Account Number: [ ]

METABOLIC HEALTH INTAKE

PATIENT DEMOGRAPHICS

Name: ______________________ Birth Date: _____ /_____ /______ Sex: ☐ Male ☐ Female

Address: ______________________ City: ______________ State: __________ Zip: __________

E-mail Address: ______________________________ Phone#: ____________________

Social Security#: __________________ Height: _____ft. _____in. Weight: ______________ lbs.

Emergency Contact Name/ Number: ____________________ /__________ Relationship: ________

How did you hear about our program? ____

HEALTH CONCERNS

Primary Concern: ______________________ Secondary Concern: ______________________

On a scale of **0** to **10** with **ZERO** being none at all and **TEN** being the worst possible, please rate your above concerns by ***checking the box:***

Primary concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

Second concern is: 0☐ 1☐ 2☐ 3☐ 4☐ 5☐ 6☐ 7☐ 8☐ 9☐ 10☐

When did the problem(s) begin? ______/______/___________

PREVIOUS HISTORY

Have you experienced these same issues in the past? ☐Yes ☐No **If yes,** how long have you been dealing with them? ______

Have you tried other treatments in the past? ☐ Yes ☐ No **If yes,** please list all health professionals you have seen: _______

Please list any and all products, procedures, medications, or supplements you have tried prior to now for this condition: ______

QUALITY OF LIFE QUESTIONNAIRE

How has your health condition(s) affected your job? Your finances? Your relationships? Your family? Your hobbies or other activities? Please give examples:

What has that ended up costing you? (Time, Money, Freedom, Sleep, Promotions, Happiness, etc.) Please give examples:

What are you most concerned about regarding your condition?

Where do you see yourself in the next 1-3 years if this problem is not taken care of? Please be specific:

What would instantly be different or better about your life if we could take this problem away immediately?

What do you desire most to get from working with us?

CURRENT MEDICATIONS/SUPPLEMENTS

Please list all medications, drugs, and supplements you currently take, the dosage, and the reason you take them:

☐ Separate List Attached

Medication/Product	Dosage	Reason You Take Them	Date Started

CELL BLUEPRINT QUESTIONNAIRE

Answer the following questions on a scale of “0” (least/never/zero symptoms). “1” (minor, mild, rarely, monthly), “2” (moderate, occasionally, weekly), to “3” (most, severe, frequently, daily). Take your time and be honest with the answers; the more accurate you are, the better you will understand which systems are a priority for you.

Category 1	0	1	2	3
Crave sweets and/or carbohydrates				
Crave sweets after meals				
Frequent thirst				
Feel tired after meals				
Blurred vision				
TOTAL				

Category 2	0	1	2	3
Shaky and irritable between meals				
Eating energizes me and/or relives fatigue				
Often wake up during the night				
Fatigue, fuzzy thinking, headaches between meals				
Anxiety and palpitations				
TOTAL				

Category 3	0	1	2	3
Bleeding gums or nosebleeds, or easily bruised				
Muscle fatigue or excessive soreness after exercise				
Tingling in hands or feet, and/or cracks in the corner of the mouth				
Restless legs and/or muscle cramping/ twitching				
Dry/scaly skin and/or bumps on the back of the arms				
TOTAL				

Category 4	0	1	2	3
Feel tired, fatigued, or weak				
Experience shortness of breath				
Coldness in hands and feet, or “poor circulation”				
Experience a rapid, or irregular, heart beat				
Dizziness or lightheadeness				
TOTAL				

Category 5	0	1	2	3
Anxiety, moodiness, irritability				
Negativism, combativeness				
Fatigue, weakness, daydreaming				
Confusion, impaired judgement				
Fasting is difficult and uncomfortable				
TOTAL				

Category 6	0	1	2	3
GI symptoms (diarrhea, constipation, heart burn, digestive enzyme)				
Musculoskeletal symptoms (exercise intolerance, weakness, cramping)				
Neurological symptoms (mood, migraines, balance coordination)				
Sensory symptoms (visual, hearing)				
Generalized fatigue or easy to fatigue				
TOTAL				

