EVALUATION FORM

PART 1: GENERAL INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIPCODE _____

PHONE NUMBER ____-_____-_____ EMAIL_____

CELL PHONE NUMBER ____-_____-_____ DATE OF BIRTH _____

AGE _____ OCCUPATION _____ REFERRED BY _____

PART 2: HEALTH HISTORY

	Abnormal Bleeding		Vascular Disease		Lyme Disease
	Pneumonia		Tuburculosis		Irritable Bowel Syndrome
	Cancer		Polio		Chron's Disease
	Ulcer		Back/Neck Injuries		Skin Conditions
	High Blood Pressure		Hepatitis E		Environmental Allergies
	Arthiritis		ADD/ADHD		Chemical Sensitivities
	Osteoporosis		Fibromyalgia		Other (List Below)
	AIDS/HIV Positive		Developmental Delay		
	Liver Disease		Chronic Fatigue		
	Anxiety		Depression		

PLEASE LIST YOUR MAJOR HEALTH CONCERNS IN ORDER OF IMPORTANCE:

_____

_____

_____

_____

_____

_____

_____

Joy Feldman
JHF NUTRITIONAL CONSULTING

Wickford Chiropractic and Wellness Center
610 Ten Rod Road
North Kingstown, RI 02852
401-855-8800

PLEASE LIST YOUR MAJOR HEALTH GOALS IN ORDER OF IMPORTANCE:

PLEASE LIST ALL MEDICATION YOU ARE CURRENTLY TAKING

DO YOU SMOKE? IF SO, HOW MANY PACKS PER DAY?

DO YOU HAVE A HIGH LEVEL OF STRESS?

DO YOU SLEEP WELL AT NIGHT? HOW MANY HOURS PER NIGHT DO YOU SLEEP?

HOW MUCH WATER DO YOU CONSUME PER DAY?

DO YOU CRAVE CERTAIN FOODS? IF SO WHAT ARE THEY?

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH YOU'D LIKE TO SHARE WITH ME?

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PLEASE TELL ME ABOUT YOUR TYPICAL DIET AND MEALS YOU HAVE AT BREAKFAST, LUNCH AND DINNER

BREAKFAST	LUNCH	DINNER

WHAT TYPES OF SNACKS DO YOU HAVE MID-MORNING AND MID-AFTERNOON?

ARE YOU CONSTIPATED OR HAVE LOOSE BOWL MOVEMENTS? HOW OFTEN DO YOU HAVE BOWEL MOVEMENTS PER DAY?

PLEASE LIST ALL NUTRITIONAL SUPPLEMENTS YOU ARE CURRENTLY TAKING

WHAT TYPE OF EXERCISE DO YOU DO? HOW MANY TIMES PER WEEK DO YOU EXERCISE?

IS THERE ANYTHING ELSE ABOUT YOUR HEALTH YOU WOULD LIKE TO SHARE WITH ME?

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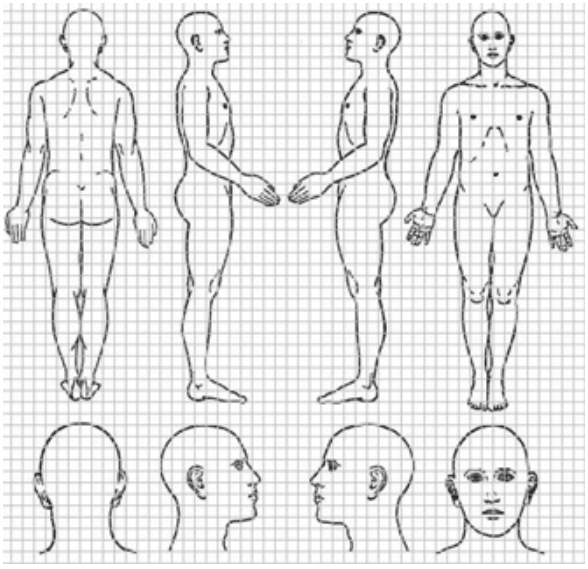
DO YOU HAVE ANY PAIN IN YOUR BODY?
IF YES PLEASE DESCRIBE WHERE THE PAIN IS
AND LOCATE THE PAIN ON THE DIAGRAM:



PHYSICIAN'S NAME _____

OFFICE ADDRESS _____

CITY _____

STATE _____

ZIP CODE _____

PHONE NUMBER _____

I request that Joy Feldman perform a nutritional evaluation and set up a diet and supplement program for the purpose of enhancing health and improving well being. I understand that nutritional analysis is a means to reduce stress by identifying and correcting nutritional deficiencies and imbalances. It is not intended as diagnosis, treatment or prescription for any mental or physical disease.

SIGNATURE _____ DATE _____

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CIRCLE any conditions or symptoms that presently describe you.

PLACE A STAR next to the symptoms most important to you.

Joint Pain
Joint Stiffness
Arthritis, Otheo
Arthritis, Rhuematoid
Muscle Pain
Muscle Weakness
Muscle Cramps
Bursitis
Fractures
Osteoporosis
Gout
Sweet Cravings
Sugar Reactions
Irritable Before Meals
Can't Skip Meals
Hypoglycemia
Crave Starches
Fat Cravings
Other Food Cravings
Food Allergies
Excessive Hunger
No Hunger
Diabetes
Rapid Heart Rate
Skipped Heart Beats
Heart Palpitations
Heart Attack
Poor Circulation
Dizziness
Low or High Blood Pressure
Angina
Arteriosclerosis
High Cholesterol
High Triglycerides
Cough
Bronchitis
Asthma
Post-Nasal Drip
Sinus Congestion
Allergies
Emphysema
Fatigue
Hypothyroidism
Low Body Temperature
Cold in Winter/Dry skin
Tend to gain weight
Hyperthyroidism
Acne
Eczema
Fungal Infections/Candida
Psoriasis
Hives
Hair Loss
Slow Wound Healing
Cataracts
Glaucoma
Meniere's Disease
Tooth Decay
Excessive Plaque on teeth
Gum Disease
Infections/Viruses
Tumors/Cancer
Multiple Sclerosis
Parkinson's Disease
Scleroderma
Anger
Anxiety
Bipolar Disorder
Brain Fog
Confusion
Depression
Irritability
Mind Races
Mood Swings
Obsessive/Compulsive
Panic Attacks
Poor Memory
Schizophrenia
Trouble Sleeping
Autism
Attention Deficit
Hyperkinesis
Dyslexia
Seizures
Learning Disability
Mental Retardation
Delayed Development
Bladder Infections
Kidney Infections
Trouble Urinating
Frequent Urination
Painful Urination
Kidney Stones
Water Retention
Sinus Headaches
Tension Headaches
Migraine Headaches
Neuritis
Constipation
Diarrhea
Intestinal Gas
Bloating
Heartburn
Ulcer
Stomach Pain
Colitis
Gall Stones
Fissures
Hemorrhoids
Cirrhosis
Diverticulitis
Tend to Gain Weight
Tend to Lose Weight
Anemia
Easy Bruising
Drug Addiction
Alcoholism
Smoking

WOMEN:

Premenstrual Syndrome
Water Retention
Cramps
No Menstruation
Heavy Periods
Light/Irregular Periods
Ovarian Cysts
Fibroid Tumors
Abnormal Pap Smear
Menopause
Fibrocystic Breasts
Breast Tumors
Yeast Infections
Hot Flashes

MEN:

Prostate Problems
Impotence
Infertility