

Welcome to our clinic! Here's a checklist to help get you ready for your first visit.

___ New patient paperwork filled out

___ Bring all the supplements/medications that you are currently taking

___ Women please wear pants (no skirts) to your visits

___ Avoid wearing perfumes, essential oils, scented hair products, scented lotions

- The first visit will be approx *one hour 30 minutes*. Please arrive 10 minutes before your scheduled time. There are 3 hour parking meters near the office on 10th and 11th Ave. We are also 5 blocks from the Whole Foods parking lot at Couch and 12th Ave.

Veritas clinic

Holistic Health through Applied Kinesiology

Intake Form

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip: _____
Telephone (home): _____ (work/cell): _____
Email address: _____
Age: _____ Date of Birth: _____ Gender: Female / Male
__ Married __ Separated __ Divorced __ Widowed __ Single __ Partnership
Live with: __ Spouse __ Partner __ Parents __ Children __ Friends __ Alone
Occupation: _____ Hours per week: _____
Employer: _____
How did you hear about this clinic? _____
Emergency contact: _____ Relationship: _____
Phone: _____

Health History Questionnaire

What are your most important health problems? List in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____

Family History

Do you have a family history of any of the following? (Please check)

- | | | |
|---|--|--|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Stroke | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hypothyroidism |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression/Anxiety |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hives | <input type="checkbox"/> Alcoholism |

Hospitalizations /Surgery /Accidents

What hospitalizations or surgeries have you had?

_____ year: _____
_____ year: _____
_____ year: _____

List any accidents:

_____ year: _____
_____ year: _____
_____ year: _____

List any broken bones and dislocations:

Were you ever knocked unconscious? Y N
Have you ever had a lapse of memory Y N

Patient Evaluation Questionnaire

1. Please rate on scale how serious you are about getting well (circle number).

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

2. Would you prefer: (Please Circle).

- A. Correction of Cause of Health Problems
- B. Temporary Symptom Relief

3. Are you willing to follow a treatment program designed to help you return to health?
(Treating the Cause)

- A. Yes
- B. No

4. Are you willing to take nutritional and/or homeopathic supplements?

- A. Yes
- B. No

5. Are you willing to make dietary changes?

- A. Yes
- B. No

6. Are you willing to start a moderate exercise program?

- A. Yes
- B. No

7. Please rate on scale how serious you are about staying healthy after your initial intensive care.

0 1 2 3 4 5 6 7 8 9 10
Not Serious Very Serious

8. Are you familiar with Applied Kinesiology?

- A. Yes
- B. No
- C. Very little (somewhat)

9. Have you ever been treated by a Chiropractor or Naturopath?

- A. Yes
 - B. No
- If yes, how were your results? _____

10. Please rate your stress on scale.

0 1 2 3 4 5 6 7 8 9 10
No Stress Total Stress

11. Are any doctors or practitioners currently treating you?

- A. Yes
- B. No

If yes, please list _____

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Toxic Profession Past or Present

(Artist, graphic designer, dental asst, gas station worker, painter, industry, cleaners, etc.)

Age: _____

Age: _____

Age: _____

Major Psychological Trauma

Age: _____

Age: _____

Age: _____

Serious Infections/Diseases

(pneumonia, mono, TB, cancer, heart attack, stroke, hepatitis, etc)

Age: _____

Age: _____

Age: _____

Long periods on prescriptions or street drugs

Age: _____

Age: _____

Age: _____

Long visits or lived in a foreign country like India, Mexico, Africa, etc.

Age: _____

Age: _____

Age: _____

Treated for parasites, infection? Y N

Allergies

Are you hypersensitive or allergic to...

Any drugs? _____

Any foods? _____

Any environmental? _____

Current Medications

- | | |
|--|--|
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Thyroid medication |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Birth control pills |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Antacids |
| <input type="checkbox"/> Pain relievers | <input type="checkbox"/> Sleeping Pills |
| <input type="checkbox"/> Appetite suppressants | <input type="checkbox"/> Antibiotics |

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

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Typical Food Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Drinks: _____

