

HOLISTIC HEALTH CHIROPRACTIC CENTER

9894 BISSONNET, SUITE 405 *HOUSTON, TX 77036 *281-948-6046 PHONE * 832-383-4896 FAX

PLEASE PRINT

PERSONAL INFORMATION

NAME _____ DATE _____

EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

CELL PHONE _____ SOC. SEC. NO. _____ DATE OF BIRTH _____

HOME PHONE _____ MARITAL STATUS _____ SEX _____ AGE _____ # OF CHILDREN _____

OCCUPATION _____ EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

NAME OF SPOUSE _____ SPOUSE'S OCCUPATION _____

EMPLOYER _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

EMERGENCY NOTIFICATION

NAME _____

ADDRESS _____ CITY/ZIP _____ TELEPHONE _____

REFERRED BY _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each session at the time of the session. I also agree to the \$20 returned check charge in the event that my check is returned.

Date _____ Patient's Signature _____

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PURPOSES

I hereby authorize Holistic Health Chiropractic to release any information required in the course of my examination or treatment necessary to satisfy medical insurance claims.

Date _____ Patient's Signature _____

CURRENT HEALTH CONDITION

PURPOSE OF THIS APPOINTMENT _____

HOW DID IT HAPPEN? _____

TODAYS CONDITION STARTED WHEN? _____

WHAT ACTIVITIES AGGRAVATE YOUR CONDITION? _____

WHAT ACTIVITIES LESSEN YOUR CONDITION? _____

IS CONDITION WORSE DURING CERTAIN TIMES OF THE DAY? _____

IS THIS CONDITION INTERFERING WITH WORK? _____ SLEEP? _____ ROUTINE? _____

IS CONDITION GETTING PROGRESSIVELY WORSE? _____

OTHER DOCTORS SEEN FOR THIS CONDITION _____

TYPE OF TREATMENT _____ RESULTS _____

Habits

- Alcohol: Type _____
Amount _____
- Diet: Salt intake _____
Fat intake _____
Other _____
- Sleep: Difficulty falling asleep _____
- Continuity disturbances _____
Early morning awakenings _____
Daytime drowsiness _____
Other _____
- Smoking: Packs daily _____
How long _____
Interested in stopping? _____
- Exercise routine: _____
- Caffeine: Coffee, cups daily _____
Other _____

