ARCHEUS Chiropractic and Wellness

Nutritional Consultation

Your Information

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Date:_____

First Name: _____ Middle Initial: _____ Last Name:_____

Address: _____

City: _____ State:_____ Zip Code:_____

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____ Ethnicity:_____

Date of Birth: _____/_____/_____ Sex: Male / Female Marital Status: ☐ Single ☐ Married ☐ Other

Family Medical Doctor: _____ Location:_____

Current Weight:_____ Height:_____ Body Frame Size: Small Medium Large Blood Type: _____

Emergency Contact

Contact Name: _____

Contact Phone: (_____)_____-_____

Major Reason for Today's Consultation

_____

What treatments if any, have you sought?:_____

_____

Any known Allergies? _____

_____

Do you currently have any diagnosed conditions? Yes ☐ No ☐ Please list below if yes.

Diagnosis	Treatment	Date Diagnosed

Please list all current medications: ☐ No Current Medications

Medication	Dosage	Reason	How long

Please list all current supplements: ☐ No Current Supplements (please fill out another page if needed)

Supplement	Dosage	Reason	How long

Current Lifestyle

Physical

How often do you exercise? ☐ Daily ☐ 3x week ☐ Occasionally ☐ Rarely ☐ Never Hours per week?:_____

Do you stretch daily? Y/N If yes, for how long? _____ Do you pay attention to your posture? Y/N

Please list your hobbies or activities: _____

_____

_____

Bio-Chemical

Do you smoke or have you in the past? Y/N If yes how often and how much?_____

Do you use / consume? ☐ Tobacco ☐ Alcohol ☐ Caffeine How often day/week?_____

Do you eat prepared, processed or fast foods? Y/N How often?_____

Do you consume carbonated or drinks high in sugar daily? Y/N How often do you drink water?_____

Are you on any special diet? Y/N If yes for what reason?_____

Your diet emphasizes fruits, vegetables, whole grains, lean meats and other protein sources and is low in sugar and artificial sweeteners? Y/N Please rate your diet (10 being healthy): 1 2 3 4 5 6 7 8 9 10.

Health Goals

I would like to improve my health beyond my current state Y/N. I am interested in nutrition and lifestyle changes Y/N.

If offered I would attend nutrition/lifestyle and health improvement activities. Y/N.

What are your specific goals for today's visit?_____

_____

_____

_____

It is important that we have the same health objectives concerning nutrition and wellness care. Regardless of what a disease or condition is called our practice objective for nutritional consultations is to support the expression of the body's internal ability to heal and thrive. By removing poor environmental influences contained within food products, and balancing a person's lifestyle and nutritional needs, with the addition of specific supplementation, we help maximize the bodies inborn abilities, bringing you beyond the comfort zone of no symptoms and constantly challenge you to reach for optimal health! These recommendations are for nutritional enhancement only, they have not been evaluated by the FDA to diagnose, treat, cure or prevent any disease. If any medical condition arises while carrying out the recommendations, please contact us immediately (understand some reactions may be normal). Your signature verifies that the information provided on this form is complete and correct and that you are willing to begin your journey with nutritional care.

Patient Signature: _____Date:_____