Category 7	0	1	2	3
Bloating shortly after a meal				
Experience heartburn, or use antacids				
Excessive belching or burping				
Sensitive to a number of foods				
Indigestion or nausea after eating				
TOTAL				

Category 8	0	1	2	3
Excessive and/or foul-smelling gas				
Lower abdominal bloating relieved by gas				
Constipation, diarrhea, both (circle which apply)				
History of antibiotic use				
History of laxative use				
TOTAL				

Category 9	0	1	2	3
Nausea or diarrhea from high-fat foods				
“Greasy” stool that tends to float				
Sensitive to caffeine, alcohol, and/or other synthetic chemicals				
General itchiness, or itchy palms				
Gall bladder removed: **Yes (3) No (0)**				
TOTAL				

Category 10	0	1	2	3
Sensitive to the smell of gasoline, paint, cleaning products, perfumes, or other fragrances				
I live, or work near, heavy traffic, industrial pants, farms, or electricity, or cell phone, towers				
Chronic airways issues including nasal congestion, mucous production, or throat or nasal irritation				
Chronic headaches, muscle or joint stiffness or pain, or skin issues (circle which apply)				
Exposure to chemicals, i.e. synthetic fabrics, tap water, cosmetics, cleaning products, and processed foods				
TOTAL				

Category 11	0	1	2	3
Less than 6 hours of sleep a night, disrupted sleep, or sleep, or sleep at abnormal hours				
Routinely consume canola, corn or safflower oil				
Experience chronic psychological stress				
Physical inactivity				
Have ever been diagnosed with elevated iron				
TOTAL				

Category 12	0	1	2	3
Joint pain and swelling				
Skin problems, rashes				
Sudden onset of symptoms, which have progressively worsened over time				
Swollen glands and/or sore, achy muscles				
Family history of autoimmunity				
TOTAL				

Category 13	0	1	2	3
Chronic pain and/or lasting fatigue				
Unrefreshing sleep				
Extreme fatigue after exertion				
persistent mental/emotional challenges				
Frequent headaches and/or pain				
TOTAL				

Category 14	0	1	2	3
Constipation, diarrhea, gas, or IBS				
Difficulty falling asleep or staying asleep				
Skin irritations, rash, hives, eczema				
Often hungry or unsatisfied after meals				
History of allergies and/or asthma				
TOTAL				

Category 15	0	1	2	3
Red, Itchy, or flaky skin				
Visual changes				
Headaches, “spaciness”, or neurological deficits				
History of antibiotic use				
History of jock itch, athlete’s foot, toe nail fungus, or other yeast infection				
TOTAL				

Category 16	0	1	2	3
Difficult time getting going in the morning				
Difficulty falling asleep, a “night person”				
Feel “wired and tired”				
Perspire easily, even with minimal activity				
Elevated blood pressure				
TOTAL				

Category 17	0	1	2	3
Crave salt or liberally salt food				
Lightheaded when standing up quickly				
Difficult staying asleep				
Low blood pressure				
Fatigue and/or depression				
TOTAL				

Category 18	0	1	2	3
Tendency to be cold, especially hands and feet				
Difficulty losing weight				
Low energy, or tired all the time				
Brain fog, mental sluggishness				
Dry skin, brittle nails, hair loss				
TOTAL				

Category 19 (Males)	0	1	2	3
Decreased libido				
Decrease in morning erections or strength in erections				
Decreased enjoyment in life				
Decreased strength and/or endurance				
Difficulty building or maintaining muscle				
TOTAL				

Category 20 (Females-Menstruating)	0	1	2	3
Acne and/or unwanted facial hair growth				
Abnormal menstruation (heavy, extended, shortened, scanty)				
Pain, cramping, and/or breast tenderness during menses				
Significant moods changes during menses				
Currently taking, or history of taking birth control				
TOTAL				

