

Please fill out the application entirely and legibly. We need all information for insurance purposes.

Name _____ **Nickname** _____

Address _____

City _____ **State** _____ **Zip** _____

Phone _____ **Email** _____

We will need to contact you both by phone & email. Please be sure to give us the best phone number to reach you

Date of Birth _____ **Social Security** _____

If you have Medicare, we need you to list your SSN above or provide us with the Medicare card

Spouse's Name _____ **PhoneNumber** _____

Your Occupation _____ **Retired?** Yes No

How did you hear about us? Please Circle: Referral Facebook tv radio newspaper other _____

REVIEW OF SYMPTOMS

➔ Please check all that apply

- | | | | | |
|--|--|--|--|--|
| <input type="checkbox"/> Foot Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Spinal Stenosis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Pinched Nerve |
| <input type="checkbox"/> Hand Pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Degenerative Disc | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Poor Circulation |
| <input type="checkbox"/> Low Back Pain | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Vascular Problems | <input type="checkbox"/> Arthritis in Hands | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Arthritis in Feet | <input type="checkbox"/> Foot Surgery |
| <input type="checkbox"/> Foot Numbness | <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Plantar Fasciitis | <input type="checkbox"/> Implanted Cord/Bladder Stimulator | <input type="checkbox"/> Poor wound healing |
| <input type="checkbox"/> Hand Numbness | <input type="checkbox"/> Bulging Disc | <input type="checkbox"/> Morton's Neuroma | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Excessive thirst or urination |

PRESENT HEALTH CONDITION

➔ In order of importance, list the health problems you are most interested in getting corrected:

1. _____
2. _____
3. _____
4. _____

➔ List approximately how long you have noticed these problems:

1. _____
2. _____
3. _____
4. _____

➔ Is there a certain time of day any of these problems are better or worse?

➔ List the things you have used for these problems:

*Gabapentin Neurontin Lyrica Cymbalta
Physical Therapy Pain Medications Aleve
Tylenol Ibuprofen Motrin Chiropractic
Massage Therapy Injections Creams*

➔ Is your balance/walking ability affected?
If yes, please describe:

➔ What do you think is causing your problem?

Name of all doctors you have seen for these problems and treatment you received:

➔ **Have your symptoms:** Improved Worsened Stayed the same

List anything that makes your condition worse _____

List anything that makes your condition better _____

➔ **How would you describe the symptoms? Please check ALL that apply**

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Aching Pain | <input type="checkbox"/> Numbness | <input type="checkbox"/> Hot Sensation | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Stabbing Pain | <input type="checkbox"/> Tingling | <input type="checkbox"/> Throbbing Pain | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Sharp Pain | <input type="checkbox"/> Pins & Needles Pain | <input type="checkbox"/> Dead Feeling | <input type="checkbox"/> Burning |
| <input type="checkbox"/> Tiredness | <input type="checkbox"/> Heavy Feeling | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Electric Shocks |

➔ **Is this condition interfering with any of the following?**

- | | | |
|--|----------------------------------|---|
| <input type="checkbox"/> Sleep | <input type="checkbox"/> Work | <input type="checkbox"/> Daily Activities |
| <input type="checkbox"/> Recreational Activities | <input type="checkbox"/> Walking | <input type="checkbox"/> Standing |

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many cigarettes daily? _____

Do you drink? Yes No If yes, how many drinks per week? _____

Do you exercise regularly? Yes No If yes, please describe type & how often: _____

CURRENT PAINLEVELS

➔ **How would you rate your pain in the last week?**

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

➔ **If you had to accept some level of pain after completion of treatment, what would be an acceptable level?**

NO PAIN **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** WORST PAIN POSSIBLE

PREVIOUS HEALTH HISTORY/HEALTH

This is a confidential record of your medical history and pertinent personal information. The doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here indicating that we can release copies by your verbal request.

Name _____ **Signature** _____

Please give name, address, and oice phone number of your primary care physician.

Name _____ **Phone** _____ **Address** _____

When were you last seen there?

May we send them updates on your treatment/condition? Yes No

List ALL allergies/sensitivities to medication, food, and other items here:

<i>Item you react to:</i>	<i>Reaction:</i>
_____	_____
_____	_____
_____	_____
_____	_____

List the prescription drugs you are currently taking (or you may attach a list):

<i>Name</i>	<i>Dose (mg or IU)</i>	<i>Times Daily</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

➔ PIVOTAL HEALTH

Patient Quality Of Life Survey

Name: _____

Date: _____

*Please take several MINUTES to answer these QUESTIONS so we can help you get better.
(Please circle as many that apply)*

- 1 How have you taken care of your health in the past?
 - a. Medications
 - b. Emergency Room
 - c. Routine Medical
 - d. Exercise
 - e. Nutrition/Diet
 - f. Holistic Care
 - g. Vitamins
 - h. Chiropractic
 - i. Other (please specify): _____

- 2 How did the previous method(s) work out for you?
 - a. Bad results
 - b. Some results
 - c. Great results
 - d. Nothing changed
 - e. Didnotgetworse
 - f. Did not work very long
 - g. Still trying
 - h. Confused

- 3 How have others been affected by your health condition?
 - a. No one is affected
 - b. Haven't noticed any problem
 - c. They tell me to do something
 - d. People avoid me

- 4 What are you afraid this might be (or beginning) to affect (or will affect)?
 - a. Job
 - b. Kids
 - c. Future ability
 - d. Marriage
 - e. Self-esteem
 - f. Sleep
 - g. Time
 - h. Finances
 - i. Freedom

- 5 Are there health conditions you are afraid this might turn into?
 - a. Family health problems
 - b. Heart disease
 - c. Cancer
 - d. Diabetes
 - e. Arthritis
 - f. Fibromyalgia
 - g. Depression
 - h. Chronic Fatigue
 - i. Need surgery

→ How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

→ What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples:

→ What are you most concerned with regarding your problem?

→ Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific

→ What would be different/better without this problem? Please be specific

→ What do you desire most to get from working with us?

→ What would that mean to you?

Trust Your Gut Wellness Evaluation

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggering limiting your health in process

Let's get started.

Please circle any that apply to you prior to taking the quiz below:

Sub-Clinical symptoms including:

Headaches and migraines

Hormone imbalance including:

PMS

Emotional imbalance

Gastrointestinal issues including:

Abdominal bloating and cramps or painful gas

Irritable Bowel Syndrome

Ulcerative Colitis

Crohn's Disease and other intestinal disorders

Respiratory Conditions including:

Chronic sinusitis

Asthma

Allergies

Autoimmune Conditions including:

Diabetes Mellitus

Lupus

Rheumatoid Arthritis

Fibromyalgia

Chronic Fatigue

Developmental and social concerns including:

Austism

ADD/ADHD

Skin Conditions: (urticaria)

Eczema

Skin rashes

Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

TYG Wellness Questionnaire	None	Mild	Moderate	Severe		None	Mild	Moderate	Severe
Constipation and/or diarrhea	0	1	2	3	Asthma, hayfever, or airborne allergies	0	1	2	3
Abdominal pain or bloating	0	1	2	3	Confusion, poor memory or mood swings	0	1	2	3
Mucous or blood in stool	0	1	2	3	Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3	History of antibiotic use	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3	Alcohol consumption makes you feel sick	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3	Ulcerative colitis or celiac's disease	0	1	2	3
Sinus or nasal congestion	0	1	2	3	Nausea	0	1	2	3
Chronic or frequent inflammations	0	1	2	3	Weight Trouble	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3					

YOUR TOTAL: _____