Quantum Chiropractic Assessment Form

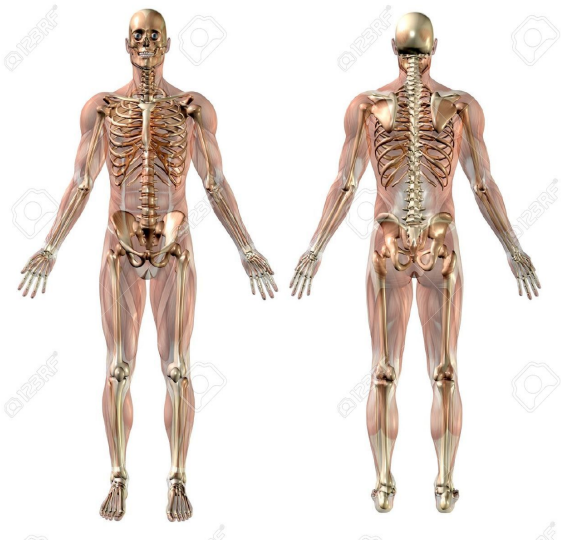
Name: _____ Date:_____ Age:_____ Date of Last Lab: _____

Please list your top 5 health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

PLEASE MARK THE AREAS OF YOUR SYMPTOMS: Please use the space to the right of the diagram to detail pain patterns, intermittent pains, spasms, sharp pains, radiating pains, deep pain, poor circulation or temperature variations, etc. Any and all data will be helpful.

Right Left Left Right



_____
_____
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Headaches / Migraines:
Where: Top of head / circling the head / both temples / behind eyes / base of skull / forehead / sinus
Other: _____
Type of pain: pounding / dull / achy / sharp / other: _____

Medications / Supplements taken & dosage: _____
_____

Foods: What are your eating habits like? Please circle all that apply.

Carnivore: Meat eater	100%	“Meat and Carbs”	“Meat and Veggies”
Paleo type diet	Better off carbohydrates	Better off lectins	I like Primal diet regimine
Gluten Free	100%	90%	I try to be
Vegetarian (no meat)	Personal choice	Religious	Cruelty to animals
Sensitivity to foods	Mild to none	Mild to moderate	Moderate to sever

Below are questions that are important for you to answer to the best of your knowledge. Some questions may be repeated but it is to assist the doctor categorize and understand to the fullest extent possible where to direct your therapy. If you need to elaborate or specify on a particular question, please make a note by the question(s), and the doctor will ask you for details. Thank you!

Section A: Mark (X) in box	**Yes**	**No**	
Do you fatigue easily after work-outs?			Explain:
Have you ever been told you were anemic?			Explain:
Have you ever been rejected from donating blood?			Explain:
Are you able to do activities to a certain threshold and then crash?			Explain:
Do your hands or feet get cold while eating?			Explain:
Do supplements with iron upset your gut?			Explain:
Do you suffer from anxiety?			Explain:
Go into elevation and feel sick?			Explain:

Section A2:

Are you sensitive to supplements?			Explain:
Are your lips cracked and/or dry?			Explain:
Is your skin dry, loose, look like “old” skin?			Explain:
Do you feel you have lost significant muscle mass or strength?			Explain:
Bruise easily?			Explain:
Do you feel better when you blend your food?			Explain:

Section B. I.R.

Fatigue after meals, especially carbs?	Never	Occassionaly	Always
Crave sweets before or after meals?	Never	Occassionaly	Always
Trouble falling asleep at night?	Never	Occassionaly	Always
Frequent Urination?	< 3x a day	< 6x a day	+7 x a day
Difficulty losing weight?	Never	Occassionaly	Always
Poor motivation and self-drive?	Never	Occassionaly	Always
Depression-like symptoms?	Never	Occassionaly	Always

Section C. R.H.

Crave sweets throughout the day?	Never	Occassionaly	Always
Irritable if meals are missed?	Never	Occassionaly	Always
Feel energized, think better after eating?	Never	Occassionaly	Always
Depend on coffee or other stimulants to get yourself going or started?	Never	Occassionaly	Always
Get light headed if meals are missed?	Never	Occassionaly	Always
Agitated and easily upset or nervous?	Never	Occassionaly	Always
Feel shaky or jittery?	Never	Occassionaly	Always
Never eat breakfast?	Never	Occassionaly	Always
Trouble staying asleep?	Never	Occassionaly	Always

Section D. A.A.: Mark (X) in box	**Yes**	**No**	
Have you had abdominal surgery?			Explain:
Gallbladder removed?			Explain:
Appendix removed?			Explain:
Cesarean {C} section?			Explain:
Hysterectomy?			Explain:
If had colonoscopy, polyps?			Explain:
Bad menstrual cramps?			Explain:
Constipation?			Explain:
Reduced flexibility and overall stiffness in joints?			Explain:

Pulling sensation upon stretching?			Explain:
No longer able to pass gas?			Explain:
Pain with breath? Inhale or exhale?			Explain:

Section E. O.I.: Have you had?

