

THE CHIROPRACTIC wellnessconnection

Nutrition Policies and Expectations

First, let me start by congratulating you on taking the first step towards improving your health, and tell you that I am honored to play a part. –Dr. Olivia Joseph

Time: I respect your time and do my best to remain on time. To help with this, I ask you to please be on time and prepared for your evaluation. Having paperwork turned in along with any lab testing that has been done in the past year allows me to be more efficient and effective in serving you. Please allow 45 minutes for your initial evaluation and 15 minutes for any follow ups.

Payment: Payment is due in full at the time of service unless prior arrangements have been made. Any testing and supplements can not leave our facility until paid in full. As a courtesy to our patients we will diagnose and bill appropriately to ensure maximum reimbursement. Any payment received from insurance will be turned over to you or can be used as a credit for supplements.

Supplements and Testing: If any supplements are recommended for you, it is expected that you take them as recommended for optimal benefits to your health. If for any reason you are not fully satisfied, or have any concerns about your supplements, please let us know immediately. We do guarantee all supplements bought from our office.

Questions: We expect you will have questions along your journey to health. We are here to help you in any way we can, and want to be a resource to better health for our community. It is highly recommended that you keep a list of questions and bring that with your folder to your consultations. If your questions can not wait or there is an emergency please call us immediately. I will disclose my personal e-mail to help serve you on days I am not in the office (**ojosephdc@yahoo.com**). Please understand if my responses are short, I am not trying to be rude, I am only trying to get your question (*and many others*) returned as efficiently as possible.

Say this affirmation **out loud**, daily, and *like you mean it*, and Failure is not an option:

TODAY, I DECIDE, THAT IT DOESN'T MATTER HOW MANY TIMES IN THE PAST I HAVE TRIED TO CHANGE AND FAILED, BECAUSE TODAY IS THE DAY I TAKE RESPONSIBILITY FOR MAKING THE CHANGE AND SUCCEED.

Patient Information

Date: ____/____/____ Phone # ____--____

Name: _____ Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Social Security Number: ____--____--____ Date of Birth ____/____/____

Sex: [] Male [] Female Marital Status: [] Married [] Single [] Widowed [] Separated [] Divorced

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: ____--____

Spouse/Partner Name: _____ Spouse/Partner Date of Birth: ____/____/____

Spouse/Partner Phone: ____--____ Spouse/Partner SS #: ____--____--____

Spouse/Partner Employer: _____

Whom may we thank for referring you? _____

Insurance Information (please provide copy of card to receptionist)

Responsible party: _____ Relationship to Patient: _____

Insurance Co.: _____ Group #: _____

Date of Birth: ____/____/____ Social Security #: ____--____--____

Is the patient covered by additional insurance? [] Yes [] No

Insurance Co.: _____ Group #: _____

RELEASE

I, the undersigned, authorize the Dr. and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

Responsible Party Signature Relationship to Patient to Patient

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship to Patient

Nutritional Assessment Questionnaire

Section 2

70. ____ Pain between shoulder blades
71. ____ Stomach upset by greasy foods
72. ____ Greasy or shiny stools
73. ____ Nausea
74. ____ Sea, car or airplane sickness, motion sickness
75. ____ History of morning sickness (1 = yes, 0 = no)
76. ____ Light or clay colored stools
77. ____ Dry skin, itchy feet and/or skin peels on feet
78. ____ Headache over the eye
79. ____ Gallbladder attacks (past or present)
80. ____ Gallbladder removed (1 = yes, 0 = no)
81. ____ Bitter taste in mouth, especially after meals
82. ____ Become sick if drinking wine
83. ____ If drinking alcohol, easily intoxicated
84. ____ Alcoholic beverages per week (0 = < 3/ week, 1 = < 7/ week, 2 = < 14/ week, 3 = > 14/week)
85. ____ Recovering alcoholic (1 = yes, 0 = no)
86. ____ Hangovers after drinking alcohol
87. ____ History of drug or alcohol abuse (1 = yes, 0 = no)
88. ____ History of hepatitis (1 = yes, 0 = no)
89. ____ Long term use of prescription medications (1 = yes, 0 = no)
90. ____ Sensitive to chemicals (perfume, cleaning solvents, insecticides, exhaust, etc.)
91. ____ Sensitive to tobacco smoke
92. ____ Exposure to diesel fumes
93. ____ Pain under right side of rib cage
94. ____ Hemorrhoids or varicose veins
95. ____ Nutrasweet (aspartame) consumption
96. ____ Bothered by aspartame (NutraSweet)
97. ____ Chronic fatigue or Fibromyalgia

