Plum Creek Chiropractic PA
Dr. Cynthia Shepard, 24875 Panama Ave. Elko, MN 55020
952-461-3675

Name: _____ Date: _____

Reason for visit: _____

When did your symptoms begin?_____ Have you previously had similar symptoms? Y N

Have your symptoms changed in any way? Y N If so, how? _____

Does anything make your symptoms better? _____

Does anything make your symptoms worse? _____

Do they interfere with: work sleep daily routine recreation other: _____

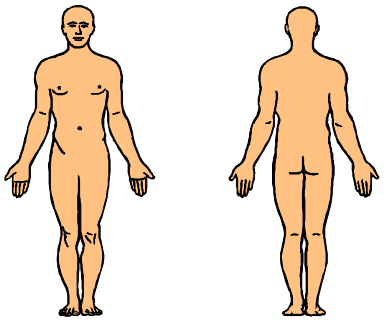
What is your opinion about the cause? _____

Have you seen any other providers for this condition?

Provider	Treatment Given	Helpful?	Treatment dates
_____	_____	Y N	_____
_____	_____	Y N	_____

Are you in pain? Y N Describe the location: _____

Mark an X on the picture to show where you feel pain.



What does the pain feel like? (circle all that apply)

sharp burning stabbing dull achy sore

weak throbbing tender numb tingling shooting tight cramping

pulling surface deep constant comes and goes

Rate your pain intensity (0=No pain, 10=Excruciating pain)

<0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10>

Activities that are painful to perform: sitting walking bending lying down other: _____

Past Health History

Have you had chiropractic care before? Y N Name of Doctor: _____

When was your last visit? _____

Date of last: Physical exam _____ Spinal x-ray _____ Blood test_____

Spinal exam _____ Chest x-ray _____ Urine test_____

Dental x-ray _____ MRI, CT-scan, Bone scan_____

Discuss important results of these tests: _____

List any major surgeries or illnesses: _____

Have you ever been hospitalized? Y N If so, when _____

Do you have any allergies? Y N If so, list _____

CONDITIONS Check conditions you have or have had in the past:

? AIDS	? Chicken Pox	? Kidney Disease	? Rheumatoid Arthritis
? Alcoholism	? Diabetes	? Liver Disease	? Rheumatic Fever
? Anemia	? Emphysema	? Measles	? Scarlet Fever
? Anorexia	? Epilepsy	? Migraine Headaches	? Stroke
? Appendicitis	? Glaucoma	? Miscarriage	? Thyroid Problems
? Arthritis	? Goiter	? Mononucleosis	? Tonsillitis
? Asthma	? Gonorrhea	? Multiple Sclerosis	? Tuberculosis
? Bleeding Disorders	? Gout	? Mumps	? Tumors, Growths
? Breast Lump	? Heart Disease	? Osteoporosis	? Typhoid Fever
? Bronchitis	? Hepatitis	? Pacemaker	? Ulcers
? Bulimia	? Hernia	? Pneumonia	? Vaginal Infections
? Cancer	? Herpes	? Polio	? Venereal Disease
? Cataracts	? High Cholesterol	? Prostate Problem	? Whooping Cough
? Chemical Dependency	? HIV Positive	? Prosthesis	? Other _____

Do you have a family history of: Heart Disease Lung Disease Diabetes Cancer Depression

Birth History (Please try to obtain this information, it can be important for your care.)

Did your mother have a difficult pregnancy with you? Y N

Describe: _____

Did your mother have any falls, accidents, or physical injuries during pregnancy? Y N

Describe: _____

Was your delivery difficult? Y N

Check all that apply: suction forceps "c" section cord around the neck breech drug induced pain medications prolonged labor

While pregnant with you, was your mother regularly taking any: medications alcohol or smoking?

During your delivery, was your mother: conscious semiconscious unconscious

Are there any chemicals your mother may have been exposed to during her pregnancy? Y N

Describe: _____

My birth was at: home birthing center hospital

Were you full term? Y N Were you incubated or isolated after birth? Y N

Vehicular accidents

Have you, even as a passenger or if you were fine, been involved in a moving vehicle collision or near collision?

Please list approximate dates and severity: mild, moderate or extreme.