Category 21 (Female - Menopausal)	0	1	2	3
Experience hot flashes				
Acne and/or unwanted facial hair growth				
Mood swings, depression, night sweats				
Vaginal thinning, dryness, or itchiness				
Low libido				
TOTAL				

Category 22	0	1	2	3
Lack of motivation				
Feeling of worthlessness, or self-distructive thoughts				
Quick to anger or frustration				
Inattentive, poor circulation, disorganized thinking				
Decreased pleasure in life				
TOTAL				

Category 23	0	1	2	3
Loss of enjoyment in favorite activities, or relationships				
Feelings of depression and sadness				
Gut distress and/or decreased pain tolerance				
Feeling of overwhelm, or obsessive thoughts				
Lack of deep, restful sleep				
TOTAL				

Category 24	0	1	2	3
Feelings of anxiety, panic or inner tension				
Experience restlessness, mentally or physically				
Easily worried				
Feel easily overwhelmed and overworked				
Insomnia or difficulty sleeping				
TOTAL				

Category 25	0	1	2	3
Rapid or shallow breathing				
Rapid heart rate				
Fatigue				
Headaches				
Lack of appetite				
TOTAL				

Category 26	0	1	2	3
Lightheadedness				
Muscle twitching, spasm, or cramps				
Numbness of tingling in face/hands/feet				
Slow respiration or breathing rate				
TOTAL				

Category 27	0	1	2	3
I often drink water between meals				
Urinate frequently				
Loose or watery stools				
Excessively salty sweat				
Frequent thirst				
TOTAL				

Category 28	0	1	2	3
I feel as if nobody understands me				
It is difficult for me to make friends				
People are around me, but not with me				
My social relationships are superficial				
No one really knows me well				
TOTAL				

Category 29	0	1	2	3
I feel in control of my life				
Life is rewarding, I am optimistic about the future				
I am satisfied with my life				
I feel healthy, attractive, and am pleased with who I am				
I find beauty and joy in things, and laugh often				
TOTAL				

Category 30	0	1	2	3
I can easily, succinctly articulate my purpose in life				
I have discovered who I really am				
I get intensely involved in, and feel greatly fulfilled by, many of the things I do each day				
My life is centered around a set of core beliefs that give meaning to my life				
It is more important that I enjoy what I do, rather than if people are impressed by it				
TOTAL				

STRUCTURAL HEALTH

Do you suffer from any of the following

☐ Neck/Back Pain	☐ Feet/Ankle problems
☐ Low back/Hip pain	☐ Shoulder problems
☐ SI joint/Pelvic pain	☐ Elbow/Wrist/Hand problems
☐ Sciatica/Radiating pain	☐ TMS/Jaw pain
☐ Knee Pain	☐ Neuropathy - hands or feet

Rate your stress level on a scale of 0-10

0 1 2 3 4 5 6 7 8 9 **10**

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

None at all **Extremely stressed**

How would you rate the quality of sleep you get from 0-10?

0 1 2 3 4 5 6 7 8 9 **10**

○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○

No Sleep **Great Sleep**

How many hours of sleep do you get per night? ____________________

How often do you exercise per week? ____________________

What kind of exercise? ____________________

How physically active are you in your daily life? ____________________

How many hours of screen time do you get daily? ____________________

How many hours per week do you spend outside in the sunshine? ____________________

Are you content with your current body weight? ☐ **Yes** ☐ **No**

Please Circle *If no, do you want to: increase / decrease / other? Please explain* ____________________

Do you practice any deep breathing techniques? ☐ **Yes** ☐ **No**

If yes, what and how often? ____________________

Do you follow any faith based or meditative practices? ☐ **Yes** ☐ **No**

If yes, what and how often? ____________________

DIETARY FOOD LOG

Please list 3 examples of typical food and drink consumption

BREAKFAST	Example 1	Example 2	Example 3
Time of Day? ______			
Beverage Examples: 1. ______ 2. ______			
3. ______			

LUNCH	Example 1	Example 2	Example 3
Time of Day? ______			
Beverage Examples: 1. ______ 2. ______			
3. ______			

DINNER	Example 1	Example 2	Example 3
Time of Day? ______			
Beverage Examples: 1. ______ 2. ______			
3. ______			

SNACKS	Example 1	Example 2	Example 3
Time of Day? ______			
Beverage Examples: 1. ______ 2. ______			
3. ______			

How often do you consume each of the following?