Section 3

98. ____ Food allergies
99. ____ Abdominal bloating 1 to 2 hours after eating
100. ____ Specific foods make you tired or bloated (1 = yes, 0 = no)
if yes, what _____
101. ____ Pulse speeds after eating
102. ____ Airborne allergies
103. ____ Experience hives
104. ____ Sinus congestion, "stuffy head"
105. ____ Crave bread or noodles
106. ____ Alternating constipation and diarrhea
107. ____ Crohn's disease (1 = yes, 0 = no)
108. ____ Wheat or grain sensitivity
109. ____ Dairy sensitivity
110. ____ Are there foods you could not give up (1 = yes, 0 = no)
if yes, what _____
111. ____ Asthma, sinus infections, stuffy nose
112. ____ Bizarre vivid or nightmarish dreams
113. ____ Use over-the-counter pain medications
114. ____ Feel spacey or unreal

Section 4

115. ____ Anus itches
116. ____ Coated tongue
117. ____ Feel worse in moldy or musty place
118. ____ Taken any antibiotic for a combined time of
(1 = < 1 mo., 2 = < 3 mos., 3 = > 3 mos.)
119. ____ Fungus or yeast infections
120. ____ Ring worm, "jock itch", "athletes foot", nail fungus
121. ____ Eating sugar, starch or drinking alcohol increases yeast
symptoms
122. ____ Stools hard or difficult to pass
123. ____ History of parasites (1 = yes, 0 = no)
124. ____ Less than one bowel movement per day
125. ____ Stools have corners or edges are flat or ribbon shaped
126. ____ Stools are not well formed (loose)
127. ____ Irritable bowel or mucus colitis
128. ____ Blood in stool
129. ____ Mucus in stool
130. ____ Excessive foul smelling lower bowel gas
131. ____ Bad breath or strong body odors
132. ____ Painful to press along outer sides of thighs (Iliotibial Band)
133. ____ Cramping in lower abdominal region
134. ____ Dark circles under eyes

Section 5

135. ____ History of Carpal Tunnel Syndrome (1 = yes, 0 = no)
136. ____ History of lower right abdominal pain (1 = yes, 0 = no)
137. ____ History of stress fractures
138. ____ Bone loss (reduced density on bone scan)
139. ____ Are you shorter than you used to be? (1 = yes, 0 = no)
140. ____ Calf, foot or toe cramps at rest
141. ____ Cold sores, fever blisters or herpes lesions
142. ____ Frequent fevers
143. ____ Frequent skin rashes and / or hives
144. ____ Have you ever had a herniated disc? (1 = yes, 0 = no)
145. ____ Excessively flexible joints, "double jointed"
146. ____ Joints pop or click
147. ____ Pain or swelling in joints
148. ____ Bursitis or tendonitis
149. ____ History of bone spurs (1 = yes, 0 = no)
150. ____ Morning stiffness
151. ____ Vomiting or nausea
152. ____ Crave chocolate
153. ____ Feet have a strong odor
154. ____ Tendency to anemia
155. ____ Whites of eyes (sclera) blue tinted
156. ____ Hoarseness
157. ____ Difficulty swallowing
158. ____ Lump in throat
159. ____ Dry mouth, eyes and / or nose
160. ____ Gag easily
161. ____ White spots on fingernails
162. ____ Cuts heal slowly and / or scar easily
163. ____ Decreased sense of taste or smell

Key: 0 (or leave blank) = **No** or Do not have symptom, symptom does not occur
1 = **Yes** or Minor or mild symptom (once a month or less)

2 = Moderate symptom, occurs occasionally (weekly)
3 = Severe symptom, frequently occurs (daily)

Nutritional Assessment Questionnaire

Section 6

164. ____ Aspirin is an effective pain reliever (1 = yes, 0 = no)
165. ____ Crave fatty or greasy foods
166. ____ Low or reduced fat diet (past or present)
167. ____ Tension headaches at base of skull
168. ____ Headaches when out in the hot sun
169. ____ Sunburn easily or suffer sun poisoning
170. ____ Muscles easily fatigued
171. ____ Dry flaky skin and or dandruff