Automobile: _____

Bus, Motorcycle: _____

Bicycle, Rollerblades, etc: _____

General Physical Trauma

Have you ever been knocked unconscious? Y N

Describe: _____

Have you ever broken any bones? Y N

Describe: _____

Have you ever had any impacts or falls that you felt specifically may have injured your head or spine or that required recovery time? Y N

Describe: _____

Have you had extensive dental or orthodontic work performed? Y N

Describe: _____

Sports and Leisure

Were you previously active in any particular sports or hobbies? Y N

Please list: _____

Are you currently active in any particular sports or hobbies? Y N

Please list: _____

Are there activities in which you spend any length of time in a particular position (TV, reading, musicians, etc.)?

Describe: _____

During the day I: (circle all that apply)

Sit Stand Walk Do phone work Drive Do mechanical work Do repetitive work Do heavy lifting

Do you exercise? Y N What do you do? _____

How often? daily weekly monthly For how long? _____minutes hours

Do you use safety equipment like bike helmets, wrist guards and seat belts? Y N

Have you been hurt in any of these activities? Y N

Describe: _____

Do you wear arch supports orthotics heel lifts?

How much sleep do you get? _____hours/night Do you sleep on your: side back stomach?

Chemical Exposure

Did you or do you work with any chemicals or in a place with fumes, dust or smoke for long periods? Y N

Describe: _____

Please indicate any **medications** you have taken in the past by circling P, or if you are currently taking it circle C.

Allergy/Cold/Flu	P	C	Aspirin/Tylenol/Ibuprofen	P	C	Laxatives	P	C
Antacids	P	C	Birth Control Pills	P	C	Lithium	P	C
Anti-anxiety	P	C	Blood pressure meds	P	C	Pain medications	P	C
Antibiotic	P	C	Cortisone	P	C	Pep pills/Stimulants	P	C
Antidepressant	P	C	Diabetic medications	P	C	Recreational	P	C
Antifungal	P	C	Heart medications	P	C	Relaxant/Sleeping pills	P	C
Anti-inflammatory	P	C	Hormones	P	C	Thyroid medications	P	C
Anti-parasitic(worms)	P	C	Insulin	P	C	Ulcer medications	P	C
Other	P	C	List:_____					

What immunizations have you received? _____

Are you now or have you ever used tobacco products? Y N What types do you use? _____

Packs/tins per day _____for how many years _____

Dietary Choices

Approximately how much do you consume of each food item per **day**?

Fresh fruit _____	Fresh vegetables _____	Canned fruit _____	Canned vegetables _____
Fresh fish _____	Canned fish _____	Seafood _____	Pork/Beef _____
Chicken _____	Eggs _____	Whole grains _____	Diet food _____
Candy _____	Junk food _____	Fast food _____	Fried food _____

Do you take vitamins? Please list:_____

_____

_____

Do you take herbs or homeopathy? Please list: _____

How many pats of butter _____ margarine _____ spread _____

How many glasses of water _____ beer _____ wine _____ alcohol _____

carbonated drinks _____ juice _____

How many cups of regular coffee _____ decaf coffee _____ black tea _____

green tea _____ herbal tea _____

How many slices of bread? _____ What kind of bread? _____

Do you use salt sparingly moderately freely

What oils do you use in cooking? _____

What foods if any disagree with you? _____

What is your favorite food? _____

Do you have any food cravings?_____

Do you feel your food habits are: excellent good fair poor They are: getting better getting worse

I usually have: _____bowel movements per day Urination _____per day

Amount of Stress

Please indicate stress you have had in the past by circling P, or stress you are currently experiencing by circling C.

Indicate the intensity of the stress by choosing mild, moderate, or extreme.

	Mild	Moderate	Extreme		Mild	Moderate	Extreme
Childhood stress	P C	P C	P C	Work related stress	P C	P C	P C
School stress	P C	P C	P C	Stress of commuting	P C	P C	P C
Play or recreation	P C	P C	P C	Loss of loved one	P C	P C	P C
Family stress	P C	P C	P C	Major life change	P C	P C	P C
Stress of being sick	P C	P C	P C	Money stress	P C	P C	P C
Personal relationships	P C	P C	P C	Abuse	P C	P C	P C

Have you ever received professional help for any emotional or behavioral problems? Y N

Do you feel safe at home? Y N

Recent Health History

Have you had any recent weight change (loss or gain)? Y N Have you been trying to lose weight? Y N

