Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

Last Name: ______________________________ First: ________________________________
Address: ____
City: ____________________________ State: ____________________ Zip: ______________
Home Phone: (_____)_____________________ Cell: (_____)_________________________
Email: ____
Date of Birth: ________________________________ Sex: Male Female
Marital Status: Married Single Divorced Widowed Other
Social Security #: _______________________ Referred to this office by: _________________

Have you been treated by a Physician for any condition in the past year?
Yes No If yes by whom? ____
Describe condition: ____

Have you received Chiropractic Care before? Yes No
Are you currently receiving Chiropractic Care? Yes No

List Current Medications:

1. ____________________________________ 6. ____________________________________
2. ____________________________________ 7. ____________________________________
3. ____________________________________ 8. ____________________________________
4. ____________________________________ 9. ____________________________________
5. ____________________________________ 10. ___________________________________

Any known medication allergies? Yes No
List: ____

List nutritional / herbal supplements you are currently taking:

1. ____________________________________ 4. ____________________________________
2. ____________________________________ 5. ____________________________________
3. ____________________________________ 6. ____________________________________

Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

1. Why did you decide to come to this clinic?
   ____
   ____

2. What do you know about our approach to natural health?
   ____
   ____

3. What expectations do you have from this visit?
   ____
   ____

4. What long-term expectations do you have from working with our clinic?
   ____
   ____

5. What expectations do you have for Dr. Lozier as your health care provider?
   ____
   ____

6. What is your present level of commitment to address your health concerns?

   Rate from 0 to 10 (10 being 100% committed)

7. What behaviors/habits do you currently engage in that support your health?
   ____
   ____

8. What behaviors/habits do you currently engage in that are self-destructive?
   ____
   ____

9. List any potential obstacles that might undermine your ability to adhere to the therapeutic protocol we will be sharing with you?
   1. ____
   2. ____
   3. ____

Lozier Natural Health Center, PC

Integrative Treatments for Whole Body Health

10. List someone that will support you with the beneficial changes you will be making? ____

11. What do you love to do? ____

Please list your Primary Health Concerns:

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Please list your Health Goals:

1. ______________________ 3. ______________________
2. ______________________ 4. ______________________

Surgical History:

1. ______________________________ Date: ____________
2. ______________________________ Date: ____________
3. ______________________________ Date: ____________
4. ______________________________ Date: ____________
5. ______________________________ Date: ____________

Dietary:

How many times per week do you eat out? ______________________

Do you have food allergies or food sensitivities? ______________________

How many times per week do you eat raw nuts and seeds? ______________________

How many times per week do you eat fish? ______________________

List the 3 worst foods you eat during an average week? ______________________

List the 3 healthiest foods you eat during an average week? ______________________

How much water do you drink in a typical day? ______________________

How many fresh fruit do you eat in a typical day? ______________________

How many fresh vegetables do you eat in a typical day? ______________________

Family History Checklist

Name: ____________________

	You	Mother	Father	Children	Siblings	Father's Parents	Mother's Parents
Allergies							
Alcohol Abuse							
Alzheimer's or Dementia							
Anemia							
Asthma							
Arthritis							
Bleeding Problems							
Birth Defects							
Any Cancer							
Breast Cancer							
Ovarian Caner							
Lung Cancer							
Colon Cancer							
Other Cancer							
High Cholesterol							
Chronic Infections							
Chicken Pox							
Clotting Problems							
Depression							
Diabetes Type I							
Diabetes Type II							
Drug Abuse							
Downs Syndrome							
Emphysema							
Epilepsy / Seizures							

	You	Mother	Father	Children	Siblings	Father's Parents	Mother's Parents
Epstein Barr Virus							
Glaucoma							
Hearing Loss							
Heart Trouble							
Hemochromatosis							
High Blood Pressure							
Infertility							
Kidney / Renal Issues							
Memory Loss							
Measles							
Mental Illness							
Mental Retardation							
Mononucleosis							
Mumps							
Neurofibromatosis							
Obesity							
Osteoporosis							
PKU / "metabolic disease" at birth							
Sickle Cell Anemia							
Smoking							
Stillborn / Infant Death							
Stroke							
Violence / Domestic Abuse							