MEDICATIONS: _____

DRUG ALLERGIES: _____

Medical History

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> RINGING IN EAR | <input type="checkbox"/> GALL BLADDER TROUBLE | <input type="checkbox"/> TREMOR/HANDS SHAKING | <input type="checkbox"/> MEASLES <input type="checkbox"/> RUBELLA <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> EAR INFECTIONS - FREQUENT | <input type="checkbox"/> JAUNDICE/HEPATITIS | <input type="checkbox"/> MUSCLE WEAKNESS | <input type="checkbox"/> SCARLET FEVER <input type="checkbox"/> TUBERCULOSIS <input type="checkbox"/> HERPES |
| <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> CHANGE IN BOWEL HABITS | <input type="checkbox"/> NUMBNESS/TINGLING SENSATIONS | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> FALLING VISION | <input type="checkbox"/> DIARRHEA <input type="checkbox"/> CONSTIPATION | <input type="checkbox"/> HEADACHES - FREQUENT | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> EYE INFECTIONS | <input type="checkbox"/> DIVERTICULOSIS <input type="checkbox"/> CROHN'S/COLITIS | <input type="checkbox"/> ARTHRITIS/RHEUMATISM | Females - Please Complete |
| <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> BLOODY OR TARRY STOOLS | <input type="checkbox"/> OSTEOPOROSIS | PREGNANT? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> SINUS TROUBLE | <input type="checkbox"/> HEMORRHOIDS | <input type="checkbox"/> BACK PAIN - RECURRENT | PLANNING PREGNANCY? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> SORE THROATS - FREQUENT | <input type="checkbox"/> HERNIA | <input type="checkbox"/> BONE FRACTURE/JOINT INJURY | Menstrual Flow: |
| <input type="checkbox"/> HAYFEVER/ALLERGIES | <input type="checkbox"/> URINE INFECTIONS - FREQUENT | <input type="checkbox"/> GOUT | <input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> Pain/Cramps |
| <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> BLOOD IN URINE | <input type="checkbox"/> FOOT PAIN <input type="checkbox"/> COLD NUMB FEET | Days of Flow _____ Length of Cycle _____ |
| <input type="checkbox"/> BRONCHITIS/CHRONIC COUGH | URINATION: <input type="checkbox"/> OVERNIGHT > THAN TWICE | <input type="checkbox"/> RASHES <input type="checkbox"/> HIVES | Date-1st day of last period _____ |
| <input type="checkbox"/> ASTHMA/WHEEZING | <input type="checkbox"/> PAINFUL <input type="checkbox"/> LOSS OF CONTROL | <input type="checkbox"/> PSORIASIS <input type="checkbox"/> ECZEMA | <input type="checkbox"/> Pain/Bleeding during or after sex |
| <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> DECREASE IN FORCE/FLOW | <input type="checkbox"/> NERVOUSNESS <input type="checkbox"/> DEPRESSION | Number of: _____ |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> MEMORY LOSS | Pregnancies _____ Abortions _____ |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> VENEREAL DISEASE | <input type="checkbox"/> MOODINESS - EXCESSIVE | Miscarriages _____ Live Births _____ |
| <input type="checkbox"/> SWOLLEN ANKLES | <input type="checkbox"/> URETHRAL DISCHARGE | <input type="checkbox"/> PHOBIAS | Birth Control Method _____ |
| <input type="checkbox"/> LEG PAIN - WALKING | <input type="checkbox"/> CHRONIC FATIGUE | <input type="checkbox"/> MENTAL ILLNESS | B.C. Pill (Name) _____ |
| <input type="checkbox"/> VARICOSE VEINS/PHLEBITIS | <input type="checkbox"/> WEIGHT LOSS - RECENT | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> Flushing/Menopause |
| <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> ANEMIA <input type="checkbox"/> BRUISE EASILY | <input type="checkbox"/> PROSTATE DISEASE | Date of Last PAP Test _____ |
| <input type="checkbox"/> DIFFICULTY SWALLOWING | <input type="checkbox"/> CANCER | <input type="checkbox"/> SEXUAL/MENSTRUAL DYSFUNCTION | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> INDIGESTION OR HEARTBURN | <input type="checkbox"/> DIABETES | <input type="checkbox"/> FREQUENT INFECTIONS | Date of Last Mammogram _____ |
| <input type="checkbox"/> PERSISTENT NAUSEA/VOMITING | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> DIPHTHERIA | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal |
| <input type="checkbox"/> PEPTIC ULCERS | <input type="checkbox"/> CONVULSIONS/SEIZURES | <input type="checkbox"/> TETANUS | |
| <input type="checkbox"/> ABDOMINAL PAIN - CHRONIC | <input type="checkbox"/> STROKE | <input type="checkbox"/> CHICKEN POX <input type="checkbox"/> POLIO <input type="checkbox"/> MUMPS <input type="checkbox"/> | |

HOSPITALIZATIONS:

Date	Reason	Date	Reason

FAMILY HISTORY

PLEASE GIVE THE FOLLOWING INFORMATION ABOUT YOUR IMMEDIATE FAMILY:

HAVE ANY BLOOD RELATIVES HAD THE FOLLOWING ILLNESSES? IF SO, PLEASE INDICATE RELATIONSHIP:

RELATIONSHIP	AGE IF LIVING	AGE AT DEATH	STATE OF HEALTH OR CAUSE OF DEATH	ILLNESS	FAMILY MEMBER
FATHER				DIABETES	
MOTHER				CANCER	
BROTHERS AND SISTERS				BLOOD DISEASE	
				GLAUCOMA	
				EPILEPSY	
SPOUSE				RHEUMATOID	
				ARTHRITIS	
CHILDREN				TUBERCULOSIS	
				GOUT	
				HIGH BLOOD PRESSURE	
				HEART DISEASE	
				BACK PROBLEMS	

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____
Birth Date ____ / ____ / ____ Approx Weight _____ Sex: Male Female
Pulse: Recumbent _____ Standing _____ Vegetarian Gluten-free
Blood pressure: Recumbent ____ / ____ Standing ____ / ____ Ragland's Test is Positive

INSTRUCTIONS: Fill in only the circles which apply to you.

- ○ ○ MILD symptoms (occurs rarely).
- ● ○ MODERATE symptoms (occurs several times a month).
- ○ ● SEVERE symptoms (occurs almost constantly)
- ○ ○ Leave circles **BLANK** if they don't apply to you!

