



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.



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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. _____
2. _____
3. _____
4. _____

Please list your Health Goals:

1. _____
2. _____
3. _____
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 Cancer

 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 _____

Symptom Survey.xls

Date _____

Symptom Survey

Write which number 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 1- SYM			GROUP 2- PARA			GROUP 3- SUGAR HANDLING		
Acids Food Upset			Joint Stiffness after rising			Eat when nervous		
Get Chilled Often			Muscle, leg, toe cramps at night			Excessive appetite		
"Lump in Throat"			"Butterfly" Stomach			Hungry between meals		
Dry Mouth, eyes, nose			Eyes or Nose watery			Irritable before meals		
Pulse speeds after meal			Eyes Blink often			Get "shaky" if hungry		
Keyed up- Fail to calm			Eyelids swollen, puffy			Fatigue, eating relieves		
Cuts Heal Slowly			Indigestion Soon after meals			"Lightheaded" if meals delayed		
Gag Easily			Always seem hungry "lightheaded"			Heart palpitation if meals missed		
Unable to Relax- Startle easily			Digestion rapid			Afternoon headaches		
Extremities cold, clammy			Vomiting frequent			Overeating Sweets upsets		
Strong light irritates			Hoarseness frequent			Awaken after few hour sleep		
Urine amount reduced			Breathing Irregular			hard to get back to sleep		
Heart Pounds after retiring			Pulse Slow, feels "irregular"			Crave candy or coffee afternoons		
"Nervous" Stomach			Gagging reflex slow			Moods of depression-		
Appetite reduced			Difficulty swallowing			"blues" or melancholy		
Cold Sweats often			Constipation/ diarrhea alternating			Abnormal craving for sweets		
Fever Easily raised			"Slow Starter"					
Neuralgia like pains			Get "chilled" infrequently					
Staring, Blinks little			Perspire easily			GROUP 5A-BIL		
Sour stomach frequently			Circulation poor, sensitive to cold			Greasy or high-fat foods cause distress		
			Subject to colds, asthma, bronchitis			Lower bowel gas and/or bloating several hours		
						after eating		
GROUP 3A-BLOOD SUGAR HYPO			GROUP 3B- INSULIN RESISTANCE			Bitter metallic taste in mouth especially in the morning		
Crave sweets during the day			Fatigue after meals			Burp, fishy taste after consuming fish oils		
Irritable if meals are missed			Crave sweets during the day			Difficulty losing weight		
Depend on coffee to keep going/ get started			Eating sweets does not relieve cravings for sugar			Unexplained itchy skin		
Get light-headed if meals are missed			Must have sweets after meals			Yellowish cast to eyes		
Eating relieves fatigue			Waist girth is equal or larger than hip girth			Stool color alternates from clay colored to normal		
Feel shaky, jittery, or have tremors			Frequent urination			Reddened skin, especially palms		
Agitated, easily upset, nervous			Increased thirst and appetite			Dry or flaky skin and/or hair		
Poor memory/ forgetful			Difficulty losing weight			History of gallbladder attacks or stones		
Blurred vision						Had gallbladder removed		
						GROUP 5B-HEP DETOX		
						Acne and unhealthy skin		
GROUP 4- CARDIO			GROUP 5- GB/LVR			Excessive hair loss		
Hands & feet go to sleep easily			Dizziness			Overall sense of bloating		
Sigh frequently			Dry Skin			Bodily swelling for no reason		
Aware of "breathing heavily"			Burning Feet			Hormone imbalances		
High altitude discomfort			Blurred Vision			Weight gain		
Opens windows in closed rooms			Itchy skin & feet			Poor bowel function		
Susceptible to colds & fevers			Excessive falling hair			Excessively foul-smelling sweat		
Afternoon "yawner"			Frequent skin rashes					
Get drowsy often			Bitter metallic taste in mouth			GROUP 6A-STM HYPO		
Swollen ankles worse at night			in morning			Excessive belching, burping, or bloating		
Muscle cramps, worse during			Bowel movements painful			Gas immediately following a meal		
exercise; get "charley horses"			Worrier, feels insecure			Offensive breath		
Shortness of breath on exertion			Feeling queasy; headache over eyes			Difficult bowel movements		
Dull pain in chest or radiating into			Greasy foods upset			Sense of fullness during and after meals		
left arm, worse on exertion			Stools Light colored			Difficulty digesting fruits and vegetables;		
Bruise easily, "black & blue" spots			Skin peels on foot soles			undigested foods found in stools		
Tendency to anemia			Pain between shoulder blades			GROUP 6A- HYPER		
"Nose bleeds" frequent			Use Laxatives			Stomach pain, burning or aching 1-4 hours after eating		
Noises in head or "ringing in ears"			Stools alternate from soft to watery			Frequently use antacids		
Tension under breastbone or			History of gallbladder attacks			Feeling hungry an hour or two after eating		
feeling of "tightness"			or gallstones			Heartburn when lying down or bending forward		
worse on exertion			Sneezing attacks			Temporary relief using antacids, food, milk,		
			Dreaming, nightmare type dreams			or carbonated beverages		
			Bad Breath (halitosis)			Digestive problems subside with rest & relaxation		
			Milk products cause distress			Heartburn due to spicy foods, chocolate, citrus,		
			Sensitive to hot weather			peppers, alcohol, and caffeine		
			Burning or itching anus					
			Crave Sweets					

