
- 14) How many cups of tea do you drink daily? _____
- 15) Type of tea? _____
- 16) How many soft drinks do you drink daily? _____
- 17) How many glasses of alcohol do you drink daily? _____
- 18) How many ounces of juice do you drink daily? _____
- 19) Please describe any food cravings you have.
(For specific foods such as bread or chocolate, or types of foods such as salty, crunchy, etc) _____

(Over please)

20) Please list any foods that you know negatively affect you in any way

21) How often do you have a bowel movement? _____

22) Do you have to use anything to make your bowels move?

Yes No If yes, what? _____

23) Are your stools easy to pass? Yes No

**24) Are your stools ever very light brown, yellowish, greenish, or putty colored?
(Circle all that apply)**

25) Do you ever have discomfort under your ribs on the right side, especially after eating a high fat meal? Yes No

26) Have you ever noticed bubbles in your urine that don't disappear immediately? Yes No

27) Please list any prescription medications you are taking

28) Please list any vitamins or supplements that you take regularly

29) Do you receive regular chiropractic adjustments? Yes No