Name____ Date______________

Symptom Survey

<u>Write which number applies to you.</u> Use (1) for MILD (occurs 1-2 times per month)

Use (2) for MODERATE (occurs several times per month) Use (3) SEVERE (occurs almost constantly)

GROUP 1- SYM
Acids Food Upset
Get Chilled Often
" Lump in Throat"
Dry Mouth, eyes, nose
Pulse speeds after meal
Keyed up- Fail to calm
Cuts Heal Slowly
Gag Easily
Unable to Relax- Startle easily
Extremities cold, clammy
Strong light irritates
Urine amount reduced
Heart Pounds after retiring
"Nervous" Stomach
Appetite reduced
Cold Sweats often
Fever Easily raised
Neuralgia like pains
Staring, Blinks little
Sour stomach frequently

GROUP 2- PARA
Joint Stiffness after rising
Muscle, leg, toe cramps at night
"Butterfly" Stomach
Eyes or Nose watery
Eyes Blink often
Eyelids swollen, puffy
Indigestion Soon after meals
Always seem hungry "lightheaded"
Digestion rapid
Vomiting frequent
Hoarseness frequent
Breathing Irregular
Pulse Slow, feels "irregular"
Gagging reflex slow
Difficulty swallowing
Constipation/ diarrhea alternating
"Slow Starter"
Get "chilled" infrequently
Perspire easily
Circulation poor, sensitive to cold
Subject to colds, asthma, bronchitis

GROUP 3- SUGAR HANDLING
Eat when nervous
Excessive appetite
Hungry between meals
Irritable before meals
Get "shaky" if hungry
Fatigue, eating relieves
"Lightheaded" if meals delayed
Heart palpitation if meals missed
Afternoon headaches
Overeating Sweets upsets
Awaken after few hour sleep
hard to get back to sleep
Crave candy or coffee afternoons
Moods of depression-
"blues" or melancholy
Abnormal craving for sweets

GROUP 3A-BLOOD SUGAR HYPO
Crave sweets during the day
Irritable if meals are missed
Depend on coffee to keep going/ get started
Get light-headed if meals are missed
Eating relieves fatigue
Feel shaky, jittery, or have tremors
Agitated, easily upset, nervous
Poor memory/ forgetful
Blurred vision

GROUP 3B- INSULIN RESISTANCE
Fatigue after meals
Crave sweets during the day
Eating sweets does not relieve cravings for sugar
Must have sweets after meals
Waist girth is equal or larger than hip girth
Frequent urination
Increased thirst and appetite
Difficulty losing weight

GROUP 4- CARDIO
Hands & feet go to sleep easily
Sigh frequently
Aware of "breathing heavily"
High altitude discomfort
Opens windows in closed rooms
Susceptible to colds & fevers
Afternoon "yawner"
Get drowsy often
Swollen ankles worse at night
Muscle cramps, worse during
exercise; get "charley horses"
Shortness of breath on exertion
Dull pain in chest or radiating into
left arm, worse on exertion
Bruise easily, "black & blue" spots
Tendency to anemia
"Nose bleeds" frequent
Noises in head or "ringing in ears"
Tension under breastbone or
feeling of "tightness"
worse on exertion

GROUP 5- GB/LVR
Dizziness
Dry Skin
Burning Feet
Blurred Vision
Itchy skin & feet
Excessive falling hair
Frequent skin rashes
Bitter metallic taste in mouth
in morning
Bowel movements painful
Worrier, feels insecure
Feeling queasy; headache over eyes
Greasy foods upset
Stools Light colored
Skin peels on foot soles
Pain between shoulder blades
Use Laxatives
Stools alternate from soft to watery
History of gallbladder attacks
or gallstones
Sneezing attacks
Dreaming, nightmare type dreams
Bad Breath (halitosis)
Milk products cause distress
Sensitive to hot weather
Burning or itching anus
Crave Sweets

