

# PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_

*This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 1-2 times per week is notable and would be marked. Please take your time...*

## Primary Complaints

- |   |  |  |
|---|--|--|
| 090 <input type="checkbox"/> General Good Health                      | 042 <input type="checkbox"/> Numbness 782.0                  | 072 <input type="checkbox"/> Infertility, female 628.9       |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis | 043 <input type="checkbox"/> Constipation 564.0              | 073 <input type="checkbox"/> Interstitial Cystitis           |
| 001 <input type="checkbox"/> Skin Disorder 692.9                      | 044 <input type="checkbox"/> Indigestion 536.8               | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4 |
| 002 <input type="checkbox"/> Acne 706.1                               | 045 <input type="checkbox"/> Ulcerative Colitis 556.9        | 075 <input type="checkbox"/> Menopausal Symptoms 627.2       |
| 003 <input type="checkbox"/> Psoriasis 696.1                          | 046 <input type="checkbox"/> Depression 311.0                | 076 <input type="checkbox"/> Hot Flashes 627.2               |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9                  | 047 <input type="checkbox"/> Diabetes Mellitus 250.0         | 077 <input type="checkbox"/> Mental Disorder                 |
| 005 <input type="checkbox"/> ADD/ADHD 314.01                          | 048 <input type="checkbox"/> Hypoglycemia 251.2              | 078 <input type="checkbox"/> Insomnia 780.52                 |
| 006 <input type="checkbox"/> Allergies 477.0                          | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4 | 079 <input type="checkbox"/> Mouth/Throat/Tongue             |
| 007 <input type="checkbox"/> Food Allergy 691.8                       | 050 <input type="checkbox"/> Ear Infection 386.30            | 080 <input type="checkbox"/> Canker Sores 528.2              |
| 008 <input type="checkbox"/> Sinusitis 461.9                          | 051 <input type="checkbox"/> Epstein Barr 075.0              | 081 <input type="checkbox"/> Overweight 278.0                |
| 009 <input type="checkbox"/> Alzheimer's 333.1                        | 052 <input type="checkbox"/> Eye Problems 379.91             | 082 <input type="checkbox"/> Underweight 783.2               |
| 010 <input type="checkbox"/> Poor Concentration/Memory 310.1          | 053 <input type="checkbox"/> Cataracts 366.9                 | 083 <input type="checkbox"/> Sexual Disorder 302.9           |
| 011 <input type="checkbox"/> Parkinson's Disease                      | 054 <input type="checkbox"/> Glaucoma 365.62                 | 084 <input type="checkbox"/> Spinal Problems                 |
| 012 <input type="checkbox"/> Anemia 285.9                             | 055 <input type="checkbox"/> Macular Degeneration 362.5      | 085 <input type="checkbox"/> Obesity 278.0                   |
| 013 <input type="checkbox"/> Arthritic Disorder 716.9                 | 056 <input type="checkbox"/> Fever 780.6                     | 086 <input type="checkbox"/> GERD 530.81                     |
| 014 <input type="checkbox"/> Osteoporosis 733.0                       | 057 <input type="checkbox"/> Fibromyalgia 729.1              | 087 <input type="checkbox"/> HIV infection                   |
| 015 <input type="checkbox"/> Asthma 493.9                             | 058 <input type="checkbox"/> Gallbladder Disorder 575.9      | 017 <input type="checkbox"/> Cancer                          |
| 016 <input type="checkbox"/> Emphysema 492.8                          | 059 <input type="checkbox"/> Gout 274.9                      | 018 <input type="checkbox"/> Breast 174.9                    |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71                   | 060 <input type="checkbox"/> Headaches 784.0                 | 019 <input type="checkbox"/> Prostate 185.0                  |
| 036 <input type="checkbox"/> Circulatory Disorder 459.90              | 061 <input type="checkbox"/> Hearing Loss 389.90             | 020 <input type="checkbox"/> Lung 152.9                      |
| 037 <input type="checkbox"/> Heart Disease 429.90                     | 062 <input type="checkbox"/> Infertility, male 606.9         | 021 <input type="checkbox"/> Colon/Rectal 153.9              |
| 038 <input type="checkbox"/> High Cholesterol 272.0                   | 063 <input type="checkbox"/> Prostate Disorder 602.9         | 022 <input type="checkbox"/> Skin 173.9                      |
| 039 <input type="checkbox"/> High Blood Pressure 401.9                | 064 <input type="checkbox"/> Liver Disease 571.9             | 023 <input type="checkbox"/> Leukemia                        |
| 040 <input type="checkbox"/> Low Blood Pressure 458.9                 | 065 <input type="checkbox"/> Hepatitis 573.3                 | 024 <input type="checkbox"/> Lymphoma                        |
| 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00     | 066 <input type="checkbox"/> Hepatitis B                     | 025 <input type="checkbox"/> Brain Tumor 191.9               |
|   | 067 <input type="checkbox"/> Hepatitis C                     | 026 <input type="checkbox"/> Other                           |
|   | 068 <input type="checkbox"/> Kidney/Bladder Problems         | 088 <input type="checkbox"/> Crohn's Disease 555.9           |
|   | 069 <input type="checkbox"/> Hyperthyroid 242.9              | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1  |
|   | 070 <input type="checkbox"/> Hypothyroid 244.9               |  |
|   | 071 <input type="checkbox"/> Lupus 710.0                     |  |

