

TOTAL HEALTH SYSTEMS

Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

Clinton Township • (586) 228-0270 ♦ Chesterfield • (586) 949-0123
TotalHealthSystems.com

PATIENT INFORMATION (OFFICE USE) Ins Code _____ Patient ID _____ DR. _____

Please give your Driver's license and insurance card to the front desk so they can make a copy for your records.

Patient Name: Last _____ First _____ Date ____/____/____

Address _____ City _____ State _____ Zip _____

Phone (____) _____ - _____ Driver's License # _____ Birthdate ____/____/____ Age _____

Sex: ___M___F Patient Soc. Sec. # _____ - _____ Marital Status S M D W Children # _____

Spouse's Name _____ Person responsible for payment _____

Patient employed by _____ Occupation _____

Work phone (____) _____ - _____ Referred by _____ E-mail _____

CURRENT COMPLAINTS / HEALTH GOALS: _____

HEALTH HISTORY

Please indicate whether the following applies to the "I" Individual, "F" Family Member, or "B" Both.

| | | | |
|--|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neck Pain |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Dislocated Joints | <input type="checkbox"/> Hip Pain | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dizziness | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Painful Urination |
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Duodenum Ulcer | <input type="checkbox"/> Hypertension | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hyperthyroidism | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Aortic Aneurysm | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> Profuse Menstruation |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Esophageal Cancer | <input type="checkbox"/> Irregular Bowel Habits | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Irregular Menstruation | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Blood Disorder | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rapid Heart Rate |
| <input type="checkbox"/> Bone Cancer | <input type="checkbox"/> Gouty Arthritis | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Rectum Cancer |
| <input type="checkbox"/> Brain Cancer | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Knee Pain | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Breast Soreness | <input type="checkbox"/> Headaches | <input type="checkbox"/> Leg Pain | <input type="checkbox"/> Shoulder Pain |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Heart Attacks | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Bulimia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spinal Disc Disorder |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Lower Back Pain | <input type="checkbox"/> Stomach Cancer |
| <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Migraine | |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Hernias | <input type="checkbox"/> Multiple Sclerosis | |

Patient Smokes: 2+ Packs per day 2 Packs per day 1 Pack per day ½ Pack per day or less
 Never Quit (how long ago) _____

Patient uses alcohol: Excessively Moderately Occasionally Rarely Never Quit

Please list any previous injuries and/or accidents with date _____

Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications)

Past Hospitalizations (Indicate date, reason for hospitalization, and Complications)

Please list all Current Medications and Supplements: _____

WEIGHT LOSS GOALS & HISTORY

If you want to lose weight, how much weight do you want to lose?

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> 5-10 lbs | <input type="checkbox"/> 30-40 lbs |
| <input type="checkbox"/> 10-20 lbs | <input type="checkbox"/> 40-50 lbs |
| <input type="checkbox"/> 20-30 lbs | <input type="checkbox"/> 50lbs. + |

What would you consider your ideal weight to be? _____ lbs.

In your own words, would you describe your body as:

- | | |
|---------------------------------|---------------------------------------|
| <input type="checkbox"/> Loose | <input type="checkbox"/> Toned |
| <input type="checkbox"/> Flabby | <input type="checkbox"/> Strong |
| <input type="checkbox"/> Skinny | <input type="checkbox"/> Other: _____ |

Do you gain weight easily? Y N

Lose weight easily? Y N

Do you usually regain the weight you have lost on a diet? Y N

How long have you kept the weight off, after having lost it?

- | | |
|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> 1 month | <input type="checkbox"/> 6-12 months |
| <input type="checkbox"/> 2 months | <input type="checkbox"/> Over a year. |
| <input type="checkbox"/> 3-6 months | |

EATING HABITS

Check if you eat, drink or use:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> Coffee /Tea | <input type="checkbox"/> Soda/Pop | <input type="checkbox"/> Artificial Sweeteners |
| <input type="checkbox"/> Processed Meats | <input type="checkbox"/> Salt | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Refined sugars | <input type="checkbox"/> Fried Foods | |
| <input type="checkbox"/> Candy | <input type="checkbox"/> Margarine | |

Describe your daily water intake:

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> 2-4 glasses | <input type="checkbox"/> 8-10 glasses |
| <input type="checkbox"/> 4-6 glasses | <input type="checkbox"/> 10 or more |
| <input type="checkbox"/> 6-8 glasses | |

What other liquids do you drink regularly?