GROUP 5A-BIL
Greasy or high-fat foods cause distress
Lower bowel gas and/or bloating several hours
after eating
Bitter metallic taste in mouth especially in the morning
Burp, fishy taste after consuming fish oils
Difficulty losing weight
Unexplained itchy skin
Yellowish cast to eyes
Stool color alternates from clay colored to normal
Reddened skin, especially palms
Dry or flaky skin and/or hair
History of gallbladder attacks or stones
Had gallbladder removed

GROUP 5B-HEP DETOX
Acne and unhealthy skin
Excessive hair loss
Overall sense of bloating
Bodily swelling for no reason
Hormone imbalances
Weight gain
Poor bowel function
Excessively foul-smelling sweat

GROUP 6A-STM HYPO
Excessive belching, burping, or bloating
Gas immediately following a meal
Offensive breath
Difficult bowel movements
Sense of fullness during and after meals
Difficulty digesting fruits and vegetables;
undigested foods found in stools

GROUP 6A- HYPER
Stomach pain, burning or aching 1-4 hours after eating
Frequently use antacids
Feeling hungry an hour or two after eating
Heartburn when lying down or bending forward
Temporary relief using antacids, food, milk,
or carbonated beverages
Digestive problems subside with rest & relaxation
Heartburn due to spicy foods, chocolate, citrus,
peppers, alcohol, and caffeine

Name____ Date________________

Symptom Survey

Write the number that applies to you. Use (1) for MILD (occurs 1-2 times per month)
Use (2) for MODERATE (occurs several times per month) Use (3) SEVERE (occurs almost constantly)

GROUP 6- GB
- Loss of Taste for meats
- Lower bowel gas several hours after eating
- Burning stomach sensations, eating relieves
- Coated tongue
- Pass large amounts of foul-smelling gas
- Indigestion 1/2- 1 hour after eating, maybe up to 3-4 hours
- Mucous colitis or "irritable bowel"
- Gas shortly after eating
- Stomach bloating after eating

GROUP 6C-INTESTIONAL INTEGRITY
- Increasing frequency of food reactions
- Unpredictable food reactions
- Aches, pains, & swelling throughout the body
- Unpredictable abdominal swelling
- Frequent bloating and distention after eating
- Abdominal intolerance to sugars and starches

GROUP 7B- THY HYPO
- Increase in weight
- Decrease in appetite
- Fatigue easily
- Ringing in ears
- Sleepy during day
- Sensitive to cold
- Dry or scaly skin
- Constipation
- Mental Sluggishness
- Hair Coarse, falls out
- Headaches upon arising wear off during day
- Slow pulse, below 65
- Frequency of urination
- Impaired hearing
- Reduced initiative

GROUP 7E
- Dizziness
- Headaches
- Hot flashes
- Increased Blood pressure
- Hair growth on face or body(female)
- Sugar in urine (not diabetes)
- Masculine tendencies (female)

GROUP 7E- ADR HYPER
- Cannot fall asleep
- Perspire easily
- Under high amounts of stress
- Weight gain when under stress
- Wake up tired even after 6 or more hours sleep
- Excessive perspiration/ perspiration w/ no activity

GROUP 9- ELECTRO
- Edema and swelling in ankles and wrist
- Muscle cramping
- Poor muscle endurance
- Frequent urination
- Frequent thirst
- Crave Salt
- Abnormal sweating with minimal activity
- Alteration in bowel regularity
- Inability to hold breath for long periods
- Shallow, rapid breathing

GROUP 6B- SMI/PAN
- Roughage and fiber cause constipation
- Indigestion/ fullness lasts 2-4 hours after eating
- Pain, tenderness, soreness, on left side under rib cage
- Excessive passage of gas
- Nausea and/or vomiting
- Stool undigested, foul smelling, mucous like, greasy, or poorly formed
- Frequent urination
- Increased thirst and appetite

