

TOTAL X HEALTH SYSTEMS

Multi-Specialty Clinic

Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

Clinton Township • (586) 228-0270 ♦ Chesterfield • (586) 949-0123
TotalHealthSystems.com

PATIENT INFORMATION (OFFICE USE) Ins Code _____ Patient ID _____ DR. _____
Please give your Driver's license and insurance card to the front desk so they can make a copy for your records.

Patient Name: Last _____ First _____ Date _____
_____/_____/_____ Address _____ City _____
State _____ Zip _____ Phone (____) _____ - _____

Driver's License # _____ Birthdate ____/____/____ Age _____
Sex: ___M___F Patient Soc. Sec. # _____ - _____ - _____ Marital Status S M D W
Children # _____ Spouse's Name _____ Person responsible for payment _____

Occupation _____ Patient employed by _____
Work phone (____) _____ - _____
Referred by _____ E-mail _____

CURRENT COMPLAINTS / HEALTH GOALS: _____

HEALTH HISTORY

Please indicate whether the following applies to the "I" Individual, "F" Family Member, or "B" Both.

Abdominal Pain	Dislocated Joints	High Blood Pressure	Multiple	
Sclerosis	Dizziness	Hip Pain	Neck	
Allergies	Duodenum Ulcer	HIV/AIDS	Osteoporosis	
Pain	Emphysema	Hypertension		
Angina	Epilepsy	Hyperthyroidism		
Anorexia	Esophageal Cancer	Hypothyroidism		
Painful Urination	Fainting	Irregular Bowel Habits	Profuse	
Aortic Aneurysm	Fibromyalgia	Irregular Menstrual	Prostate Cancer	
FMS	Gouty Arthritis	Kidney Disease	Prostate	
Arthritis	Hay Fever	Kidney Stones	Rapid	
Polio	Headaches	Knee Pain	Rectum	
Asthma				
Menstrual				
Blood Disorder				
Bone Cancer				
Problems				
Brain Cancer				
Heart Rate				
Breast Soreness				
Patient Smokes: per day or less	2+ Packs per day	2 Packs per day	1 Pack per day	½ Pack
	Never		Quit (how long ago)	
Patient uses alcohol:	Excessively	Moderately	Occasionally	Rarely
Please list any previous injuries and/or accidents with date _____ _____				
Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications) _____ _____				

WEIGHT LOSS GOALS & HISTORY

If you want to lose weight, how much weight do you want to lose?

5-10 lbs
10-20 lbs
20-30 lbs

30-40 lbs
40-50 lbs
50lbs. +

What would you consider your ideal weight to be? _____ lbs.

In your own words, would you describe your body as:

Loose
Flabby
Skinny

Toned
Strong
Other: _____

Do you gain weight easily? Y N

Lose weight easily? Y N

Do you usually regain the weight you have lost on a diet? Y N

How long have you kept the weight off, after having lost it?

1 month
2 months
3-6 months

6-12 months
Over a year.

EATING HABITS

Check if you eat, drink or use:

Coffee /Tea
Processed Meats
Refined sugars
Candy

Soda/Pop
Salt
Fried Foods
Margarine

Artificial
Sweeteners
Chocolate

Describe your daily water intake:

2-4 glasses
4-6 glasses
6-8 glasses

8-10 glasses
10 or more

What other liquids do you drink regularly?

Soda
diet sodas
coffee

juices
milk
tea

alcohol
others

How many cups of coffee/tea/diet soda do you drink each day?

2-4 glasses
4-6 glasses
6-8 glasses

8-10 glasses
10 or more

Do you monitor your salt intake? __yes __no

Do you avoid foods with additives or preservatives? __yes __no

Do you feel "over-full" or uncomfortable after meals? _____

How many times do you eat each day (including snacks)?

5-7 times
3-5 times

1-3 times
less than twice a daily

When do you usually eat your last meal?

3-6pm
6-9pm

9-12am
after midnight

Are you hungry shortly after you eat? __yes __no __sometimes

Do you get sleepy during the day? __yes __no __sometimes

If so, When?

8am- noon
1-4pm

4-8pm

How many hours of sleep do you get a night?

2-4
4-6
6-8

8-10
10-12

Do you ever get shaky? ___yes ___no

What foods do you crave?

fats
sugars
chocolate

salts
alcohol
bread

pastry
dairy
carbohydrates

Do you have to eat out frequently for business reasons? ___yes ___no

Do you eat when you are:

Depressed
Stressed
happy

not hungry
frustrated

How would you rate your metabolism?

Sluggish
Slow

Medium
fast

Are you allergic to any of the following foods?

seafood
nuts
wheat

dairy
grains
corn

fruit
sugars
other:

EXERCISE HABITS

Are you following an exercise program? __Yes __No

What time do you usually work out?

6-9am
9-12pm

12-3pm
3-6pm

6-9pm

Do you stretch before working out? ___yes ___no

Do you incorporate weights (resistance) into your workout routine? ___yes ___no

What is your daily activity level?

Low
Moderate

Medium
very active

MERIDIAN TESTING CONTRAINDICATIONS

Do you have a pacemaker __Yes __No

Are you currently doing a nutritional detoxification program or purification? __Yes __No

MERIDIAN ASSESSMENT

Please use the following key to indicate your responses to the following questions:

1= Never 2=Rarely 3=Sometimes 4=Frequently 5= Daily

Mark only one answer for each question.

Meridian	Question	Rating
LY	Do you experience recurrent infections, sinusitis, postnasal drip, or swollen lymph nodes, etc.?	
LU	Do you experience recurrent respiratory infections, coughs, bronchitis, pneumonia, asthma, etc.?	
LI	Do you experience bouts of diarrhea or constipation, gas, bloating, etc.?	
NE	Do you experience irritability, nervousness, trembling, anxiety, or memory problems?	
CI	Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc.?	
AL	Do you react to pollens, molds, foods, seasonal irritants, perfumes, animal dander, etc.?	

OR	Do you have slow metabolism, are you always hungry, have low energy at specific times of day?	
TW	Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc.?	
HT	Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc.?	
SI	Do you have recurrent yeast infections, frequent antibiotic use, poor diet gas, bloating, etc.?	
GV	Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc.?	
PA	Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc.?	
SP	Do you experience chronic fatigue, recurring infections, lowered immune response, etc.?	
LV	Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc.?	
JO	Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc.?	
ST	Do you experience digestive disturbances, acid reflux, burping or upper digestive bloating meals, etc.?	
FI	Do you have fibromyalgia, rheumatism, carpal tunnel, slow recovery after exercise, etc.?	
SK	Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis, etc.?	
FA	Do you have lipomas, degenerative liver disease, breast tumors, problems burning fat, etc.?	
GB	Do you have a history of gallstones, discomfort after eating rich foods low fat metabolism, etc.?	
CV	Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders, etc.?	
KI	Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc.?	
UB	Do you have recurring infections, itching or yeast problems, painful urination, "leaking", etc.?	
Female	Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, hot flashes, menopausal symptoms, etc.?	
Male	Do you experience urinary discomfort, frequency of urination, etc.?	
Teeth	Do you have sensitive teeth or experience pain or discomfort in the teeth, gums, or jaw region?	
Stress	Do you experience stress from work, finances, society, or relationships that you feel cause physical ailments?	
Energy	Do you lack motivation, drive, perseverance, stamina, or endurance?	
Well-Being	Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?	
Immune	Are you susceptible to infections, allergies, or sensitive to pollution, or work environment?	