Section 7

172. ____ Awaken a few hours after falling asleep, hard to get back to sleep
173. ____ Crave sweets
174. ____ Eat desserts or sugary snacks
175. ____ Binge or uncontrolled eating
176. ____ Excessive appetite
177. ____ Crave coffee or sugar in the afternoon
178. ____ Sleepy in afternoon
179. ____ Fatigue that is relieved by eating
180. ____ Headache if meals are skipped or delayed
181. ____ Irritable before meals
182. ____ Shaky if meals delayed
183. ____ Family members with diabetes (0 = none, 1 = 2 or less, 2 = Between 2 - 4, 3 = More than 4)
184. ____ Frequent thirst
185. ____ Frequent urination

Section 8

186. ____ Muscles become easily fatigued
187. ____ Feel worse, sore after moderate exercise
188. ____ Vulnerable to insect bites
189. ____ Loss of muscle tone, heaviness in arms / legs
190. ____ Enlarged heart, or heart failure
191. ____ Pulse slow / below 65 (1 = yes, 0 = no)
192. ____ Ringing in the ears / Tinnitus
193. ____ Numbness, tingling or itching in extremities
194. ____ Depressed
195. ____ Fear of impending doom
196. ____ Worrier, apprehensive, anxious
197. ____ Nervous or agitated
198. ____ Feelings of insecurity
199. ____ Heart races
200. ____ Can hear heart beat on pillow at night
201. ____ Whole body or limb jerk as falling asleep
202. ____ Night sweats
203. ____ Restless leg syndrome
204. ____ Cheilosis (cracks at corner of mouth)
205. ____ Fragile skin, easily chaffed, as in shaving
206. ____ Polyps or warts
207. ____ MSG sensitivity
208. ____ Wake up without remembering dreams
209. ____ Take birth control pills
210. ____ Small bumps on back of arms
211. ____ Strong light at night irritates eyes
212. ____ Nose bleeds and / or tend to bruise easily
213. ____ Bleeding gums especially when brushing teeth

Section 9

214. ____ Tend to be a "night person"
215. ____ Difficulty falling asleep
216. ____ Slow starter in the morning
217. ____ Keyed up, trouble calming down
218. ____ High blood pressure (normal 120/80)
219. ____ Headache after exercising
220. ____ Feeling wired or jittery if drinking coffee
221. ____ Clench or grind teeth
222. ____ Calm on the outside, troubled inside
223. ____ Chronic low back pain, worse with fatigue
224. ____ Become dizzy when standing up suddenly
225. ____ Difficult maintaining manipulative correction
226. ____ Pain after manipulative correction
227. ____ Arthritic tendencies
228. ____ Crave salty foods
229. ____ Salt foods before tasting
230. ____ Perspire easily
231. ____ Chronic fatigue, or get drowsy often
232. ____ Afternoon yawning
233. ____ Afternoon headache
234. ____ Asthma, wheezing or difficulty breathing
235. ____ Pain on the medial or inner side of the knee
236. ____ Tendency to sprain ankles or "shin splints"
237. ____ Tendency to need to wear sunglasses
238. ____ Allergies and / or hives
239. ____ Weakness, dizziness

Section 10

240. ____ Over 6' 6" tall (Mature height)
241. ____ Early sexual development (before age 10) (1 = yes, 0 = no)
242. ____ Increased libido
243. ____ Splitting type headache
244. ____ Memory failing
245. ____ Ability to tolerate sugar
246. ____ Under 4' 10" (Mature height)
247. ____ Decreased libido
248. ____ Abnormal thirst
249. ____ Weight gain around hips or waist
250. ____ Menstrual disorders
251. ____ Delayed (after age 13) sexual development (1 = yes, 0 = no)
252. ____ Tendency to ulcers or colitis

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Nutritional Assessment Questionnaire

Section 11

- | | |
|---------------------------------------------------------------|---------------------------------------------------------------------|
| 253. ____ Allergic to iodine | 261. ____ Mentally sluggish, reduced initiative |
| 254. ____ Difficulty gaining weight, even with large appetite | 262. ____ Easily fatigued, sleepy during the day |
| 255. ____ Nervous, emotional, can't work under pressure | 263. ____ Sensitive to cold, poor circulation (cold hands and feet) |
| 256. ____ Inward trembling | 264. ____ Constipation, chronic |
| 257. ____ Flush easily | 265. ____ Excessive hair loss and / or coarse hair |
| 258. ____ Fast pulse at rest | 266. ____ Morning headaches, wear off during the day |
| 259. ____ Intolerance to high temperatures | 267. ____ Loss of lateral 1/3 of eyebrow |
| 260. ____ Difficulty losing weight | 268. ____ Seasonal sadness |

