BREAKTHROUGH HEALTHCARE

NEW PATIENT INFORMATION FORM

Please print clearly:

Name ____ Date ___/___/______

Address____ Apt. # ____________

City ____________________________ State__________ Zip ______________

Shipping address (if different from mailing address) ______________________________

____

Home phone (___) ____-______ Work phone (___) ____-______

REFERRED BY ______________________ Email Address ______________________

Occupation ________________________ Employer __________________________

Date of Birth _________________ Sex M / F Height __________ weight ________lbs

Overall health (circle one) Excellent / Good / Fair / Poor / Other: ____________________

Chief Complaint (reason you are here) ____

____

Previous treatment for this complaint ____

____

Other complaints or problems ____

Current medications/drugs being taken ____

____

Are you currently under the care of a physician or other health care professional? YES / NO

(If yes, please give the name and the date of last visit) _____________________________

Nutritional supplements you are taking ____

____

Do you smoke, drink coffee, or alcohol? (If yes, include how much)

Cigarettes ________________ Coffee ________________ Alcohol ____________

____

Office use only

BREAKTHROUGH HEALTHCARE

NEW PATIENT INFORMATION FORM

Please print clearly:

Name ____ Date ____/____/_______

HISTORY:

List any major illnesses (with approx. dates) ____

____

List any surgeries (with approx. dates) ____

____

Past Accidents or injuries ____

____

Marital Status S M D W Name of spouse ______________________________________

Describe health of Spouse ___________________________Number of children (if any) _______

Name of Child	Age	Sex	Any health concerns list here
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________
____________________	_____	M / F	____________________

Any family history of serious illness (circle those which apply) Cancer / Diabetes / Heart / Other

____

Any household pets or other animals you or your family members are in close contact with ________

____

What can we do to make you happier healthwise? ____________________________________

____

SIGNED ____ DATE ____/____/_________

Systems Survey Form | Restricted to Professional Use

NAME: AGE: HEALTH CARE PROFESSIONAL: DATE:

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, don't circle anything** for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

___ 1 ___ 2 ___ 3 TOTAL

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

___ 1 ___ 2 ___ 3 TOTAL

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals
45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

___ 1 ___ 2 ___ 3 TOTAL

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

___ 1 ___ 2 ___ 3 TOTAL

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles
85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

___ 1 ___ 2 ___ 3 TOTAL

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion ½-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

___ 1 ___ 2 ___ 3 TOTAL

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

___ 1 ___ 2 ___ 3 TOTAL

GROUP 7B

- 119. 1 2 3 Increase in weight
- 120. 1 2 3 Decrease in appetite
- 121. 1 2 3 Fatigue easily
- 122. 1 2 3 Ringing in ears
- 123. 1 2 3 Sleepy during day
- 124. 1 2 3 Sensitive to cold
- 125. 1 2 3 Dry or scaly skin
- 126. 1 2 3 Temporary constipation
- 127. 1 2 3 Mental sluggishness
- 128. 1 2 3 Hair coarse, falls out
- 129. 1 2 3 Tension in head upon arising wears off during day
- 130. 1 2 3 Slow pulse below 65
- 131. 1 2 3 Changing urinary function
- 132. 1 2 3 Sounds appear diminished
- 133. 1 2 3 Reduced initiative

____ ____ ____ TOTAL
1 2 3

GROUP 7C

- 134. 1 2 3 Failing memory with age
- 135. 1 2 3 Increased sex drive
- 136. 1 2 3 Episodes of tension in head
- 137. 1 2 3 Decreased sugar tolerance

____ ____ ____ TOTAL
1 2 3

GROUP 7D

- 138. 1 2 3 Abnormal thirst
- 139. 1 2 3 Bloating of abdomen
- 140. 1 2 3 Weight gain around hips or waist
- 141. 1 2 3 Sex drive reduced or lacking
- 142. 1 2 3 Tendency for stomach issues
- 143. 1 2 3 Immune system challenges
- 144. 1 2 3 Menstrual disorders

