INITIAL NERVE SYSTEM PROFILE

When was your most recent auto accident? _____Speed ? _____

Does your job require you remain in long term stressful postures? Y/N Describe_____

Spinal traumas in the past? Sports, job, or as a child, etc _____

INITIAL NUTRITIONAL PROFILE

Have you tested with High triglycerides (Y / N) High cholesterol? (Y / N) or High blood pressure? (Y / N)

Are you diabetic? Have you been diagnosed as pre-diabetic or with metabolic syndrome? (Y / N)

How many fast food, refined foods, or pre-pared meals do you eat per week? (0) (1-3) (4-6) (7+)

How many servings of fruit do you have per day? (0-1) (2-3) (4+) vegetables (0-1) (2-3) (4-5)

Do you regularly drink (1 or more per day) any of the following? (circle all that apply)
Diet Soda Coffee Juice Milk Soda Alcohol

INITIAL FITNESS PROFILE

How many times per week do you exercise? Cardiovascular ___Hours ___Days/Wk
Weight Training ___Hours ___Days/Wk Low Impact (Yoga, etc.) ___Hours ___Days/Wk

What is your target weight? _____What is your current weight? _____

How willing are you to change any of these things to reach your health goals? ***(Scale of 1-10)*** **_____**

INITIAL TOXICITY PROFILE

Are you regularly exposed to cleaning products or industrial chemicals? (Y / N)

Have you ever noticed mold growing in your home or your place of work? (Y / N)

Have you received a full standard profile of vaccinations? (Y / N)

Do you receive yearly flu shots? (Y / N) How many flu shots have you received? _____ (estimate)

Family members diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities? (Y / N)

INITIAL STRESS PROFILE

Average hours of sleep per night _____ Do you ever take pills to go to sleep or relax? (Y/N)

Do you experience feelings of anxiety about completing tasks? (Y / N)

Do you feel you don't give enough time/attention to areas in your life like family, personal growth, or a hobby? (Y / N)

Patient Signature _____Date_____HR_____

Doctor Signature _____Date_____JDD, DC 5/2011