SYCAMORE CHIROPRACTIC & NUTRITION

Confidential Health Questionnaire

***** All of your personal information will remain strictly confidential! *****

Consultation Date: _____ Consultation Time: _____

Name: _____
E-mail Address: _____
Street Address:_____
City/State/Zip: _____
Home Phone: _____ Work/Cell Phone: _____
Date of Birth: _____ Place of Birth: _____
Age: _____ Gender: _____ Height: _____ Current Weight: _____
Would you like your weight to be different? Y N If so, what? _____ Blood Type: _____
Occupation: _____ How many hours do you work per week? _____
Relationship Status: _____ Children Y N How many? _____

Who referred you? _____

Describe the symptoms you are currently experiencing: _____
_____
_____

What would you like to accomplish/gain from this consultation? _____
_____
_____
_____

Do you sleep well? Y N Do you wake up during the night? Y N If so, what time(s)? _____
What time do you go to bed? _____ What time do you usually wake-up? _____
How do you feel when you wake up? _____
Do you drink caffeinated drinks? Y N What kind, how much & how often? _____
Do you smoke? Y N If yes, how much & how often? _____
If no, did you recently quit? How? _____
Do you drink alcohol? Y N How much & how often? _____
Do you drink soda? Y N If so, diet or regular. How much & how often? _____
How often do you exercise? _____ Type of exercise? _____
How much water do you drink per day? _____
Please list any vitamins/minerals, herbal or homeopathic remedies, prescription drugs, over-the-counter medications or any other supplements you are currently taking. _____
_____
_____
_____
_____
_____

Do you have any known allergies to medications, supplements or herbs? Y N Please list all below:
_____
_____
_____
Are you currently under a doctor's care for a specific health issue? If so, what issue and what treatments are you currently undergoing? _____
_____
_____
_____

Please list the name and date of any surgeries, accidents, injuries or childhood diseases for which you've received treatment.
_____
_____
_____

Were you ever diagnosed with Mononucleosis? Y N

Have you recently gone through a serious life change such as a divorce, loss of a loved one, moving to a new home? Y N Please give a short explanation. _____
_____
_____

On a scale of 0 to 5, how stressful is your life right now? 0 1 2 3 4 5 Off the Chart!

What are your eating/drinking habits these days?
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Liquids:_____

Do you buy organic fruits and vegetables? _____ What percentage? _____
What types of foods did you eat as a child? _____
_____
_____
_____
What percentage of your food is home cooked? _____
How often do you eat out? _____ What is your favorite restaurant? _____
What are the three worst foods you eat on a regular basis? _____
_____
What are the three healthiest foods you eat on a regular basis? _____
_____
Is there any food you would be unwilling to give up? Y N What? _____
Do you crave sugar? Y N Do you crave salt? Y N Do you ever have heartburn/GERD? Y N
Do you feel tired, bloated, and/or gassy after meals? Y N How often? _____
Do you experience constipation or diarrhea? Y N
How often? _____ When? _____
Do you have a bowel movement daily? Y N If yes, how many times daily? _____

Please list any known food allergies, intolerances, or foods you cannot currently eat. _____
_____
_____
_____

Family Health History

Please list any significant genetic health concern or conditions that run in your family?
_____
_____
_____
_____

Women Only

Age of your first period: _____ Are your periods regular? Y N
How frequent? _____ How many days is your flow? _____
Do you experience PMS? Y N Is it mild or severe? _____
Are you peri-menopausal? Y N When did this change first occur? _____
Are you menopausal? Y N When was your last period? _____
List any current symptoms of peri/menopause:_____
_____
Number of pregnancies _____ Did you receive antibiotics during labor? Y N
How many children have you delivered by vaginal birth? _____
How many children have you delivered by cesarean birth? _____

Men Only

Approximate age of onset of puberty: _____ Do you feel your libido is adequate? _____
Do you wake at night to urinate? Y N If so, how many times? _____
Do you have any difficulty and/or pain with urination? _____ Diminished volume or flow? _____
Do you enjoy daily activities? Y N
Do you feel apathetic or complacent about previously enjoyed activities? Y N
Do you notice feeling more agitated/irritable than previously in your life? Y N