Are you feeling unusually tired or fatigued? Y N

Have you had a recent abnormal temperature? Y N

GENERAL SYMPTOMS Check symptoms you currently have or have had in the past year

GENERAL
- ? Bruise Easily
- ? Chills
- ? Confusion
- ? Convulsions
- ? Dental Problems
- ? Depression
- ? Dizziness
- ? Fainting
- ? Fever
- ? Forgetfulness
- ? Headache
- ? Loss of Sleep
- ? Muscle Jerking
- ? Nervousness
- ? Numbness or Tingling
- ? Paralysis
- ? Sweats

GENITO-URINARY
- ? Blood in Urine
- ? Frequent Urination
- ? Lack of Bladder Control
- ? Painful Urination

GASTROINTESTINAL
- ? Appetite Poor
- ? Bloating
- ? Bowel Changes
- ? Constipation
- ? Diarrhea
- ? Excessive Hunger
- ? Excessive Thirst
- ? Gas
- ? Hemorrhoids
- ? Indigestion or Heart Burn
- ? Nausea
- ? Rectal Bleeding
- ? Stomach Pain
- ? Vomiting

CARDIOVASCULAR
- ? Chest Pain
- ? High Blood Pressure
- ? Irregular Heart Beat
- ? Low Blood Pressure
- ? Poor Circulation
- ? Rapid Heart Beat
- ? Swelling of Ankles
- ? Varicose Veins

E,E,N,T
- ? Bleeding Gums
- ? Blurred Vision
- ? Crossed Eyes
- ? Difficulty Swallowing
- ? Double Vision
- ? Earache or Discharge
- ? Hay Fever
- ? Hoarseness
- ? Loss of Hearing
- ? Nosebleeds
- ? Persistent Cough
- ? Ringing in Ears
- ? Sinus Problems
- ? Vision - Flashes
- ? Vision - Halos

SKIN
- ? Bruise Easily
- ? Hives
- ? Itching
- ? Change in Moles
- ? Rash
- ? Scars
- ? Sores That Won't Heal

MEN only
- ? Breast Lump
- ? Erection Difficulty
- ? Lump in Testicles
- ? Penis Discharge
- ? Sore on Penis
- ? Other

_____

WOMEN only
- ? Abnormal Pap Smear
- ? Breast Lump
- ? Hot Flashes
- ? Menstrual Pain
- ? Menstrual Spotting
- ? Nipple Discharge
- ? Painful Intercourse
- ? Vaginal Discharge
- ? Other

_____

For Women Only:

Are you still menstruating? Y N Date of most recent menstruation: _____

Date of last pap smear: _____ Have you had a mammogram? Y N Are you pregnant now? Y N

Age of first menses: _____ Number of pregnancies: _____ Number of children: _____

How were your pregnancies? _____

How were your deliveries? _____

Age of last menses: _____ Reason: _____

Rate your health:

(Low)0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10(High)

Family Health History (Parents and Siblings)

Arthritis	Drug Addiction	Mental Illness	Other
Asthma	Eating Disorder	Mental Handicap	
Alcoholism	Genetic Disorsder	Migraine Headaches	
Alzheimers	Glaucoma	Neuroligical Issues	
Cancer	Heart Disease	Obesity	
Depression	Infertility	Stroke	
Diabetes	Learning Disabilities	Suicide	

Is there anything else you feel I should know which has not been discussed?

Thank you for taking the time to help me understand your health.

Doctors notes:

BM:_____

_____

SLEEP:_____

EXERCISE:_____

_____

BREAKFAST_____

LUNCH_____

DINNER_____

SNACKS_____

AVOIDED FOODS_____

TOBACCO_____

RECREATIONAL DRUGS

Plum Creek Chiropractic PA

Dr. Cynthia L. Shepard
24875 Panama Ave. Elko, MN. 55020
Phone: 952-461-2975 Fax: 952-461-3675

Confidential Patient History

Today's Date: _____

Name: _____ Name you would like to be called: _____

Address: _____
Street City State Zip

Home Phone: _____ Business Phone: _____

Cell Phone: _____ Email: _____

Date of Birth: _____/_____/_____ Age: _____ Gender: M F Social Security # _____

Current Lifestyle Status (circle one) Single Married Living w/ Partner Separated Divorced Widowed

Name of Significant Other: _____

Number of Children: _____ Their Names and Ages: _____

Employer: _____ Employed: full-time part-time Student: full-time part-time

Employer Address:_____
Street City State Zip

Job Description: _____

How did you hear about our office? _____

Reason(s) you are consulting our office: (check all that apply)
- ❑ I have a specific problem and want help with eliminating this problem.
- ❑ I am willing to participate in strategies to ensure the problem does not return.
- ❑ I want to learn about what I can do to improve my general health.
- ❑ I have no current symptoms. I am here for wellness care and to improve my overall level of health.

