Dr. Joseph Byus, D.C.

Intuitive Holistic Chiropractic Physician
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Name:_____ Date:_____

Address: _____

City: _____State: _____ Zip Code: _____

Best Phone Numbers to Reach You At: 1) _____ 2) _____

Email Address: _____

Please mark your preference for occasional follow up from our office: _____ Email _____ Phone

Age: _____ Birthdate: _____ Sex: M F Marital Status: M S W D No. Children: _____

Occupation: _____ Employer: _____ Years Employed: _____

Spouse's Name: _____ Occupation: _____ Employer: _____

Person responsible or this account: _____ Referred by: _____

Insurance ID#:_____

Insurance Name & Phone #:_____

Second Insurance Name, ID# & Phone #:_____(when applicable)

What is your major complaint? _____ If in pain, please describe location and how it feels (burning, stabbing, throbbing?) _____

When did it begin? _____ Is it the result of an accident? _____Does it interfere with your daily life? _____Have you had this problem before? _____ Do you have any other complaints? _____

Have you been to a chiropractor before? _____If yes, when? _____Who?_____

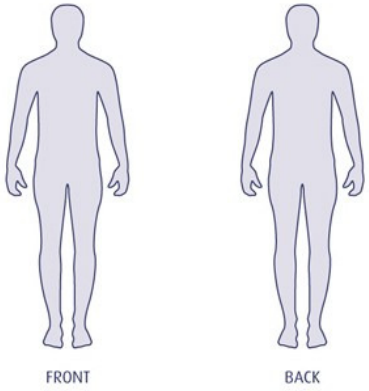
What are your overall health goals once your complaints are resolved? _____

I clearly understand and agree that I am responsible for all services rendered to me. I also understand that if I suspend or terminate my care and treatment, any fees for the professional services rendered to me will be immediately due and payable.

Patient's Signature :_____ Date: _____

Please answer all questions frankly, to the best of your knowledge. All information is confidential.

Please place "x's" where you are feeling pain on the diagram below:



Weight _____ **Height** _____ **Blood Pressure** (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins?
(*please list-attach sheet if necessary)*

_____

_____

2. In the past, have you used birth control pills and/or antibiotics?

If yes, for how long? _____

3. If you have fillings, please list materials used, if known: _____

4. Do you presently, or have you ever had any of these conditions? Please circle.

Addictions	Depression	Liver Problems
Anemia	Diabetes Fatigue	Migraines
Anxiety	Fatigue	OCD
ADHD	Fibromyalgia	Osteoporosis
Arthritis	Heartburn	PTSD
Asthma	High Blood Pressure	Restless Leg Syndrome
Chest pains	High Cholesterol	Thyroid Condition
Chronic Pain	Hypoglycemia	Tinnitus
Constipation	Insomnia	Tourette's Syndrome
Crohn's Dx/Ulcerative Colitis	Kidney problems	Unexplained weight change

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions? _____

_____

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often? _____

b. How often do you drink caffeinated beverages? _____

8. Please list foods you tend to overeat or crave (Sweets, breads, fatty foods, meats, milk, etc.)

_____

_____

9. Are there foods that you eat on a daily basis, almost daily basis? _____

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history: _____

_____

a. What do you feel triggered your weight fluctuation? (circle)

Heredity Stress Boredom Eating Habits Busy Schedule

b. Was your weight gain/loss: (circle) Sudden Gradual Problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity: _____

_____

12. What methods have you tried to lose/gain weight? _____

_____

13. How is your energy level? _____

14. Are you happy with your life right now?_____

15. What are your main sources of stress? _____

16. How do you deal with your stress? _____

17. Please answer the following questions Yes or No: (circle)

a. If I'm feeling down, a snack makes me feel better. Yes No

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes No

c. I get tired and/or hungry in the mid-afternoon. Yes No

d. I get sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.
Yes No

e. Now and then I think I am a secret eater. Yes No

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes No

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes No

h. I experience cravings for sugar, breads, pasta and baked goods. Yes No

i. I feel shaky if I don't eat on time or if I don't snack. Yes No

j. I often find myself irritable or angry. Yes No

18. Check off any of the following that have applied to you <u>within the last 30 days:</u>

_____ Do you feel nauseous? **_____ Do you have abdominal/intestinal pain?**

_____ Do you have bloating? **_____ Do you get bloated after meals?**

_____ Do you get heartburn? **_____ Do you have diarrhea?**

_____ Do you have constipation? **_____ Do you travel outside of the U.S.?**

_____ Do you have gas? **_____ Are your stools compact/hard to pass?**

_____Do you belch following meals? **_____ Do you have gurgles in your stomach?**

_____ Do your bowel movements alternate between constipation and diarrhea?

19. In your estimation, how physically fit are you right now?

Unfit _____ Below Average_____ Average_____ Above Average_____ Very Fit_____

20. If you exercise, how often do you exercise and what is your regime?

_____

21. Surgeries, starting with most recent: _____

_____

22. Hospitalizations: _____

23. Briefly describe where you have lived since childhood: _____

_____

24. What is your heritage? (Irish, German, Spanish, etc.)

_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I hereby consent that I and/or my dependents(s) desire to receive spinal care, including nutritional evaluations and wellness education in this office by Dr. Joseph Byus **who provides a combination of low force techniques and nutritional recommendations. I understand that the care offered at this office is not a form of, or replacement for, the diagnosis or treatment of any symptom, disease, or malady. Instead, it is a form of wellness care and self-education that develops new strategies for spinal and nervous system integrity and overall health and wellness.**

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Dr. Joseph Byus **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 authorize the use of my signature on all insurance submissions.**

Dr. Joseph Byus **may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.**

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative **Date**

Thank you for taking the time to fill out this questionnaire. The information you have provided will be used to create an appropriate action plan to support your health goals.

Electronic Signatures Are Legally Binding