TOTAL HEALTH SYSTEMS
Multi-Specialty Clinic
Chiropractic • Medical • Physical Therapy • Massage Therapy • Nutrition

Chesterfield (586) 949-0123 ◆ Clinton Township (586) 228-0270 ◆ Washington (586) 781-0800
TotalHealthSystems.com

FOR OFFICE USE ONLY:
Patient Number _____
Insurance _____
Emp. Initials _____

PATIENT INFORMATION

Please give your Driver's license and insurance card to the front desk for your records.
Patient Name: Last _____ First _____ Date _____/_____/_____
Address _____ City _____ State_____ Zip_____
Phone: (home)_____ (cell)_____ (work) _____
Birth date_____/_____/_____ Age_____ Sex: ___M___F Driver's License # _____
Patient Soc. Sec. # _____-_____-_____ Marital Status S M D W Spouse's Name _____
Person responsible for payment _____Patient Employed by _____
Occupation _____ Referred by _____
E-mail _____Emergency Contact: _____
Preferred method of contact for appointment reminders (please circle one) *phone call (home or cell) / text / email*

HEALTH HISTORY

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

☐ Abdominal Pain	☐ Bulimia	☐ Hay Fever	☐ Kidney Disease	☐ PMS
☐ Acid Reflux (GERD)	☐ Colon Cancer	☐ Headaches	☐ Kidney Stones	☐ Polio
☐ Allergies	☐ Convulsions	☐ Heart Attacks	☐ Knee Pain	☐ Prostate Cancer
☐ Angina/Chest Pain	☐ Depression	☐ Heart Disease	☐ Leg Pain	☐ Prostate Problems
☐ Anorexia	☐ Diabetes	☐ Hepatitis A	☐ Liver Disease	☐ Rapid Heart Rate
☐ Anxiety	☐ Dislocated Joints	☐ Hepatitis B	☐ Low Blood Pressure	☐ Rectum Cancer
☐ Aortic Aneurysm	☐ Dizziness	☐ Hepatitis C	☐ Lower Back Pain	☐ Scoliosis
☐ Arm Pain	☐ Duodenum Ulcer	☐ Hernias	☐ Lung Cancer	☐ Shoulder Pain
☐ Arthritis	☐ Emphysema	☐ High Blood Pressure	☐ Mid-Back Pain	☐ Sinus Trouble
☐ Asthma	☐ Epilepsy	☐ High Cholesterol	☐ Migraine	☐ Spinal Disc Disorder
☐ Blood Disorder	☐ Esophageal Cancer	☐ HIV/AIDS	☐ Multiple Sclerosis	☐ Stomach Cancer
☐ Bone Cancer	☐ Fainting	☐ Hyperthyroidism	☐ Neck Pain	☐ Stroke
☐ Brain Cancer	☐ Fatigue	☐ Hypothyroidism	☐ Osteoporosis	☐ Underweight
☐ Breast Soreness	☐ Fibromyalgia	☐ Irregular Bowel Habits	☐ Overweight	☐ Upper Back Pain
☐ Breast Cancer	☐ Gouty Arthritis	☐ Irregular Menstruation	☐ Painful Urination	☐ Vision Problems

Patient Smokes: ☐ 2+ Packs per day ☐ 2 Packs per day ☐ 1 Pack per day ☐ ½ Pack per day or less
☐ Never ☐ Quit (how long ago) _____

Patient uses alcohol: ☐ Excessively ☐ Moderately ☐ Occasionally ☐ Rarely ☐ Never ☐ Quit _____

Please list any previous injuries and/or accidents with date: _____
_____
_____

Past Surgical History (Indicate date, location, surgeon's name, type of surgery, and complications):
_____
_____

Current Medications and Vitamin Supplements: (Please use reverse side if more space is required.)

NAME:	STRENGTH:	FREQUENCY:	NAME:	STRENGTH:	FREQUENCY:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Recent Diagnostic Testing and Procedures (Within the last year):

☐ Plain X-Rays	Date: _____	Location: _____	Results: _____
☐ CT Scan	Date: _____	Location: _____	Results: _____
☐ MRI	Date: _____	Location: _____	Results: _____
☐ EMG	Date: _____	Location: _____	Results: _____
☐ Bone Scan	Date: _____	Location: _____	Results: _____
☐ Ultrasound	Date: _____	Location: _____	Results: _____

☐ Nerve Block Injection ☐ Trigger Point Injection ☐ Epidural Injection ☐ Botox Injection

☐ Bone Density: _____ ☐ Other: _____ ☐ Other: _____ ☐ Other: _____

CIRCLE IF YOU HAVE A: PACEMAKER OR DEFIBRILLATOR

WEIGHT LOSS GOALS & HISTORY

What are you short term health goals with this program (1-3 months)?

_____

What are you long term health goals with this program (3-12 months)?

_____

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.**

PATIENTS' INITIALS____ DATE_____

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**

PATIENTS' INITIALS____ DATE_____

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 currently following an exercise program? __Yes __No

Briefly describe you exercise program._____

_____

_____

How long have been consistently following an exercise program?_____

How many days a week can you commit to an exercise routine?_____

How much time can you commit each day to your workout?_____

What kind of exercise do you enjoy? Dislike?_____

Do you have any experience with using a Heart Rate Monitor?_____

What type of cardio exercise do you enjoy? Dislike?_____

_____

Do you have any experience with resistance training? Briefly describe_____

_____

Have you ever worked with a personal trainer? Briefly describe your experience._____

_____

_____

What hobbies and or special interests do you enjoy?

_____

_____

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

What is your daily activity level?

- ☐ **Low**
- ☐ **Moderate**
- ☐ **Medium**
- ☐ **Very active**

PATIENTS' INITIALS____ DATE_____