*If necessary, please state your most significant concern.*

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## Behavior Patterns

- 150  Afraid to eat anywhere except home  
151  Always needs someone to advise  
152  Cries often  
153  Difficulty concentrating  
154  Difficulty falling asleep  
155  Difficulty staying asleep  
156  Easily angered  
157  Feelings are easily hurt  
158  Frequently becomes scared for no reason  
159  Frequently miserable or blue  
160  Has to be on guard even with friends  
161  Often annoyed by people  
162  Recurrent bad dreams  
163  Sometimes wishes to be dead or away from it all  
164  Upset by criticism  
165  Poor memory  
166  Scared to be alone  
167  Strange people or places cause fear  
168  Under considerable emotional stress  
169  Unhappy when other are happy  
170  Brain fog

## Urinary

- 555  Urinates more than 2 times per night  
556  Bed wetting  
557  Blood in the urine  
558  Difficulty starting urination  
559  Painful urination  
560  Frequent urination  
561  Troubled by urgent urination  
562  Incontinence when sneezing or laughing  
563  Loses bladder control  
564  Frequent bladder infections  
565  Frequent kidney infections  
566  Kidney stones

## Men Only

- 585  Difficulty completing intercourse  
586  Difficulty getting or keeping an erection  
587  Discharge from the urethra  
588  Had a vasectomy  
589  Had difficulty fathering children  
590  Lumps in the testicles  
591  Painful genitals  
592  Prostate troubles  
593  Sores on external genitalia  
594  Herpes  
595  Sexual diseases

## Women Only

- 610  Heavy hair growth on face or body  
611  Cycles are every 27-29 days  
612  Abnormal cycle >29 days and/or <26 days  
613  PMS  
614  Menstrual cramps  
615  Painful periods  
616  Acne worse at menstruation  
617  Excessive menstrual flow  
618  Retains fluid during periods  
619  Pre-menstrual depression  
620  Currently taking birth control medication  
621  Has taken birth control medication more than 1 year  
622  Has taken birth control medication within the last year  
623  Has had miscarriage  
624  Hot flashes  
625  Takes hormone replacement medication  
627  Diminished sexual desire  
628  Painful intercourse  
629  Poor or infrequent orgasm  
630  Lumps in the breasts  
631  Tender breasts  
633  Vaginal discharge  
634  Bloody spotting discharge  
635  Yeast infections  
636  Sores on external genitalia  
637  Herpes  
638  Sexual diseases

- 190  Cold feet
- 191  Cold hands
- 192  Experiences shortness of breath while sitting still
- 193  Heart skips beats
- 194  Tendency of High blood pressure

## Cardiovascular

- 195  Leg cramps during bedtime
- 196  Leg cramps during daytime
- 197  Low blood pressure at times
- 198  Pain in leg/hips when walking
- 199  Frequent swollen ankles
- 200  Pains in the heart or chest
- 201  Spells of rapid heart rate
- 202  Troubled with blood clots
- 203  Unusually slow pulse rate
- 204  Varicose veins

- 520  Bruises easily
- 521  Excessive perspiration
- 522  Frequent goose bumps
- 523  Has acne
- 524  Has Psoriasis
- 525  Hives