GROUP 7A- PIT UP
- Insomnia
- Nervousness
- Can't gain weight
- Intolerance to heat
- Highly emotional
- Flush easily
- Night Sweats
- Thin, moist skin
- Inward trembling
- Heart palpitates
- Increased appetite without weight gain
- Pulse fast at rest
- Eyelids and face twitch
- Irritable and restless
- Can't work under pressure

GROUP 7B- THY HYPO
- Tired/ sluggish
- Feel cold- hands, feet, all over
- Require excessive amounts of sleep to function
- Increase in weight even with low calorie diet
- Gain weight easily
- Difficult, infrequent bowel movements
- Depression/ lack of motivation
- Morning headaches that wear off as day progresses
- Outer third of eyebrows thin
- Thinning of hair on head or body, excessive hair loss
- Dryness of skin and/or scalp
- Mental sluggishness

GROUP 7F-ADR HYPO
- Weakness, dizziness
- Chronic Fatigue
- Low blood pressure
- Nails weak, ridged
- Tendency to hives
- Arthritic tendencies
- Perspiration increase
- Bowel disorders
- Poor circulation
- Swollen ankles
- Crave salt
- Brown spots or bronzing of skin
- Allergies- tendency to asthma
- Weakness after colds, influenza
- Exhaustion- muscular & nervous
- Respiratory Disorders

GROUP 6C- COLON
- Feeling that bowel do not empty completely
- Lower abdominal pain relief by passing gas
- Alternating constipation and diarrhea
- Diarrhea
- Constipation
- Hair, dry, or small stool
- Coated tongue of "fuzzy" debris on tongue
- Pass large amount of foul smelling gas
- More than 3 bowel movements daily
- Use laxatives frequently

GROUP 7A- THY HYPER
- Heart palpitations
- Inward trembling
- Increased pulse even at rest
- Nervous and emotional
- Insomnia
- Night sweats
- Difficulty gaining weight

GROUP 7C- PIT HYPER
- Failing memory
- Low blood pressure
- Increased sex drive
- Headaches "splitting or rending"
- Decreased sugar intolerance
- Increased sex drive
- Tolerance to sugars reduced
- "Splitting" type headaches

GROUP 7D- PIT HYPO
- Abnormal thirst
- Bloating of abdomen
- Weight gain around hips or waist
- Sex drive reduced or lacking
- Tendency to ulcers, colitis
- Increased sugar tolerance
- Women: menstrual disorders
- Young Girls: lack of menstrual function
- Diminished sex drive
- Menstrual disorders of lack of menstruation
- Increased ability to eat sugars without symptoms

GROUP 8
- Apprehension
- Irritability
- Morbid fears
- Never seems to get well
- Forgetfulness
- Indigestion
- Poor appetite
- Craving for sweets
- Muscular soreness
- Depression; feelings of dread
- Noise sensitivity
- Acoustic hallucinations
- Tendency to cry without reason
- Hair is coarse and/or thinning
- Weakness
- Fatigue
- Skin sensitive to touch
- Tendency toward hives
- Nervousness
- Headache
- Insomnia
- Anxiety
- Anorexia
- Inability to concentrate; confusion
- Frequently stuffy nose; sinus infections
- Allergy to foods
- Loose joints

Name________________________________ Date______________ consistency taking supplements________%

MEN'S FUNCTIONAL HEALTH ANALYSIS

FOR YOUR 1ST VISIT-CHECKMARK ANY SYMPTOM YOU HAVE EXPERIENCED IN THE LAST MONTH.
FOR RE-EXAMS- CHECKMARK SYMPTOMS YOU ARE CURENTLY EXPERIENCING.