1 2 3 GROUP 1

- 1 ○ ○ ○ Acid foods upset
- 2 ○ ○ ○ Get chilled often
- 3 ○ ○ ○ "Lump" in throat
- 4 ○ ○ ○ Dry mouth-eyes-nose
- 5 ○ ○ ○ Pulse speeds after meal
- 6 ○ ○ ○ Keyed up - fail to calm
- 7 ○ ○ ○ Gag occasionally
- 8 ○ ○ ○ Unable to relax; startles easily
- 9 ○ ○ ○ Extremities cold, clammy
- 10 ○ ○ ○ Strong light irritates
- 11 ○ ○ ○ Occasionally weak urine flow
- 12 ○ ○ ○ Heart pounds after retiring
- 13 ○ ○ ○ "Nervous" stomach
- 14 ○ ○ ○ Appetite reduced occasionally
- 15 ○ ○ ○ Cold sweats often
- 16 ○ ○ ○ Get heated easily
- 17 ○ ○ ○ Nerve discomfort
- 18 ○ ○ ○ Staring, blinks little
- 19 ○ ○ ○ Sour stomach frequent

GROUP 2

- 20 ○ ○ ○ Joint stiffness on arising
- 21 ○ ○ ○ Muscle-leg-toe cramps at night
- 22 ○ ○ ○ "Butterfly" stomach, cramps
- 23 ○ ○ ○ Eyes or nose watery
- 24 ○ ○ ○ Eyes blink often
- 25 ○ ○ ○ Eyelids swollen, puffy
- 26 ○ ○ ○ Indigestion soon after meals
- 27 ○ ○ ○ Always seems hungry; feels "lightheaded" often
- 28 ○ ○ ○ Digestion rapid
- 29 ○ ○ ○ Vomit occasionally
- 30 ○ ○ ○ Hoarseness frequent
- 31 ○ ○ ○ Uneven breathing
- 32 ○ ○ ○ Pulse slow
- 33 ○ ○ ○ Gagging reflex slow
- 34 ○ ○ ○ Difficulty swallowing
- 35 ○ ○ ○ Temporary constipation or diarrhea
- 36 ○ ○ ○ "Slow starter"
- 37 ○ ○ ○ Get "chilled"
- 38 ○ ○ ○ Perspire easily
- 39 ○ ○ ○ Sensitive to cold
- 40 ○ ○ ○ Upper respiratory challenges

GROUP 3

- 41 ○ ○ ○ Eat when nervous
- 42 ○ ○ ○ Excessive appetite
- 43 ○ ○ ○ Hungry between meals
- 44 ○ ○ ○ Irritable before meals
- 45 ○ ○ ○ Get "shaky" if hungry
- 46 ○ ○ ○ Fatigue, eating relieves
- 47 ○ ○ ○ "Lightheaded" if meals delayed
- 48 ○ ○ ○ Heart palpitates if meals missed or delayed
- 49 ○ ○ ○ Fatigue in afternoons
- 50 ○ ○ ○ Overeating sweets upsets

1 2 3

- 51 ○ ○ ○ Awaken after few hours sleep - hard to get back to sleep
- 52 ○ ○ ○ Crave candy or coffee in afternoons
- 53 ○ ○ ○ Moods of "blues" or melancholy
- 54 ○ ○ ○ Craving for sweets or snacks

GROUP 4

- 55 ○ ○ ○ Hands and feet go to sleep easily, numbness
- 56 ○ ○ ○ Sigh frequently, "air hunger"
- 57 ○ ○ ○ Aware of "breathing heavily"
- 58 ○ ○ ○ High altitude discomfort
- 59 ○ ○ ○ Opens windows in closed rooms
- 60 ○ ○ ○ Immune system challenges
- 61 ○ ○ ○ Afternoon "yawner"
- 62 ○ ○ ○ Get "drowsy" often
- 63 ○ ○ ○ Swollen ankles, worse at night
- 64 ○ ○ ○ Muscle cramps, worse during exercise; get "charley horses"
- 65 ○ ○ ○ Difficulty catching breath, especially during exercise
- 66 ○ ○ ○ Tightness or pressure in chest, worse on exertion
- 67 ○ ○ ○ Skin discolors easily after impact
- 68 ○ ○ ○ Tendency to anemia
- 69 ○ ○ ○ Noises in head, or "ringing in ears"
- 70 ○ ○ ○ Fatigue upon exertion

