

# 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 \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: (cell) \_\_\_\_\_ (work) \_\_\_\_\_

### 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"/> Hypertthyroidism	<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"/> Prostaté 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 pervious injuries and/or accidents with dates:  
\_\_\_\_\_  
\_\_\_\_\_

Please list any previous surgeries and/or treatment for injuries with dates:  
\_\_\_\_\_  
\_\_\_\_\_

Please list all Current Medication and Supplements with Dosages:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## WEIGHT LOSS GOALS & HISTORY

What are you short term health goals with this program (1-3 months)?

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What are you long term health goals with this program (3-12 months)?

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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 |                                       |

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## 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)?

- 5-7 times
- 3-5 times

- 1-3 times
- less than twice a daily

When do you usually eat your last meal?

- 3-6pm
- 6-9pm

- 9-12am
- after midnight

Are you hungry shortly after you eat? \_\_yes \_\_no \_\_sometimes

Do you get sleepy during the day? \_\_yes \_\_no \_\_sometimes

If so, When?

- 8am- noon
- 1-4pm

- 4-8pm

How many hours of sleep do you get a night?

- 2-4
- 4-6
- 6-8

- 8-10
- 10-12

Do you ever get shaky? \_\_yes \_\_no

What foods do you crave?

- fats
- sugars
- chocolate

- salts
- alcohol
- bread

- pastry
- dairy
- carbohydrates

Do you have to eat out frequently for business reasons? \_\_yes \_\_no

Do you eat when you are:

- Depressed
- Stressed
- happy

- not hungry
- frustrated

How would you rate your metabolism?

- Sluggish
- Slow

- Medium
- fast

Are you allergic to any of the following foods?

- seafood
- nuts
- wheat

- dairy
- grains
- corn

- fruit
  - sugars
  - other:
-

# EXERCISE HABITS

Are you currently following an exercise program? \_\_Yes \_\_No

Briefly describe you exercise program. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have been consistently following an exercise program? \_\_\_\_\_

How many days a week can you commit to an exercise routine? \_\_\_\_\_

How much time can you commit each day to your workout? \_\_\_\_\_

What kind of exercise do you enjoy? Dislike? \_\_\_\_\_

Do you have any experience with using a Heart Rate Monitor? \_\_\_\_\_

What type of cardio exercise do you enjoy? Dislike? \_\_\_\_\_  
\_\_\_\_\_

Do you have any experience with resistance training? Briefly describe \_\_\_\_\_  
\_\_\_\_\_

Have you ever worked with a personal trainer? Briefly describe your experience. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What hobbies and or special interests do you enjoy? \_\_\_\_\_  
\_\_\_\_\_

What time do you usually work out?

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

Do you stretch before working out? \_\_\_yes \_\_\_no

What is your daily activity level?

- |                                   |                                      |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Low      | <input type="checkbox"/> Medium      |
| <input type="checkbox"/> Moderate | <input type="checkbox"/> very active |
-