HEADACHES
___ Base of Skull (back)
___ Side of Head (Temples)
___ Frontal (above eyes)
___ Top of Head
___ Entire Head
___ Migraines
___ TMJ
___ Cluster
Other______________________

EARS
___ Noise (Ring/Hiss/Pound)
___ Plugged
___ Popping
___ Ear Ache
___ Ear Infections
___ Draining
___ Itchy
___ Hearing Loss
___ Dizziness/ Vertigo
___ Excessive Ear Wax
Other________________________

EYES
___ Burn
___ Tear
___ Ache
___ Red
___ Dry
___ Eye Film
___ Crust in morning
___ Itchy Eyes
___ Bouts of Blurriness
___ Floaters
___ Spots
___ Tired
___ Puffy
___ Stye
___ Twitching around eyes
___ Dark Circles
___ Light Bothers Eyes
___ Nearsighted
___ Farsighted
___ Other________________________

SINUS
___ Dry
___ Drain
___ Stuffy/Plugged/ pressure
___ Post nasal drip….Write Color white/yellow/green/gray brown/blood/clear
___ Excessive sneezing
___ Loss of smell
___ Loss of Taste
___ Thirsty
___ Not Thirsty
___ Unquenchable thirst
___ Other________________________

MOUTH/THROAT/IMMUNE
___ Sore Throat
___ Hoarseness
___ Cough (dry or productive)
___ Allergies
___ Upper Respiratory Infection
___ Fever
___ Chills
___ Bad Breath
___ Canker Sores
___ Blisters
___ Frequent colds/flu
___ Neck Stiffness
___ Shoulder Tension
___ Cracks at lip corner/ Chielosis
___ Dry Mouth
___ Cold sweaty hands & feet
___ Bleeding gums
___ Receeding gums
___ Teeth Health Problems
___ Swelling of glands

Chest
___ Tension
___ Tight
___ Pressure
___ Heaviness
___ Anxiety
___ Congestion
___ Chest Pain
___ Sternal Pain
___ Sharp Heart Pain
___ Palpitations-Heart skip/ Flutter
___ Mitral Valve Prolapse
___ Tachycardia/ Heart Racing
___ Bradycardia/ Heart Slowing down
___ Murmur
___ Arm Pain
___ Constant shortness of breath
Other________________________

SHORTNESS OF BREATH
___ Constant
___ Upon Exertion
___ Asthma
___ Wheezing
___ Air Hunger/ Frequent Sighs
___ Yawning
___ Emphysema
___ Other________________________

STOMACH
___ Heartburn
___ Indigestion
___ Stomach Aches
___ Stomach Cramps
___ Nausea/ Queasy
___ Bloat after eat
___ Gas/ Flatulence
___ Belching
___ Ulcer
___ Hiatal Hernia
___ Other________________________

BOWELS
___ Bowels Movements ______Per day
___ Regular
___ Incomplete Bowel Evacuation
___ Skip days_______per (week/month)
___ Sluggish bowels every ______days
___ Cramps in abdomen
___ Taking laxatives
___ Using Suppositories
___ Enemas
___ Colonics
___ Take Herbal laxatives/ Supplements
___ Bulky
___ Pain with bowel movements
___ Irritable Bowel Syndrome
___ Chrons
___ Colitis
___ Other________________________

FECAL CONSISTENCY
___ Color feces light or dark_________
___ Soft/ Unformed
___ Ribbon-like
___ Mucous
___ Normal/ Banana Shaped
___ Hard
___ Pebbles
___ Dry
___ Painful
___ Diarrhea
___ Constipation
___ Broken
___ Other________________________

PECKS
___ Breast Shrinking
___ Fibrosis
___ Lump
___ Discharge
___ Prosthesis
___ Augmentation Surgery
___ Reduction Surgery
___ Pathology
___ Breast Tender Constant

CRAMPS/ACHES/RESTLESS
___ Cramps(legs/ feet/ arms/ hands)
___ Aches(legs/ feet/ arms/ hands)
___ Restless(legs/ feet/ arms/ hands

STAMINA
___ Decreased morning Erections
___ Decreased Fullness Erections
___ Inability to Concentrate
___ Episodes of Depression
___ Decreased physical Stamina
___ Sweating attacks
___ More emotional than past
___ Unexplained weight gain
___ Avoids Activity
___ Lack of Energy
___ Tire too easily
___ Leg Nervousness at night
___ Pain on the inside of legs

PROSTATE
___ History
___ Current
___ Burn
___ Achyness
___ Pain
___ Restriction
___ Dribbling
___ Emission
___ Swelling
___ Testicular Pain