Root canal, crown or dental implant?			Explain:
Abscess or tooth infection?			Explain:
Acid pH in mouth?			Explain:
Bad breath?			Explain:
Dental or pain in the head that was relieved only by loss or extraction of tooth?			Explain:
Diagnosed or treated for TMJ issues?			Explain:
Dental cavities or caries?			Explain:
Swollen or bleeding gums?			Explain:
Acne - face or cheeks?			Explain:
Receding gum line?			Explain:
Popping jaw when eating?			Explain:

Section F. EX PD: Mark (X) in box.	**Yes**	**No**	
Gain weight easily?			Explain:
Lethargic / fatigued / tired most days?			Explain:
Cold hands and feet?			Explain:
Low blood pressure?			Explain:
Sensitive to noises or touch?			Explain:
Difficulty concentrating / focusing?			Explain:
ADD/ADHD?			Explain:
Mental sluggishness / brain fog?			Explain:
Digestive problems subside with rest?			Explain:

Section G. EX SD: Mark (X) in box.	Yes	No	
Anxiety? Rate your level			Explain:
Enlarged pupils?			Explain:
High blood pressure?			Explain:
Infrequent bowel movements?			Explain:
Difficulty relaxing? Always nervous/tense?			Explain:
Poor digestion? Heartburn? Cramps?			Explain:
Hard, dry, or small stool?			Explain:
Feeling that bowels do not empty completely?			Explain:

Gut Health:

Section H. U GI:

Heartburn?	Never	Occassionaly	Always
TMJ issues?	Never	Occassionaly	Always
Left shoulder pain that is intermittent?	Never	Occassionaly	Always
Feel tension under diaphragm with deep inhale?	Never	Occassionaly	Always
Difficulty with full neck rotation. Limited by tension?	Yes	No	Loss of motion to R / L:
Feel bloated / distended after eating?	Never	Occassionaly	Always
Excessive belching or burping?	Never	Occassionaly	Always
Offensive breath?	Never	Occassionaly	Always
Use of antacids?	Yes	No	Frequency: _____ a day
Headaches on right side of head generally?	Never	Occassionaly	Always

Section I. GB:

Greasy or high fat foods cause distress?	Never	Occassionaly	Always
Lower bowel gas and/or bloating several hours after eating?	Never	Occassionaly	Always
Bitter metallic taste in mouth, especially in morning?	Never	Occassionaly	Always
Burpy, fishy taste after consuming fish oils?	Never	Occassionaly	Always
Stool color alternates from clay colored to normal brown?	Never	Occassionaly	Always
History of gallbladder attacks or stones?	Never	Occassionaly	Always
Pain in right shoulder that is intermittent?	Never	Occassionaly	Always
Headaches on sides of head, right behind eyes?	Never	Occassionaly	Always
Foot spasms, typically in early morning (1-3 am)	Never	Occassionaly	Always

J. PAN:

Pain under left rib cage that is intermittent?	Never	Occassionaly	Always
Headaches on both sides of head? (Temples)	Never	Occassionaly	Always
Stool undigested, foul smelling, mucous like, greasy	Never	Occassionaly	Always
Excessive passage of foul smelling gas	Never	Occassionaly	Always
Excessive passage of gas (no smell)	Never	Occassionaly	Always
Muscle pain between shoulder blades	Never	Occassionaly	Always
Muscle pain over left shoulder blade	Never	Occassionaly	Always

Section K. SI:

Headaches around head? Like wearing a hat?	Never	Occassionaly	Always
Pain on or around belly button?	Never	Occassionaly	Always
Feel bloated an hour or two after eating?	Never	Occassionaly	Always
Hard time doing sit-ups regardless of weight?	Never	Occassionaly	Always

Section L. LB Mark (X) in box.	Yes	No	
Low back pain?			Explain (side, frequency):
Front right hip pain?			Explain:
Sciatica or sciatica-like pains?			Explain:
Pass large amounts of foul smelling gas?			Explain:
Headaches on top of head?			Explain:
Hands and feet swelling after eating foods?			Explain:
Diarrhea?			Explain:
Constipation?			Explain:
Coated tongue or “fuzzy” debris?			Explain:
Use laxatives frequently?			Explain:

Additional comments relating to gut health / history:

_____

_____

_____

Immunity: Mark (X) in box.	Yes	No	
Increasing frequency of food reactions?			Explain:
Aches, pains, and swelling throughout the body?			Explain:
Frequent bloating and distention after eating?			Explain:
Intolerance or sensitivity to sugars?			Explain:
Intolerance to smells?			Explain:
Intolerance to jewelry?			Explain:
Intolerance to shampoos, lotions, etc.?			Explain:
Multiple smell and chemical sensitivities?			Explain:
Constant skin outbreaks?			Explain:
Have had bad reaction to supplements?			Explain:

Neurotransmitters:

Section M:

Constipated?	Never	Occassionaly	Always
Poor bowel motility?	Never	Occassionaly	Always
Digestive problems subside with rest?	Never	Occassionaly	Always
How often do you feel overwhelmed by stress?	Never	Occassionaly	Always
Able to have morning erections?	Never	Occassionaly	Always
Do you feel confident?	Never	Occassionaly	Always
How often do you fall into deep restful sleep?	Never	Occassionaly	Always

Section N:

Do you suffer from “racing-mind” syndrome?	Never	Occassionaly	Always
Do you feel anxious or panicky for no reason?	Never	Occassionaly	Always
How difficult is it to turn your mind off?	Never	Occassionaly	Always
Do you have feelings of inner tension or excitability?	Never	Occassionaly	Always
ADD/ADHD	Never	Occassionaly	Always