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			GROUP 6B- SMI/PAN			GROUP 6C- COLON		
		Loss of Taste for meats			Roughage and fiber cause constipation			Feeling that bowel do not empty completely
		Lower bowel gas several hours after eating			Indigestion/ fullness lasts 2-4 hours after eating			Lower abdominal pain relief by passing gas
		Burning stomach sensations, eating relieves			Pain, tenderness, soreness, on left side under			Alternating constipation and diarrhea
		Coated tongue			rib cage			Diarrhea
		Pass large amounts of foul-smelling gas			Excessive passage of gas			Constipation
		Indigestion 1/2- 1 hour after eating,			Nausea and/or vomiting			Hair, dry, or small stool
		maybe up to 3-4 hours			Stool undigested, foul smelling, mucous like,			Coated tongue of "fuzzy" debris on tongue
		Mucous colitis or "irritable bowel"			greasy, or poorly formed			Pass large amount of foul smelling gas
		Gas shortly after eating			Frequent urination			More than 3 bowel movements daily
		Stomach bloating after eating			Increased thirst and appetite			Use laxatives frequently
GROUP 6C-INTESTINAL INTEGRITY			GROUP 7A- PIT UP			GROUP 7A- THY HYPER		
		Increasing frequency of food reactions			Insomnia			Heart palpitations
		Unpredictable food reactions			Nervousness			Inward trembling
		Aches, pains, & swelling throughout the body			Can't gain weight			Increased pulse even at rest
		Unpredictable abdominal swelling			Intolerance to heat			Nervous and emotional
		Frequent bloating and distention after eating			Highly emotional			Insomnia
		Abdominal intolerance to sugars and starches			Flush easily			Night sweats
					Night Sweats			Difficulty gaining weight
					Thin, moist skin			
GROUP 7B- THY HYPO			GROUP 7B- THY HYPO			GROUP 7C- PIT HYPER		
		Increase in weight			Inward trembling			Failing memory
		Decrease in appetite			Heart palpitates			Low blood pressure
		Fatigue easily			Increased appetite without weight gain			Increased sex drive
		Ringing in ears			Pulse fast at rest			Headaches "splitting or rending"
		Sleepy during day			Eyelids and face twitch			Decreased sugar intolerance
		Sensitive to cold			Irritable and restless			Increased sex drive
		Dry or scaly skin			Can't work under pressure			Tolerance to sugars reduced
		Constipation						"Splitting" type headaches
		Mental Sluggishness			Tired/ sluggish			
		Hair Coarse, falls out			Feel cold- hands, feet, all over			
		Headaches upon arising wear off			Require excessive amounts of sleep to function			Abnormal thirst
		during day			Increase in weight even with low calorie diet			Bloating of abdomen
		Slow pulse, below 65			Gain weight easily			Weight gain around hips or waist
		Frequency of urination			Difficult, infrequent bowel movements			Sex drive reduced or lacking
		Impaired hearing			Depression/ lack of motivation			Tendency to ulcers, colitis
		Reduced initiative			Morning headaches that wear off as day progresses			Increased sugar tolerance
					Outer third of eyebrows thin			Women: menstrual disorders
					Thinning of hair on head or body, excessive hair loss			Young Girls: lack of menstrual function
GROUP 7E			GROUP 7E- ADR HYPER			GROUP 7D- PIT HYPO		
		Dizziness			Dryness of skin and/or scalp			Diminished sex drive
		Headaches			Mental sluggishness			Menstrual disorders of lack of menstruation
		Hot flashes						Increased ability to eat sugars without symptoms
GROUP 7E- ADR HYPER			GROUP 7F-ADR HYPO			GROUP 8		
		Cannot fall asleep			Tendency to hives			Apprehension
		Perspire easily			Arthritic tendencies			Irritability
		Under high amounts of stress			Perspiration increase			Chronic Fatigue
		Weight gain when under stress			Bowel disorders			Morbid fears
		Wake up tired even after 6 or more hours sleep			Poor circulation			Never seems to get well
		Excessive perspiration/ perspiration w/ no activity			Swollen ankles			Forgetfulness
					Crave salt			Indigestion
					Brown spots or bronzing of skin			Poor appetite
					Allergies- tendency to asthma			Craving for sweets
					Weakness after colds, influenza			Muscular soreness
					Exhaustion- muscular & nervous			Depression; feelings of dread
					Respiratory Disorders			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 CURRENTLY EXPERIENCING.