Section 12 - Men Only

- | | |
|----------------------------------------------------|---------------------------------------------------|
| 269. ____ Prostate problems | 273. ____ Waking to urinate at night |
| 270. ____ Urination difficult or dribbling | 274. ____ Interruption of stream during urination |
| 271. ____ Difficult to start and stop urine stream | 275. ____ Pain on inside of legs or heels |
| 272. ____ Pain or burning with urination | 276. ____ Feeling of incomplete bowel evacuation |
| | 277. ____ Decreased sexual function |

Section 13 - Women Only

- | | |
|-----------------------------------------------------|--------------------------------------------------------|
| 278. ____ Depression during periods | 288. ____ Breast fibroids, benign masses |
| 279. ____ Mood swings associated with periods (PMS) | 289. ____ Painful intercourse (dyspareunia) |
| 280. ____ Crave chocolate around periods | 290. ____ Vaginal discharge |
| 281. ____ Breast tenderness associated with cycle | 291. ____ Vaginal dryness |
| 282. ____ Excessive menstrual flow | 292. ____ Vaginal itchiness |
| 283. ____ Scanty blood flow during periods | 293. ____ Gain weight around hips, thighs and buttocks |
| 284. ____ Occasional skipped periods | 294. ____ Excess facial or body hair |
| 285. ____ Variations in menstrual cycles | 295. ____ Hot flashes |
| 286. ____ Endometriosis | 296. ____ Night sweats (in menopausal females) |
| 287. ____ Uterine fibroids | 297. ____ Thinning skin |

Section 14

- | | |
|-------------------------------------------------------|---------------------------------------------------------------------------------------------------|
| 298. ____ Aware of heavy and / or irregular breathing | 303. ____ Ankles swell, especially at end of day |
| 299. ____ Discomfort at high altitudes | 304. ____ Cough at night |
| 300. ____ "Air hunger" and / or yawn frequently | 305. ____ Blush or face turns red for no reason |
| 301. ____ Compelled to open windows in a closed room | 306. ____ Dull pain or tightness in chest and / or radiate into right arm,
worse with exertion |
| 302. ____ Shortness of breath with moderate exertion | 307. ____ Muscle cramps with exertion |

Section 15

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|-------------------------------------------------------|--------------------------------------------|
| 308. ____ Pain in mid back region | 311. ____ Cloudy, bloody or darkened urine |
| 309. ____ Dark circles under eyes and / or puffy eyes | 312. ____ Urine has a strong odor |
| 310. ____ History of kidney stones (1 = yes, 0 = no) | |

Section 16

- | | |
|------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
| 313. ____ Runny or drippy nose | 319. ____ Acne (adult) |
| 314. ____ Catch colds at the beginning of winter | 320. ____ Itchy skin / dermatitis |
| 315. ____ Mucus producing cough | 321. ____ Cysts, boils, rashes |
| 316. ____ Frequent infections (ear, sinus, lung, skin, bladder,
kidney, etc.) | 322. ____ History of Epstein Bar, Mono, Herpes, Shingles,
Chronic Fatigue, Hepatitis or other chronic viral condition
(1 = yes, 0 = no) |
| 317. ____ Frequent colds or flu | |
| 318. ____ Never get sick (3 = not in last 7 yrs., 2 = not in last 4 yrs.,
1 = not in last 2 yrs.) | |

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Daily Food Log

Day 1

Breakfast:

Mid-Morning Snack:

Lunch:

Mid-Afternoon Snack

Dinner:

Evening Snack:

Water Intake (oz):

Other Drinks:

Energy (1-10):

Sleep Quality (1-10):

Day 2

Breakfast:

Mid-Morning Snack:

Lunch:

Mid-Afternoon Snack

Dinner:

Evening Snack:

Water Intake (oz):

Other Drinks:

Energy (1-10):

Sleep Quality (1-10):

Day 3

Breakfast:

Mid-Morning Snack:

Lunch:

Mid-Afternoon Snack

Dinner:

Evening Snack:

Water Intake (oz):

Other Drinks:

Energy (1-10):

Sleep Quality (1-10):