	2-3x / day	1x / day	2-3x / week	1x / Week	Rarely	Never
Artificial Sweeteners						
Sugar						
Gluten						
Dairy						
Corn						
Eggs						
Tomatoes						
Processed Foods						

How much water do you drink per day? ______________ Ounces

*Please include a comprehensive list of ALL medication and supplements that you currently take, the dosage of each product, and the reason for taking them.

SOCIAL HISTORY

Exercise frequency *Type?* ____________________

☐ Daily ☐ 3-4xs/wk ☐ 1-2xs/wk ☐ Rarely ☐ Never

Caffeine Usage ____________________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Alcohol Usage ____________________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Tobacco Usage *Type and amount?* ____________________

☐ Daily ☐ Occasional ☐ Former ☐ Never

Recreational Drug Usage ____________________

☐ Daily ☐ Occasional ☐ Former ☐ Never

NSAID Usage (Tylenol, Aspirin, Ibuprofen, etc.) ____________________

☐ Daily ☐ Weekly ☐ Occasional ☐ Never

Antibiotic Usage ____________________

☐ twice or more per year ☐ 1x/year ☐ 1-2 times ever ☐ Never

Occupation: ____________________

Retired? ☐ Yes ☐ No ____________________

MEDICAL HISTORY

Please mark if you have **EVER HAD** any of the following conditions. Use the comments section to provide details:

Illnesses and Injuries

☐ Cancer	☐ Arthritis/Joint Pain	☐ Aneurysm
☐ Tumors	☐ Osteoporosis	☐ CVA/TIA (stroke)
☐ Seizures	☐ Broken bones	☐ Heart Attack
☐ Diabetes	☐ Dislocations	☐ Blood Clots
☐ Autoimmunity	☐ Car Accident	☐ Heart Disease
☐ Fibromyalgia	☐ Concussions	☐ Other________

Hospitalizations and Surgeries

Procedure	Date Performed
☐ Orthopedic	____/____/_______
☐ Spinal	____/____/_______
☐ Cancer	____/____/_______
☐ Other________	____/____/_______
☐ Other________	____/____/_______

Are you currently pregnant or breastfeeding? ____________________

Comments: ____________________

____

FAMILY HISTORY

Has anyone in your immediate family (Parents, Grandparents, Siblings, or Children) suffered from any of the following?

☐ Heart Disease ☐ Hypertension ☐ Stroke ☐ Aneurysm ☐ Cancer ☐ Diabetes ☐ Other

☐ Unknown or Unremarkable (No history of disease or illness)

If yes, please explain: ____________________

____

____

ALLERGIES

Do you have any allergies to medications, supplements, foods, or other? ☐ **No known allergies** ☐ **Yes**

If Yes, please provide details on what the allergy is to, symptoms you experienced, what you currently do for treatment, and if it is well controlled or not. ____________________

____

____

I have answered the above questions on this form to the best of my ability, and certify them to be true and accurate to the best of my knowledge. I hereby authorize payment to be made directly to Motus Chiropractic, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies thereof for the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability, and that I will remain financially responsible to Motus Chiropractic for any and all services I receive at this office.

____________________ **Patient or Authorized Person's Signature**

_____/_____/__________ **Date Completed**

____________________ **Doctor's Signature**

_____/_____/__________ **Date Completed**

Lastly, in your own words, please describe what you are dealing with...

(you may use additional pages if needed)