____ ____ ____ TOTAL
1 2 3

GROUP 7E

- 145. 1 2 3 Dizziness
- 146. 1 2 3 Headaches
- 147. 1 2 3 Hot flashes
- 148. 1 2 3 Hair growth on face or body (female)
- 149. 1 2 3 Sugar in urine (not diabetes)
- 150. 1 2 3 Masculine tendencies (female)

____ ____ ____ TOTAL
1 2 3

GROUP 7F

- 151. 1 2 3 Weakness, dizziness
- 152. 1 2 3 Tired throughout day
- 153. 1 2 3 Nails weak, ridged
- 154. 1 2 3 Sensitive skin
- 155. 1 2 3 Stiff joints
- 156. 1 2 3 Perspiration increase
- 157. 1 2 3 Bowel discomfort
- 158. 1 2 3 Poor circulation
- 159. 1 2 3 Swollen ankles
- 160. 1 2 3 Crave salt
- 161. 1 2 3 Areas of skin darkening
- 162. 1 2 3 Upper respiratory sensitivity
- 163. 1 2 3 Tiredness
- 164. 1 2 3 Breathing challenges

____ ____ ____ TOTAL
1 2 3

GROUP 8

- 165. 1 2 3 Muscle weakness
- 166. 1 2 3 Lack of stamina
- 167. 1 2 3 Drowsiness after eating
- 168. 1 2 3 Muscular soreness
- 169. 1 2 3 Heart races
- 170. 1 2 3 Hyperirritable
- 171. 1 2 3 Feeling of a band around head
- 172. 1 2 3 Melancholia (feeling of sadness)
- 173. 1 2 3 Swelling of ankles
- 174. 1 2 3 Change in urinary function
- 175. 1 2 3 Tendency to consume sweets/carbohydrates
- 176. 1 2 3 Muscle spasms
- 177. 1 2 3 Blurred vision
- 178. 1 2 3 Involuntary muscle action
- 179. 1 2 3 Numbness
- 180. 1 2 3 Night sweats
- 181. 1 2 3 Rapid digestion
- 182. 1 2 3 Sensitivity to noise
- 183. 1 2 3 Redness of palms of hands and bottom of feet
- 184. 1 2 3 Visible veins on chest and abdomen
- 185. 1 2 3 Hemorrhoids
- 186. 1 2 3 Apprehension (feeling that something bad is going to happen)
- 187. 1 2 3 Nervousness causing loss of appetite
- 188. 1 2 3 Nervousness with indigestion
- 189. 1 2 3 Gastritis
- 190. 1 2 3 Forgetfulness
- 191. 1 2 3 Thinning hair

____ ____ ____ TOTAL
1 2 3

FEMALE ONLY

- 192. 1 2 3 Very easily fatigued
- 193. 1 2 3 Premenstrual tension
- 194. 1 2 3 Menses more painful than usual
- 195. 1 2 3 Depressed feelings before menstruation
- 196. 1 2 3 Painful breasts during menses
- 197. 1 2 3 Menstruate too frequently
- 198. 1 2 3 Hysterectomy/ovaries removed
- 199. 1 2 3 Menopausal hot flashes
- 200. 1 2 3 Menses scanty or missed
- 201. 1 2 3 Acne, worse at menses

____ ____ ____ TOTAL
1 2 3

MALE ONLY

- 202. 1 2 3 Less involved in exercise/social activities
- 203. 1 2 3 Difficult to postpone urination
- 204. 1 2 3 Weak urinary stream
- 205. 1 2 3 Feeling of "blues" or melancholy
- 206. 1 2 3 Feeling of incomplete bowel evacuation
- 207. 1 2 3 Lack of energy
- 208. 1 2 3 Muscles in arms and legs seem softer/smaller
- 209. 1 2 3 Tire too easily
- 210. 1 2 3 Avoid activity
- 211. 1 2 3 Leg nervousness at night
- 212. 1 2 3 Diminished sex drive