Habits

Main interests and hobbies _____

Do you exercise? Y N
If yes, what kind? _____ How often? _____
Average 7-8 hrs sleep? Y N
Sleep Well? Y N
Awaken rested? Y N
When during the day is your energy the best? _____ Worst? _____
Have a supportive Relationship Y N
Have a history of Abuse? Y P N
Use Recreational drugs? Y P N
Do you eat three meals a day? Y N
Do you eat out often? Y N
Do you drink coffee? Y N
Do you drink black/green/herbal teas? Y N
Enjoy your work? Y N
Take vacations? Y N
Spend time outside? Y N
Watch television? Y N How many hours? _____
Alcoholic beverages Y P N How many per week? _____
Smoke? Y P N How much per day? _____ How many years? _____
Do you have a religious or spiritual practice? Y N
If yes, what? _____

How does your condition affect you? _____

What do you think is happening? _____

Why? _____

What do you feel needs to happen for you to get better? _____

How long do you think it will take for you to get better? _____

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Review of symptoms

Y= a condition you have now N= never had P= a condition you have had before

Have you had, or do you have any of the following conditions:

Appendicitis	Y P N	Chicken Pox	Y P N
Polio	Y P N	Alcoholism	Y P N
Whooping cough	Y P N	Epilepsy	Y P N
Anemia	Y P N	HIV	Y P N
Measles	Y P N	Multiple Sclerosis	Y P N
Mumps	Y P N		

General

Chills	Y P N	Loss of Sleep	Y P N
Convulsions	Y P N	Loss of Weight	Y P N
Fainting	Y P N	Neuralgia	Y P N
Fatigue	Y P N	Sweats	Y P N
Fever	Y P N		

Mental/Emotional

Treated for emotional problems	Y P N	Depression	Y P N
Mood swings	Y P N	Anxiety or nervousness	Y P N
Considered/Attempted suicide	Y P N	Tension	Y P N
Poor concentration	Y P N	Memory problems	Y P N

Endocrine

Hypothyroid	Y P N	Diabetes	Y P N
Hypoglycemia	Y P N	Excessive hunger	Y P N
Excessive thirst	Y P N	Seasonal depression	Y P N
Fatigue	Y P N	Night sweats	Y P N
Heat or Cold intolerance	Y P N		

Immune

Chronic fatigue Syndrome	Y P N	Reactions to vaccinations	Y P N
Chronic swollen glands	Y P N	Chronic infections	Y P N
		Slow wound healing	Y P N

Neurologic

Seizures	Y P N	Numbness or tingling	Y P N
Muscle weakness	Y P N	Easily stressed	Y P N
Loss of Memory	Y P N	Loss of Balance	Y P N
Vertigo or dizziness	Y P N	Fainting	Y P N
Paralysis	Y P N		

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Skin			
Rashes	Y P N	Lumps	Y P N
Eczema or Hives	Y P N	Itching	Y P N
Acne/Boils	Y P N	Hair loss	Y P N
Color change	Y P N	Bruises easily	Y P N
Head Eyes Ears Nose Throat			
Headaches	Y P N	Frequent colds	Y P N
Migraines	Y P N	Stuffy nose	Y P N
Head injury	Y P N	Runny nose	Y P N
Jaw/TMJ problems	Y P N	Sinus problems	Y P N
Spots in Eyes	Y P N	Nose bleeds	Y P N
Impaired vision	Y P N	Hay fever	Y P N
Blurriness	Y P N	Loss of Smell	Y P N
Colorblindness	Y P N	Frequent sore throat	Y P N
Double vision	Y P N	Teeth grinding	Y P N
Cataracts	Y P N	Gum problems	Y P N
Glasses or contacts	Y P N	Dental Cavities	Y P N
Eye pain/strain	Y P N	Sores on tongue or lips	Y P N
Tearing or dryness	Y P N	Hoarseness	Y P N
Glaucoma	Y P N	Difficulty Swallowing	Y P N
Impaired hearing	Y P N	Goiter	Y P N
Earaches	Y P N	Swollen glands	Y P N
Ringing	Y P N		
Dizziness	Y P N		
Respiratory			
Cough	Y P N	Shortness of breath	Y P N
Persistent Cough	Y P N	Shortness of breath at night	Y P N
Spitting up blood	Y P N	Tuberculosis	Y P N
Asthma	Y P N	Spitting up phlegm	Y P N
Pneumonia	Y P N	Wheezing	Y P N
Emphysema	Y P N	Bronchitis	Y P N
Pain on breathing	Y P N		
Cardiovascular			
Heart disease	Y P N	Varicose veins	Y P N
High blood pressure	Y P N	Murmurs	Y P N
Low blood pressure	Y P N	Blood clots	Y P N
Pain over heart	Y P N	Phlebitis	Y P N
Poor circulation	Y P N	Rheumatic fever	Y P N
Rapid heart	Y P N	Swelling in ankles	Y P N
Slow heart	Y P N	Palpitations/fluttering	Y P N
Stroke	Y P N		

