Caruso Chiropractic

Lake Orion, MI

Client Information Sheet

(Please print clearly)

Date: ________________ **Name:** ________________________________

Phone: ________________ **Birthdate:** ________________________

Address: ____________________________________ **Marital status:** __________

____________________________________ **# of children:** __________

____________________________________ **Blood Type:** __________

Major complaint: ____

____

Please mark (X) all conditions that apply now. (P) for past conditions, and (F) for family history or illness:

_____ low energy, fatigue	_____ low appetite	_____ constipation, diarrhea
_____ headaches, migraines	_____ increased appetite	_____ diarrhea
_____ backache	_____ hiatal hernia	_____ cold hands/feet
_____ muscle soreness	_____ sexual dysfunction	_____ swollen/painful joints
_____ acid reflux/heartburn	_____ pregnant	_____ frequently sick
_____ heart, circulatory issues	_____ menstrual cramps	_____ insomnia
_____ high blood pressure	_____ allergies, sensitivities	_____ diabetes
_____ low blood pressure	_____ gas/bloating	_____ overweight
_____ depression	_____ asthma, lung conditions	_____ underweight
_____ acne	_____ cancer, tumors	_____ varicose veins
_____ high/low BP	_____ chronic pain	_____ high cholesterol
_____ depression	_____ memory issues	_____ skin issues
_____ tension, stress	_____ muscle, bone injuries	_____ other conditions not listed

Please specify any concerns from your doctor: ______________________________

____

Current medications	**For what?**	**How long taking it?**
____________________	____________________	________________
____________________	____________________	________________
____________________	____________________	________________
____________________	____________________	________________

Surgeries: ____

____

Forms and level of exercise, hobbies, stress reduction activities:

____

Please list any herbs, vitamins or other supplements you take: ____________________

____

____

Any major changes in your diet in the last four months? ______ **If yes, please explain** ______

____

Frequency of bowel movements: (how many daily, weekly etc): ____________________

____

Which of the following do you do?

How often and how much?

_____ **smoke** ____________________

_____ **alcohol** ____________________

_____ **pop** ____________________

_____ **food cravings** ____________________

Important: By signing below, I understand that the suggested nutritional program and dietary information is not intended as primary therapy for any disease or symptom. My intention is to find a good nutritional program that will assist me in changing my habits and establishing a new lifestyle in order to build good health naturally. I understand that this dietary health program is not for the diagnosis, cure, mitigation, treatment, or prevention of disease; this is an adjunctive schedule of nutrients solely provided to upgrade the quality of foods in my diet in order to supply good nutrition for supporting the physiological and biochemical processes of the human body.

I understand that the naturopathic doctor I am visiting is not a medical doctor and does not treat or diagnose medical conditions; that this is not a replacement for medical counseling; that if I have a medical condition, I will see a qualified medical professional.

It understand that it is my personal decision whether or not to follow the natural health suggestions offered.

____________________ ____________________

Signature **Date**