- | | | |
|-------------------------------------|---------------------------------|----------------------------------|
| <input type="checkbox"/> Soda | <input type="checkbox"/> juices | <input type="checkbox"/> alcohol |
| <input type="checkbox"/> diet sodas | <input type="checkbox"/> milk | <input type="checkbox"/> others |
| <input type="checkbox"/> coffee | <input type="checkbox"/> tea | |

How many cups of coffee/tea/diet soda do you drink each day?

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> 2-4 glasses | <input type="checkbox"/> 8-10 glasses |
| <input type="checkbox"/> 4-6 glasses | <input type="checkbox"/> 10 or more |
| <input type="checkbox"/> 6-8 glasses | |

Do you monitor your salt intake? __yes __no

Do you avoid foods with additives or preservatives? __yes __no

Do you feel "over-full" or uncomfortable after meals? _____

How many times do you eat each day (including snacks)?

- | | |
|------------------------------------|--|
| <input type="checkbox"/> 5-7 times | <input type="checkbox"/> 1-3 times |
| <input type="checkbox"/> 3-5 times | <input type="checkbox"/> less than twice a daily |

When do you usually eat your last meal?

- | | |
|--------------------------------|---|
| <input type="checkbox"/> 3-6pm | <input type="checkbox"/> 9-12am |
| <input type="checkbox"/> 6-9pm | <input type="checkbox"/> after midnight |

Are you hungry shortly after you eat? __yes __no __sometimes

MERIDIAN ASSESSMENT

Please use the following key to indicate your responses to the following questions:

1= Never 2=Rarely 3=Sometimes 4=Frequently 5= Daily

Mark only one answer for each question.

| Meridian | Question | Rating |
|------------|---|--------|
| LY | Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.? | |
| LU | Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.? | |
| LI | Do you experience bouts of diarrhea or constipation, gas, bloating, etc.? | |
| NE | Do you experience irritability, nervousness, trembling, anxiety, or memory problems? | |
| CI | Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.? | |
| AL | Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.? | |
| OR | Do you have slow metabolism, are you always hungry, have low energy at specific times of day? | |
| TW | Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.? | |
| HT | Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.? | |
| SI | Do you have recurrent yeast infections, frequent antibiotic use, poor diet gas, bloating, etc.? | |
| GV | Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.? | |
| PA | Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.? | |
| SP | Do you experience chronic fatigue, recurring infections, lowered immune response, etc.? | |
| LV | Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.? | |
| JO | Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.? | |
| ST | Do you experience digestive disturbances, acid reflux, burping or upper digestive bloating meals, etc.? | |
| FI | Do you have fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise, etc.? | |
| SK | Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis, etc.? | |
| FA | Do you have lipomas, degenerative liver disease, breast tumors, problems burning fat, etc.? | |
| GB | Do you have a history of gallstones, discomfort after eating rich foods low fat metabolism, etc.? | |
| CV | Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders, etc.? | |
| KI | Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.? | |
| UB | Do you have recurring infections, itching or yeast problems, painful urination, "leaking", etc.? | |
| Female | Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, hot flashes, menopausal symptoms, etc.? | |
| Male | Do you experience urinary discomfort, frequency of urination, etc.? | |
| Teeth | Do you have sensitive teeth or experience pain or discomfort in the teeth, gums, or jaw region? | |
| Stress | Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments? | |
| Energy | Do you lack motivation, drive, perseverance, stamina, or endurance? | |
| Well-Being | Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life? | |
| Immune | Are you susceptible to infections, allergies, or sensitive to pollution, or work environment? | |