Vaccination History

When/what was your last vaccine? _____

Did you get: Flu shot? Y N Pneumonia shot? Y N Shingles vaccine? Y N Covid vaccine? Y N

Is there anything else you would like to add that might be helpful for me to know?
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

AGREEMENT AND RELEASE OF LIABILITY

The health and nutritional information you receive from Debbie Belshaw of Sycamore Chiropractic and Nutrition, whether given by phone, in person at your home, in the Sycamore Chiropractic and Nutrition office, through lectures, workshops, brochures, emails, or newsletters is not intended to diagnose, prescribe, treat, cure, alleviate, prevent or care for any disease in any way. It consists of combined information from many educational sources and points of view to help you make informed decisions regarding your desired level of health. The sources behind this information include: modern medicine, ancient Chinese medicine, naturopathic medicine and the therapist's personal research, study, and life observation as well as patient results and experiences. Anyone deciding to act upon any information mentioned during a consultation shall assume full responsibility for any effects of their actions. There are risks and unforeseen results associated with any change of diet and lifestyle. It is not recommended that you apply these changes unless you are willing to assume full responsibility for the risks you choose to take. If you choose to implement dietary and lifestyle changes without consulting your physician, which is your constitutional right, you are, in effect, prescribing for yourself. When in doubt of the appropriateness of any treatment, whether recommended to you by a clinician or by your own intuition, please consult a physician. Consultation information should not be used as a substitute for a physician's advice. It is our hope that you do choose a physician who realizes the importance of a healthy diet and lifestyle choices in correcting imbalances in the body and who has experience in treating immune disorders and other health imbalances. Please be aware that you have the right to make your own health decisions based on any information made available to you. YOU are the driving force in guiding yourself on a path to health!

ACKNOWLEDGEMENT

I accept the terms and conditions of this disclaimer. I acknowledge that any and all information given to me by Debbie Belshaw of Sycamore Chiropractic and Nutrition is to be used for educational purposes only. I also acknowledge that neither Sycamore Chiropractic and Nutrition or Debbie Belshaw claim to be medical doctors and will not prescribe for or diagnose, treat, prevent, alleviate or cure any disease or condition.

If I experience any changes in my health or current medications, I will immediately communicate this information to Sycamore Chiropractic and Nutrition. I further acknowledge that I am fully responsible for any decisions and/or changes I make regarding my health and I will not hold Sycamore Chiropractic and Nutrition or Debra Belshaw liable for my own decisions, any results of my decisions or of any natural treatment or advice I may receive.

I understand that Muscle Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalances in these areas could cause or contribute to various health problems. I understand that Muscle Response Testing is not a method for "Diagnosing" or "Treating" of any disease including conditions of cancer, AIS, infections, or other medical conditions, and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of Muscle Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Muscle Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

In consideration of being allowed to participate in programs, modalities, and activities of Sycamore Chiropractic and Nutrition and to use its facility in addition to the payment of any fee or charge, I do hereby waive, release and forever discharge Sycamore Chiropractic and Nutrition and its directors, officers, agents, employees, representatives, successors and assigns, administrators, executors, and all others from any and all responsibilities or liability from injuries or damages resulting from my participation in any activities or my use of equipment or machinery. I do also hereby release all of these mentioned and any others acting upon their behalf from any responsibility or liability from any injury or damage to myself, including those caused by the negligent act or omission of any of those mentioned or others acting on their behalf or in any way arising out of or connected with my participation in any activities of Sycamore Chiropractic and Nutrition.

I have read and understand the foregoing. Intending to be legally bound, I hereby release Sycamore Chiropractic and Nutrition from any liability, including for negligence, regarding my health matters and my participation in Muscle Response Testing or any other program. This release applies to all subsequent visits for programs, modalities and activities at Sycamore Chiropractic and Nutrition.

Patient Name (PRINT):_____

Patient Signature: _____

Date: _____