

DR. NANCY TURNER, DC

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PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____

Patient Name _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____

Email _____

Sex M F Age _____

Birthdate _____

- Married Widowed Single Minor
 Separated Divorced Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

Employer/School Phone _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? Yes No

Date _____

Type of accident Auto Work Home Other

To whom have you made a report of your accident?

Auto Insurance Employer Worker Comp. Other

Attorney Name (if applicable) _____

HEALTH HISTORY

What treatment have you already received for your condition? _____

Medications Surgery Physical Therapy Chiropractic Services None Other

Name and address of other doctor(s) who have treated you for your condition? _____

Date of Last: Physical Exam _____ Spinal X-Ray _____ Blood Test _____ Spinal Exam _____ Chest X-Ray _____

Urine Test _____ Dental X-Ray _____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Acne	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hearing Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prostate Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Prosthesis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heart Palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Alcoholism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hemorrhoids	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recreational Drug Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Allergy Shots	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reduced Sex Drive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hernia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Reflux	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herniated Disk	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatoid Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Appendicitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Rich or Greasy Food Upsets	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Autism	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hot Flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bladder Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hyperactivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sneezing	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Increased Perspiration	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sore Throat	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Boils/Cysts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Indigestion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bronchitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Infertility	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Sugar/Candy Cravings	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Inflamed or Congested Sinus	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Suicide Attempt	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Insomnia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Intolerance to Heat or Cold	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Irritable Bowl	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Joint Stiffness/Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Tumors/Growths	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Laxative Use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Underweight	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Hands/Feet	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaccinations You've Received (list):	_____	
Cold Sores	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Colds/Frequent Colds	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Measles	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Menstrual Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Constipation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Metallic Taste	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Migraine Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Decreased Appetite	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Miscarriage	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vomiting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mononucleosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Whooping Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Multiple Sclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Other (list):	_____	
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Mumps	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Eczema/Psoriasis/Skin Rash	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Muscle Cramps	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Night Sweats	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Epilepsy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Numbness	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Fractures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No		_____	
Frequent Thirst	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Overweight	<input type="checkbox"/> Yes	<input type="checkbox"/> No	WOMEN ONLY:		
Frequent Urination	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Abortion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gas/Bloating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Parkinson's Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Breast Lump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pinched Nerve	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Goiter	<input type="checkbox"/> Yes	<input type="checkbox"/> No	PMS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Heavy Bleeding at Menses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Ovarian Cysts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Polio	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Uterine Fibroids	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Post Nasal Drip	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Vaginal Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No
						Yeast Infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No

HEALTH HISTORY CONT.

EXERCISE

None Moderate Daily Heavy

WORK ACTIVITY

Sitting Standing Light Labor Heavy Labor

HABITS

Smoking Packs/Day_____ Alcohol Drinks/Week_____ Coffee/Caffeine Drinks Cups/Day_____

High Stress Level Reason_____

Are you pregnant? Yes No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls	_____	_____
Head Injuries	_____	_____
Broken Bones	_____	_____
Dislocations	_____	_____
Surgeries	_____	_____

MEDICATIONS

ALLERGIES

VITAMINS/HERBS/MINERALS

Pharmacy Name_____

Pharmacy Phone (____)_____

REASON(S) FOR INITIAL VISIT

List health problems you are experiencing from most severe to least severe:

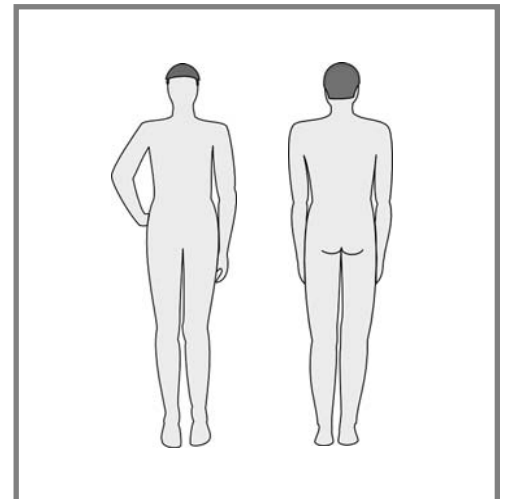
- 1) _____

- 2) _____

- 3) _____

- 4) _____

- 5) _____



If you are experiencing pain,
please mark location.

QUESTIONNAIRE

- 1) Were you sick often as a child? _____ If yes, what illness did you have? _____
- 2) When is the last time you took antibiotics? _____ What for? _____
- 3) Can you approximate the number of times you used antibiotics in your life? _____
For what conditions did you take them? _____
- 4) Have you had any chemical exposures that made you ill? _____
(examples: pesticides, dioxin, solvents, insecticides, food chemicals, cleaning chemicals, etc.)
- 5) Have you had heavy metal exposure? _____
(examples: mercury, lead, etc.)
- 6) Did you ever have allergy shots? _____ What for? _____
Did you have allergies in childhood that you no longer experience? _____
- 7) Do you use artificial sweeteners? _____ MSG? _____
- 8) Have you ever been diagnosed with intestinal parasites? _____ What type? _____
- 9) Have you ever become ill after traveling abroad? _____
- 10) How many bowel movements do you have a day? _____
- 11) Do you drink water, if yes how much (average)? _____ What type? _____
- 12) Have you needed extensive dental work? _____ What type? _____
- 13) Have you used the birth control pill? _____ If yes, how long? _____
- 14) Women: What type of contraceptive method do you use? _____
- 15) Have you ever been treated for an emotional disorder? _____
- 16) Have you ever had complications giving birth? _____
- 17) Were there complications with your own birth? _____
- 18) When is the last time you sought the care of a medical doctor? _____ What for? _____
- 19) Are you currently seeing a chiropractor? _____ Are you still under their care? _____
- 20) Is there any food or beverage you feel you cannot do without for a day? _____
- 21) How would you classify your diet? Meat and Potatoes Vegetarian Fast Foods Other

Mark the appropriate column for each of the following foods:

	Never	Weekly	Daily		Never	Weekly	Daily		Never	Weekly	Daily
<i>Animal Protein</i>				Milk				Pastries			
Chicken/Fish/Turkey				Yogurt				<i>Vegetables</i>			
Deli Meats				<i>Drinks</i>				Cooked			
Eggs				Coffee/Tea				Raw			
Lamb/Bison/Elk/Duck				Energy Drinks				<i>White Flour Products</i>			
Ham/Sausage/Bacon				Fruit Juice				Bagels/Breads/Buns/Rolls			
Hot Dogs/Ribs				Soda/Cola				Pasta			
Steak/Hamburger				<i>Fruit</i>				Pancakes/Waffles			
<i>Beans</i>				Canned				<i>Whole Grains</i>			
<i>Dairy</i>				Fresh				Barley/Oatmeal/Wheat			
Butter/Margarine				Frozen				Couscous/Millet/Quinoa			
Cheese				<i>Nuts/Seeds/Nut Butters</i>				Rice			
Cream Cheese				<i>Refined Sugar Products</i>				<i>Condiments</i>			
Cottage Cheese				Cake/Cookies				<i>Fast/Fried Foods</i>			
Ice Cream				Candy				<i>Eat At Restaurants</i>			