Nutritional Counseling

Alexander & Grenon CHIROPRACTIC CENTER, P.C.

Jeanne D. Alexander, M.S.,D.C.

Patient Information

Date:____/____/____ Name:____________________ S.S.#:____-____-____

Address:____________________ City:__________ State:____ Zip:______

Home Phone: ( )________ Work Phone: ( )________ Occupation:________

Name & Address of Employer:____________________

Age:____ Birth date:____/____/____ Height:____ Weight:____ Pregnant? ( ) Y ( ) N

Marital Status: M S W D Spouse's Name:____________ # of Children____

Who Referred You?:____________

Health Information

Have you had Nutritional Counseling Before? ( )Yes ( ) No

Please list the FIVE main Conditions you want addressed regarding Nutrition. *(In order of importance)*

1.)____________________

2.)____________________

3.)____________________

4.)____________________

5.)____________________

Please give a brief history of former treatments *(within 3 years)* for above complaints:____________

Do any of these conditions affect your work? ( ) Y ( ) N Your Family or Social Life? ( ) Y ( ) N

Have you had a medical diagnosis by a Medical Doctor? ( ) Y ( ) N Any recent Labs? ( ) Y ( ) N

If *Yes*, what was the diagnosis?____________

Are you taking any medications? ( ) Y ( ) N If *Yes*, list the medications:____________

Prior Surgery?____________

Date of your last physical examination by your primary care physician:____________

Health Checklist (Check any of the following you have had):

___Scarlet Fever	___Small Pox	___Pneumonia	___Cancer	___Goiter
___Diptheria	___Chicken Pox	___Stroke	___Yeast / Fungus	___Psorias
___Typhoid Fever	___Malaria	___Influenza	___Alcoholism	___Epilepsy
___Rheumatic Fever	___Tuberculosis	___Low Blood Sugar	___Venereal Disease	___Anemia
___Measles	___Polio	___Whooping Cough	___Diabetes	
___Mumps	___Arthritis	___Asthma	___Heart Disease	

Do You Currently Have Any:

___Headaches	___Gas / Bloating	___Circulatory Problems	___Sinus Trouble	___Depression
___Neck Pain	___Constipation	___High ___Low B.P.	___Earaches	___Fatigue
___Arm/Shoulder Pain	___Abdominal Problems	___Vaginal Discharge	___Poor Memory	___Insomnia
___Back Pain	___Digestive Problems	___Hot Flashes	___Dizziness	___Nervousnes
___Hip/Leg Pain	___Colitis	___Yeast / Fungus problems	___Numbness	___Allergies
___Swollen Joints	___Heart Trouble	___Kidney/Bladder problems	___Mental Disorder	___Overweight
___Loose Stool	___Heart Palpatation	___Lung/Bronchial problems	___Cold/Tingling Extremeties	

Habits: (Please mark with "F" –*frequent*, "M" –*moderate*, or "N" –*never*)

____Alcohol ____Drugs ____Tobacco ____Coffee ____Tea ____Sweets

Patient Agreement

Payment for services is expected at time of consultation. You understand that I provide nutritional consultation only. Insurance will not pay for nutritional consultation services; please do not ask us to fill out insurance claims forms.

Signature____________________ **Date:**____/____/____