LIBIDO/SEXUALITY
Sex Drive- Check One
Flat
Low
Normal
High
Orgasm Quality- Check One
Poor
Good
Great
___ Other ________________________

APPETITE/ DIET
___ Appetite(Low/ Normal/ High)
___ Crave Salt/ Salty foods __________
___ Crave Sweets
___ Crave Starch ________________
___ Crave Chocolate
___ Crave Spicy Foods
___ Coffee ___________cups per day
___ Alcohol _________Drinks per week
___ Soda ___________Per week
Artificial Sweetners
Animal Protein per day ________oz

HEMORRHOIDS
___ History
___ Current
___ Swollen
___ Burn
___ Blood
___ Distended

SKIN/ HAIR/ NAILS
___ Skin rash
___ Acne
___ Dry Skin
___ Itchy Skin
___ Fungus
___ Patches (skin looks different)
___ Cellulite
___ Nails (weak/ spots/ lines)
___ Hair loss
___ Limp Hair
___ Cherry Hemangiomas
___ Worts
___ Cracked Heels
___ Slow Healing
___ Bruise Easily
___ Other________________________

URINATION
______Times per day (frequency)
___ Urinate at night ________per night
___ Frequency
___ Urgency
___ Burning
___ Pain
___ Odor
___ Spasm
___ Leakage
___ Urinary Tract Infection
___ Kidney Troubles
___ Cloudy Urine
Difficulty starting Flow
Other ________________________

SLEEP
Quality (poor/ fair/ good/ great)
_________Hours in bed
_________Hours asleep
___ Difficulty falling asleep
___ Difficulty staying asleep
___ Interrupted ___________per night
___ Crave sleep during day
___ Awaken Sudden (Jolt)
___ Don't Remember Dreams
___ Nightmares
___ Night Sweats
___ Restlessness
Sleep Apnea
Wake up feeling Rested
___ Other ________________________

EMOTIONS
___ Stressed
___ Sad
___ Grief
___ Depression
___ Moodiness
___ Irritable
___ Worrisome
___ Angry
___ Nervous
___ Frustrated
___ Anxiety
___ Panic
___ Cry
___ Fear
___ Shame
___ Apathy

ENERGY
___ Low
___ Variable
___ Normal
___ High
___ Slow to Start in morning
___ Energy Crash ___________am/pm
___ Low energy after meals
___ Dizzy when stand quickly
___ Irritable with skip meals
___ Eating relieves fatigue
___ Bouts of blurred vision
___ Light headed when skip meals

EXERCISE
___ Cardiovascular ________times/week
___ Weight Training ________times/week

MEMORY
___ Short Term Loss
___ Long Term Loss
___ Forget Names
___ Forget Numbers
___ Forget Words
___ Forget Actions
___ Difficulty Concentrating
___ Other ________________________

PAIN/ STIFFNESS/ SWELLING NUMBNESS/ TINGLING
___ Facial
___ Neck
___ Trapezius
___ Upper Back
___ Shoulders
___ Arms
___ Elbows
___ Wrist
___ Hand
___ Mid Back
___ Low Back
___ Sacral Iliac
___ Hips
___ Buttocks
___ Legs
___ Sciatica
___ Knees
___ Ankles
___ Feet

LIST PRIMARY CONCERNS
1)____________________________
____
2)____________________________
____
3)____________________________
____

FOR DOCTOR'S USE
Luna Fingernails-
Rt 1 2 3 4 5 Lt 1 2 3 4 5
Splinter Hemorrhages
Frenular Cyst
Cracks in Tongue
Allergy Patches Tongue
Geographic Tongue
Red Spots Tongue
Swollen Tongue
Color Tongue __________________
Dark Veins Tongue
Coated Tongue (Mild/ Mod/ Severe)
Ear Creases (Rt/ Lt) mild/ mod/severe
Cherry Hemangioma
Height:________________________
Weight:________________________
Pulse:________________________
Blood Pressure:________________
Saliva PH________Urine PH_______
Allergies:______________________
Current Meds:___________________