GROUP 5

- 71 ○ ○ ○ Dizziness
- 72 ○ ○ ○ Dry skin
- 73 ○ ○ ○ Burning feet
- 74 ○ ○ ○ Blurred vision
- 75 ○ ○ ○ Itching skin and feet
- 76 ○ ○ ○ Hair loss
- 77 ○ ○ ○ Occasional skin rashes
- 78 ○ ○ ○ Bitter, metallic taste in mouth in mornings
- 79 ○ ○ ○ Occasional constipation
- 80 ○ ○ ○ Worrier, feels insecure
- 81 ○ ○ ○ Nausea occasionally after eating
- 82 ○ ○ ○ Greasy foods upset
- 83 ○ ○ ○ Stools light colored
- 84 ○ ○ ○ Skin peels on foot soles
- 85 ○ ○ ○ Discomfort between shoulder blades
- 86 ○ ○ ○ Occasional laxative use
- 87 ○ ○ ○ Stools alternate from soft to watery
- 88 ○ ○ ○ Sneezing attacks
- 89 ○ ○ ○ Dreaming, nightmare type bad dreams
- 90 ○ ○ ○ Bad breath (halitosis)
- 91 ○ ○ ○ Milk products cause upset
- 92 ○ ○ ○ Sensitive to hot weather
- 93 ○ ○ ○ Burning or itching anus
- 94 ○ ○ ○ Crave sweets

GROUP 6

- 95 ○ ○ ○ Loss of taste for meat
- 96 ○ ○ ○ Lower bowel gas several hours after eating
- 97 ○ ○ ○ Burning stomach sensations, eating relieves
- 98 ○ ○ ○ Coated tongue
- 99 ○ ○ ○ Pass large amounts of foul-smelling gas
- 100 ○ ○ ○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 101 ○ ○ ○ Watery or loose stool
- 102 ○ ○ ○ Gas shortly after eating
- 103 ○ ○ ○ Stomach "bloating"

1 2 3 GROUP 7A

- 104 ○ ○ ○ Difficulty sleeping
- 105 ○ ○ ○ On edge
- 106 ○ ○ ○ Can't gain weight
- 107 ○ ○ ○ Intolerance to heat
- 108 ○ ○ ○ Highly emotional
- 109 ○ ○ ○ Flush easily
- 110 ○ ○ ○ Night sweats
- 111 ○ ○ ○ Thin, moist skin
- 112 ○ ○ ○ Inward trembling
- 113 ○ ○ ○ Heart races
- 114 ○ ○ ○ Increased appetite without weight gain
- 115 ○ ○ ○ Pulse fast at rest
- 116 ○ ○ ○ Eyelids and face twitch
- 117 ○ ○ ○ Irritable and restless
- 118 ○ ○ ○ Can't work under pressure

GROUP 7B

- 119 ○ ○ ○ Increase in weight
- 120 ○ ○ ○ Decrease in appetite
- 121 ○ ○ ○ Fatigue easily
- 122 ○ ○ ○ Ringing in ears
- 123 ○ ○ ○ Sleepy during day
- 124 ○ ○ ○ Sensitive to cold
- 125 ○ ○ ○ Dry or scaly skin
- 126 ○ ○ ○ Temporary constipation
- 127 ○ ○ ○ Mental sluggishness
- 128 ○ ○ ○ Hair coarse, falls out
- 129 ○ ○ ○ Tension in head upon arising wears off during day
- 130 ○ ○ ○ Slow pulse, below 65
- 131 ○ ○ ○ Changing urinary function
- 132 ○ ○ ○ Sounds appear diminished
- 133 ○ ○ ○ Reduced initiative

GROUP 7C

- 134 ○ ○ ○ Failing memory with age
- 135 ○ ○ ○ Increased sex drive
- 136 ○ ○ ○ Episodes of tension in head
- 137 ○ ○ ○ Decreased sugar tolerance

GROUP 7D

- 138 ○ ○ ○ Abnormal thirst
- 139 ○ ○ ○ Bloating of abdomen
- 140 ○ ○ ○ Weight gain around hips or waist
- 141 ○ ○ ○ Sex drive reduced or lacking
- 142 ○ ○ ○ Tendency for stomach issues
- 143 ○ ○ ○ Immune system challenges
- 144 ○ ○ ○ Menstrual disorders

GROUP 7E

- 145 ○ ○ ○ Dizziness
- 146 ○ ○ ○ Headaches
- 147 ○ ○ ○ Hot flashes
- 148 ○ ○ ○ Hair growth on face or body (female)
- 149 ○ ○ ○ Sugar in urine (not diabetes)
- 150 ○ ○ ○ Masculine tendencies (female)