____ ____ ____ TOTAL
1 2 3

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion
- ________ Hydrochloric Acid Point
- ________ Enzyme Point
- ________ Murphy's Sign

Large Intestine (Palpate)
- ________ Ascending
- ________ Transverse
- ________ Descending

Adrenals
- Pass/Fail Pupil Dilation Exam
- Postural Hypotension
- ________ Supine
- ________ Standing

- Pass/Fail Zinc Taste Test
- Pass/Fail Cuff Test
- ________ Cuff Pressure
- ________ pH of Saliva
- ________ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 ________ Day 2 ________ Day 3 ________ Day 4 ________ Day 5 ________

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

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A QUIZ to see if you are sugar-addicted

Taken from Dr. Nancy Appleton's *Lick The Sugar Habit*

Check in the box to answer each of the following questions as truthfully as you can.

#QUESTION:	True	False
I do not eat refined sugar every day.		
I can go for more than a day without eating some type of sugar-containing food.		
I never have cravings for sugar, coffee, chocolate, peanut butter, or alcohol.		
I've never hidden candy or other sweets around my home in order to find and eat them later.		
I can stop after eating one piece of candy or one bite of pastry.		
There are times when I have no sugar of any kind in my home.		
I can go for three or more hours without eating and not experience the shakes, fatigue, perspiration, irritability, depression, or anxiety.		
I can have candy and other sweets in my home and not eat them.		
I do not eat something sweet after each meal.		
I rarely drink coffee and eat donuts or sweet rolls for breakfast.		
I can go for more than an hour after waking up in the morning without eating.		
I can go from one day to the next without drinking a sweetened soft drink.		

Quiz Results

If you answered "false" to more than four of the statements, chances you are probably sugar-sensitive. You are probably allergic to sugar and also addicted to it - the same way an alcoholic is addicted to alcohol. You crave sugar, have withdrawal symptoms when you don't get it, and probably feel better for a short time after you've eaten it. In eating sugar to feel better, you are actually making your condition worse. If you answered "false' to four statements or fewer, it doesn't mean you don't have a problem with sugar. You may not be addicted to it, but perhaps you don't quite realize just how much sugar you are eating.

AGREEMENT TO DO A "NUTRITION RESPONSE TESTING™" PROGRAM

I specifically authorize Breakthrough Healthcare to use a Nutrition Response Testing™ health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or "cure" of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that this is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

WAIVER OF LIABILITY TO DECLINE DOING A "NUTRITION RESPONSE TESTING™" PROGRAM

I understand that my health status is significantly diminished. It has been thoroughly explained to me by Breakthrough Healthcare why I should do a nutritional program in order to improve my health. I hereby state that I am of sound mind and I am making a conscious decision to DECLINE care. I will not Breakthrough Healthcare or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Breakthrough Healthcare from any liability regarding my health matters.
I have read and understand the foregoing.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

NOT A "NUTRITIONAL CASE" WAIVER OF LIABILITY

I understand that my health status is declining. I have been encouraged by Haas Chiropractic & Nutrition Center to seek medical attention for my health issues. I understand that doing a program at Haas Chiropractic & Nutrition Center would not successfully address my current health situation. I will not hold Haas Chiropractic & Nutrition Center or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Haas Chiropractic & Nutrition Center from any liability regarding my health matters.
I have read and understand the foregoing.

PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

Jennifer M. Brown, HHP

Photograph Consent Form

I, ____, consent to the taking of photographs and authorize their anonymous use for the purposes of medical audit, education, and promotion.

I certify that I have been given the opportunity to ask questions and that I have read and fully understand the contents of this form.

__________________________________ Patient Signature

_____________________ Date

__________________________________ Patient Advocate Signature

______________________ Date

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