## Skin

- 526  Itchy skin
- 527  Problems with Eczema
- 528  Has moles which are changing in size and/or color
- 529  Skin eruptions
- 530  Skin is rough, especially on the back of the arms
- 531  Skin is tender
- 532  Sores that heal slowly
- 533  Troubled with boils
- 534  Dry skin

- 220  Discharge from ears
- 221  Hard of hearing

## Ears

- 222  Punctured ear drum
- 223  Recurrent ear infection
- 224  Ringing or noises in the ears

- 320  Bloodshot eyes
- 321  Blurred vision
- 322  Cross eyes
- 323  Eye pain
- 324  Eyes feel gritty

## Eyes

- 325  Eyes watery
- 326  Mild Glaucoma
- 327  Far sighted
- 328  Developing cataracts
- 329  Mild Macular degeneration
- 330  Itchy eyes
- 331  Near sighted
- 332  Dry Eyes

- 350  Corns
- 351  Frequent foot cramps
- 352  Heel spurs

## Feet

- 353  Painful feet
- 354  Plantar warts
- 355  Swelling in the feet and/or ankles
- 356  Plantar fasciitis
- 357  Fungal Infection

- 440  Bites nails
- 441  Frequent muscle soreness
- 442  Muscle spasms
- 443  Muscle weakness
- 444  Tremors
- 445  Frequent headaches
- 446  Often dizzy
- 447  Frequently feels faint
- 448  Has Epilepsy
- 449  Has motion sickness

## Neuromuscular

- 450  Has Osteoarthritis
- 451  Has Rheumatism
- 452  Rheumatoid Arthritis
- 453  Joint stiffness in the morning
- 454  Swollen joints
- 455  Leg pain at rest
- 456  Spinal curvature
- 457  Low back pain
- 458  Neck pain
- 459  Pain between the shoulders
- 460  Shoulder/arm pain
- 461  Numbness/tingling in the body
- 462  Sleep walks
- 463  Stutters or stammers
- 464  Nerve pain

- Gastrointestinal**
- 265  4-5 bowel movements per week
  - 266  3 or less bowel movements per week
  - 267  6 or more bowel movements per week
  - 268  Black tarry stools
  - 269  Pale or yellow colored stool
  - 270  Blood stools
  - 271  Constipation
  - 272  Hemorrhoids
  - 273  Loose bowel movements
  - 274  Frequent diarrhea
  - 275  Frequent nausea
  - 276  Frequent vomiting
  - 277  Abdominal gas
  - 278  Belching and burping after eating
  - 279  Bloating after eating
  - 280  Severe abdominal pains
  - 281  Stomach ulcers
  - 282  Uses digestive aids
  - 283  Uses laxatives
  - 284  Immediate indigestion upon eating
  - 285  Indigestion in 2 hours or more after meals
  - 286  Indigestion within 1 hour after meals
  - 287  Difficulty swallowing
  - 288  Eating relieves fatigue
  - 289  Eats when nervous
  - 290  Excessive hunger
  - 291  Poor appetite
  - 292  Experiences fainting spells when hungry
  - 293  Feels shaky when hungry
  - 294  Frequently drowsy after eating a meal
  - 295  Gall bladder disease
  - 296  Has had intestinal worms
  - 297  Reflux/Hiatal hernia
  - 298  Liver disease
  - 299  Irritable Bowel Syndrome

- Respiratory**
- 485  Catches severe colds
  - 486  Chronic chest condition
  - 487  Chronic cough
  - 488  Constant runny nose
  - 489  COPD
  - 490  Difficulty breathing
  - 491  Frequent colds
  - 492  Frequent nose bleeds
  - 493  Frequent sinus infections
  - 494  Frequent stuffy nose
  - 495  Hay fever
  - 496  Nasal polyps
  - 497  Night sweats
  - 498  Post nasal drip
  - 499  Sneezing spells
  - 500  Spits up blood
  - 501  Spits up phlegm
  - 502  Wheezes