HEADACHES

- ___ Base of Skull (back)
- ___ Side of Head (Temples)
- ___ Frontal (above eyes)
- ___ Top of Head
- ___ Entire Head
- ___ Migraines
- ___ TMJ
- ___ Cluster
- ___ Other _____

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 _____

PECKS

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

SKIN/ HAIR/ NAILS

- ___ Skin rash
- ___ Acne
- ___ Dry Skin
- ___ Itchy Skin
- ___ Fungus
- ___ Patches (skin looks different)
- ___ Cellulite
- ___ Nails
- ___ Hair loss
- ___ Limp Hair
- ___ Cherry Hemangiomas
- ___ Warts
- ___ Cracked Heels
- ___ Slow Healing
- ___ Bruise Easily
- ___ Other _____

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

EARS

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

CRAMPS/ACHES/RESTLESS

- ___ Cramps
- ___ Aches
- ___ Restless

SHORTNESS OF BREATH

- ___ Constant
- ___ Upon Exertion
- ___ Asthma
- ___ Wheezing
- ___ Air Hunger/ Frequent Sighs
- ___ Yawning
- ___ Emphysema
- ___ 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 _____

EXERCISE

- ___ Cardiovascular _____times/week
- ___ Weight Training _____times/week

EYES

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

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

STOMACH

- ___ Heartburn
- ___ Indigestion
- ___ Stomach Aches
- ___ Stomach Cramps
- ___ Nausea/ Queasy
- ___ Bloat after eat
- ___ Gas/ Flatulence
- ___ Belching
- ___ Ulcer
- ___ Hiatal Hernia
- ___ Other _____

SLEEP

- ___ Quality _____
- ___ 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 _____

MEMORY

- ___ Short Term Loss
- ___ Long Term Loss
- ___ Forget Names
- ___ Forget Numbers
- ___ Forget Words
- ___ Forget Actions
- ___ Difficulty Concentrating
- ___ 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 _____

PROSTATE

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

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 _____

LIBIDO/SEXUALITY

- ___ Sex Drive- Check One
- ___ Flat
- ___ Low
- ___ Normal
- ___ High
- ___ Orgasm Quality- Check One
- ___ Poor
- ___ Good
- ___ Great
- ___ Other _____

PAIN/ STIFFNESS/ SWELLING

- ___ Facial
- ___ Neck
- ___ Trapezius
- ___ Upper Back
- ___ Shoulders
- ___ Arms
- ___ Elbows
- ___ Wrist
- ___ Hand
- ___ Mid Back
- ___ Low Back
- ___ Sacral Iliac
- ___ Hips
- ___ Buttocks
- ___ Legs
- ___ Sciatica
- ___ Knees
- ___ Ankles
- ___ Feet

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/ Cheliosis
- ___ Dry Mouth
- ___ Cold sweaty hands & feet
- ___ Bleeding gums
- ___ Receding gums
- ___ Teeth Health Problems
- ___ Swelling of glands

FECAL CONSISTENCY

- ___ Color feces light or dark _____
- ___ Soft/ Unformed
- ___ Ribbon-like
- ___ Mucous
- ___ Normal/ Banana Shaped
- ___ Hard
- ___ Pebbles
- ___ Dry
- ___ Painful
- ___ Diarrhea
- ___ Constipation
- ___ Broken
- ___ Other _____

APPETITE/ DIET

- ___ Appetite
- ___ 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 Sweeteners
- ___ Animal Protein per day _____oz

EMOTIONS

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

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: _____

HEMORRHOIDS

- ___ History
- ___ Current
- ___ Swollen
- ___ Burn
- ___ Blood
- ___ Distended