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Gastrointestinal			
Trouble swallowing	Y P N	Heart burn	Y P N
Change in thirst	Y P N	Change in appetite	Y P N
Nausea	Y P N	Constipation	Y P N
Vomiting blood	Y P N	Diarrhea	Y P N
Blood in stool	Y P N	Gallbladder trouble	Y P N
Abdominal pain/cramps	Y P N	Ulcer	Y P N
Belching or passing gas	Y P N	Hemorrhoids	Y P N
Black stools	Y P N	Poor appetite	Y P N
Liver trouble	Y P N	Poor digestion	Y P N

Bowel movements: How often? _____ Is this a change? _____

Urinary			
Pain on urination	Y P N	Kidney stones	Y P N
Frequency at night	Y P N	Blood in urine	Y P N
Frequent infections	Y P N	Kidney infection	Y P N
Increased frequency	Y P N	Prostate trouble	Y P N
Inability to hold urine	Y P N		

Male reproduction			
Hernias	Y P N	Premature ejaculation	Y P N
Testicular pain	Y P N	Testicular masses	Y P N
Venereal disease	Y P N	Prostate disease	Y P N
Impotence	Y P N	Discharge or sores	Y P N

Female Reproduction/Breasts			
Age of first menses _____		Discharge	Y P N
Age of last menses _____		Herpes	Y P N
Length of cycle _____ days		Venereal Disease	Y P N
Duration of menses _____ days		IUD	Y P N
Painful menses	Y P N	Birth control?	Y P N
Heavy or excessive flow	Y P N	What type? _____	
PMS	Y P N	Number of pregnancies _____	
If yes, what are your symptoms? _____		Number of live births _____	
Endometriosis	Y P N	Number of miscarriages _____	
Ovarian cysts	Y P N	Number of abortions _____	
Difficult conceiving	Y P N	Hot flashes	Y P N
Are cycles regular	Y P N	Lump in breast	Y P N
Bleeding between cycles	Y P N	Have you had a mammogram?	Y N
Pain during intercourse	Y P N	Last Pap smear date? _____	
Clotting	Y P N	Was it normal?	Y N

Muscles/Joints/Bones			
Backache	Y P N	Stiff neck	Y P N
Foot trouble	Y P N	Swollen Joints	Y P N
Pain between shoulders	Y P N	Tremors/Twitching	Y P N
Painful tail bone	Y P N	Arm Trouble	Y P N

If you have musculoskeletal pain, please complete the following:

Please mark the intensity of your pain today: 0 = no pain, 10= intense pain.

Area: _____ Intensity: _____
Area: _____ Intensity: _____
Area: _____ Intensity: _____
Area: _____ Intensity: _____

How long has this condition lasted? _____

Is this condition: ___ Getting worse ___ The Same ___ Improving

Was this caused by an injury/accident? Y N

If no, when did you first notice it? _____

Pain came on: ___ Gradually ___ Suddenly

The pain is: ___ Occasional ___ Frequent ___ Constant

Describe the pain: ___ Sharp (knife-like) ___ Dull (toothache) ___ Burning (hot)

Does the pain: ___ Stay in one spot ___ Radiate (shoots) ___ Go up & down spine

What time of day is the pain worst: ___ Morning ___ Afternoon ___ Evening ___ Night ___ All the time

Do you have pain in: ___ Legs ___ Feet ___ Arms ___ Hands ___ Left ___ Right

Numbness or tingling in: ___ Legs ___ Feet ___ Arms ___ Hands ___ Left ___ Right

What makes the pain worse? _____

What makes the pain better? _____

Does the pain affect your sleeping: ___ No ___ Occasionally ___ Frequently ___ Constantly

Does your pain affect your work? ___ No ___ Occasionally ___ Frequently ___ Constantly

Have you been hospitalized in the last five years?

If yes, for what? _____

Have you had major surgery in the last five years?

If yes, for what? _____

Have you seen other doctors for this condition? Y N

If yes, doctor's name: _____