- Mouth and Throat**
- 400  Bad breath
  - 401  Bitter taste in the mouth in the morning
  - 402  Dry mouth
  - 403  Excessive saliva
  - 404  Sores or cracks in the corners of the mouth
  - 405  Glands often swell
  - 406  Frequent canker sores
  - 407  Frequent fever blisters
  - 408  Frequent sore throats
  - 409  Frequently has a sore tongue
  - 410  Sore gums
  - 411  Swollen gums
  - 412  Swollen tongue
  - 413  Tongue burns
  - 414  Tongue has grooves or fissures
  - 415  Tongue is coated
  - 416  Gums bleed when brushing teeth
  - 417  Toothaches
  - 418  Amalgam dental fillings
  - 420  Other dental fillings (gold, composite, etc)
  - 419  Has had root canal(s)

- Endocrine**
- 245  Coarse hair
  - 246  Coarse skin
  - 247  Diabetic
  - 248  Excessive thirst
  - 249  Frequently feels cold
  - 250  Frequently feels hot
  - 251  Gets lightheaded when standing quickly
  - 252  Heals slowly
  - 253  Unusually jumpy or nervous
  - 254  Unusually tired most of the time

## General Health

- 100  Base of fingernails are pink  
101  Base of fingernails are purple  
102  Fingernails have ridges or white spots  
103  Fingernails are soft  
104  Fingernails are splitting  
105  Fingernails peel  
106  Pale fingernail beds  
107  Blacks out easily  
108  Balance problems  
109  Difficulty walking  
110  Has tattoos  
111  Brittle hair  
112  Dry hair  
113  Thin hair  
114  Hair loss  
115  Drinks alcoholic beverages daily  
116  Drinks less than 8 glasses of water per day  
117  Currently on Chemotherapy  
118  Currently on radiation treatment  
119  Had chemotherapy in the past  
120  Has had radiation treatments in the past  
121  Gained over 20 lbs in the last 12 months  
122  Somewhat Overweight  
123  Somewhat Underweight  
124  Unexplained weight loss of over 20lbs within the last 4 months  
125  Energy level is worse than it was 5 years ago  
127  Sleeps less than 6 hours per night  
128  Unable to recall dreams the next day  
129  Sensitive to chemicals, paint, fumes, cologne  
130  Had blood transfusion in the past  
131  Had transplant in the past  
132  Had a major accident or injury (i.e. auto, work, other)

## Lifestyle Habits

- 370  Drinks alcohol  
371  Drinks caffeinated coffee  
372  Drinks caffeinated pop/soda  
373  Drinks caffeinated tea  
374  Drinks decaffeinated coffee  
375  Drinks decaffeinated pop/soda  
376  Drinks decaffeinated tea  
377  Drinks more than 3 cups of coffee per day  
378  Drinks more than 3 cups of tea per day  
379  Drinks 1 or more pop/sodas per day  
388  Drinks diet pop/soda  
380  Drinks beverages from a can  
381  Has more than 5 alcoholic drinks per week  
382  Currently smokes  
383  Quit smoking in the last 5 years  
384  Smoked for more than 5 years  
385  Smokes more than 1 pack per day  
126  Rarely exercises  
133  Regularly exercises  
386  Takes Vitamins  
134  Vegetarian  
135  Eats no red meat  
136  Eats no meat, no dairy  
387  Frequent use of artificial sweeteners

## Surgeries

- 700  Tonsillectomy and/or Adenoids  
701  Appendix  
702  Gallbladder  
703  Thyroid  
715  Radiated thyroid  
708  Cancer  
704  Hysterectomy, complete  
705  Hysterectomy, partial  
706  Tubal ligation  
707  Breast implants  
709  Coronary by-pass  
710  Spinal surgery  
711  Extremity surgery  
712  Hip replacement  
713  Knee replacement

COMPREHENSIVE NUTRITIONAL SERVICES  
Glen T. Matejka, DN, DC, DACBN, CCN  
Nutrition Patient Questionnaire

Patient# \_\_\_\_\_ Date \_\_\_\_\_  
Classification \_\_\_\_\_ SS# \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

Email \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_ # of Children \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Place of Employment \_\_\_\_\_

In Case of Emergency, who should we contact?  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

**We will provide a receipt for you to submit to your insurance. You are responsible for payment in full at the time of service.**

**\*\* I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.**

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

If under 18 years of age, parent or guardian's signature \_\_\_\_\_

**Nutritional Informed Consent**

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "*Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*"

**A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.**

**Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.**

**Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.**

**Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic treatment.**

**I have read and understand the above:**

Signature \_\_\_\_\_ Date \_\_\_\_\_