GROUP 7F

- 151 ○ ○ ○ Weakness, dizziness
- 152 ○ ○ ○ Tired throughout day
- 153 ○ ○ ○ Nails weak, ridged
- 154 ○ ○ ○ Sensitive skin
- 155 ○ ○ ○ Stiff joints
- 156 ○ ○ ○ Perspiration increase
- 157 ○ ○ ○ Bowel discomfort
- 158 ○ ○ ○ Poor circulation
- 159 ○ ○ ○ Swollen ankles
- 160 ○ ○ ○ Crave salt
- 161 ○ ○ ○ Areas of skin darkening
- 162 ○ ○ ○ Upper respiratory sensitivity
- 163 ○ ○ ○ Tiredness
- 164 ○ ○ ○ Breathing challenges

1 2 3 GROUP 8

- 165 ○ ○ ○ Muscle weakness
- 166 ○ ○ ○ Lack of Stamina
- 167 ○ ○ ○ Drowsiness after eating
- 168 ○ ○ ○ Muscular soreness
- 169 ○ ○ ○ Heart races
- 170 ○ ○ ○ Hyperirritable
- 171 ○ ○ ○ Feeling of a band around your head
- 172 ○ ○ ○ Melancholia (feeling of sadness)
- 173 ○ ○ ○ Swelling of ankles
- 174 ○ ○ ○ Change in urinary function
- 175 ○ ○ ○ Tendency to consume sweets or carbohydrates
- 176 ○ ○ ○ Muscle spasms
- 177 ○ ○ ○ Blurred vision
- 178 ○ ○ ○ Involuntary muscle action
- 179 ○ ○ ○ Numbness
- 180 ○ ○ ○ Night sweats
- 181 ○ ○ ○ Rapid digestion
- 182 ○ ○ ○ Sensitivity to noise
- 183 ○ ○ ○ Redness of palms of hands and bottom of feet
- 184 ○ ○ ○ Visible veins on chest and abdomen
- 185 ○ ○ ○ Hemorrhoids
- 186 ○ ○ ○ Apprehension (feeling that something bad will happen)
- 187 ○ ○ ○ Nervousness causing loss of appetite
- 188 ○ ○ ○ Nervousness with indigestion
- 189 ○ ○ ○ Gastritis
- 190 ○ ○ ○ Forgetfulness
- 191 ○ ○ ○ Thinning hair

FEMALE ONLY

- 192 ○ ○ ○ Very easily fatigued
- 193 ○ ○ ○ Premenstrual tension
- 194 ○ ○ ○ Menses more painful than usual
- 195 ○ ○ ○ Depressed feelings before menstruation
- 196 ○ ○ ○ Painful breasts during menses
- 197 ○ ○ ○ Menstruate too frequently
- 198 ○ ○ ○ Hysterectomy / ovaries removed
- 199 ○ ○ ○ Menopausal hot flashes
- 200 ○ ○ ○ Menses scanty or missed
- 201 ○ ○ ○ Acne, worse at menses

MALE ONLY

- 202 ○ ○ ○ Less involved in exercise/social activities
- 203 ○ ○ ○ Difficult to postpone urination
- 204 ○ ○ ○ Weak urinary stream
- 205 ○ ○ ○ Feeling of "blues" or melancholy
- 206 ○ ○ ○ Feeling of incomplete bowel evacuation
- 207 ○ ○ ○ Lack of energy
- 208 ○ ○ ○ Muscles in arms and legs seem softer/smaller
- 209 ○ ○ ○ Tire too easily
- 210 ○ ○ ○ Avoids activity
- 211 ○ ○ ○ Leg nervousness at night
- 212 ○ ○ ○ Diminished sex drive

List the five main complaints you have in the order of their importance:

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

RESTRICTIONS ON USE

THE SYSTEMS SURVEY IS TO BE USED ONLY BY TRAINED HEALTH CARE PRACTITIONERS. IF YOU ARE A PATIENT, YOU SHOULD NOT USE THE SYSTEMS SURVEY. IF YOU ARE NOT A TRAINED HEALTH CARE PRACTITIONER, YOU SHOULD NOT USE THE SYSTEMS SURVEY. HEALTH CARE PRACTITIONERS SHOULD ONLY USE THE SYSTEMS SURVEY TO PROVIDE SERVICES THAT ARE WITHIN THE SCOPE OF THEIR LICENSE OR PROFESSIONAL TRAINING. THE SYSTEMS SURVEY IS NOT INTENDED TO DIAGNOSE ANY DISEASE. THE SYSTEMS SURVEY IS INTENDED TO BE USED AS A HELPFUL TOOL FOR HEALTH CARE PRACTITIONERS IN COLLECTING INFORMATION CONCERNING THE HEALTH AND WELLNESS OF PATIENTS.