Payment is expected at the time of service. Exceptions include Auto Accident, and Worker's Compensation. Please check the appropriate box:
- ❑ Cash or check
- ❑ Auto Accident

I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that the staff at Plum Creek Chiropractic PA will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Plum Creek Chiropractic PA will be credited to my account upon receipt.
I understand and agree that all services, supplements, or other items rendered me at Plum Creek Chiropractic PA are charged directly to me and that I am personally responsible for payment.
I understand and agree that if I suspend or terminate my care and treatment, any fees for professional services rendered me at Plum Creek Chiropractic PA will be immediately due and payable.

Patient Signature: _____ Date: _____

Family Health History (Parents and Siblings)

Arthritis	Drug Addiction	Mental Illness	Other
Asthma	Eating Disorder	Mental Handicap	
Alcoholism	Genetic Disorsder	Migraine Headaches	
Alzheimers	Glaucoma	Neuroligical Issues	
Cancer	Heart Disease	Obesity	
Depression	Infertility	Stroke	
Diabetes	Learning Disabilities	Suicide	

Plum Creek Chiropractic PA

Dr. Cynthia L Shepard

Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations, we must require you to read and sign this consent form stating that you understand and agree with how our records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information, we encourage you to read the HIPAA NOTICR that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operation and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient had the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our off ice is not obligated to agree to those restrictions.

3. A patient written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.

5. For your security and right to privacy all staff had be trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible viloations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician had the right to refuse to give care.

I have read and understand how my patient Health Information will be used and I agree to these policies and procedures.

Name of Patient Date

Plum Creek Chiropractic P.A.

Dr. Cynthia L. Shepard
24875 Panama Ave.
Elko, Mn. 55020
952-461-3675

Policies and Procedures

New Conditions:

If a new condition occurs during the course of your regular treatment program, which is brought on by an accident, on the job injury, personal injury, or a new unrelated illness, please let me know immediately. An examination will be scheduled and the proper forms completed. We may need additional information regarding insurance, etc.

Payment of Bills:

Our policy is that patients pay for service at the time of service. If you wish to submit this to insurance, we will provide you with the paperwork necessary to do so.

Office Hours:

Monday and Wednesday 8:00am to 6:00pm. Friday 2:00 – 4:00, and Saturdays by appointment only.

Diet and Food Supplements:

Diet and food supplements should be taken as recommended. Any problem with these recommendations should be communicated with Dr. Shepard. We do not prescribe, however, we will make recommendations to help speed your recovery.

Missed Appointment Policy:

With the exception of unexpected emergencies, we require that you notify us at least 24 hours in advance of a schedule conflict. **Missed appointments without a 24-hour notice will be charged $30.00.** If you should become ill, please come to your scheduled appointment, as chiropractic care will boost your recovery.

I have read and understand the previous information:

Signature: _____Date _____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a detoxification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

	Circle the corresponding number.
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Stiffness or limited movement	0 1 2 3 4
c. Pain or aches in muscles	0 1 2 3 4
d. Recurrent back aches	0 1 2 3 4
e. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

g. How often do you consume nonorganic foods? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detoxification program.

Systems Survey Form | Restricted to Professional Use

Standard Process

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

___ ___ ___ TOTAL
1 2 3

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

___ ___ ___ TOTAL
1 2 3

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

___ ___ ___ TOTAL
1 2 3

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

___ ___ ___ TOTAL
1 2 3

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

___ ___ ___ TOTAL
1 2 3

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"

___ ___ ___ TOTAL
1 2 3

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

___ ___ ___ TOTAL
1 2 3

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.

STANDARD PROCESS ***STRESS ASSESS***™

How well do you think you are handling stress? This assessment will help you and your health care professional design a personalized program to support your stress response and well-being.

Have you experienced any significant life events or changes in the last three months (illness, injury, job change, new baby, marriage, divorce, extreme training for a sporting event, major project at work, etc.)? If so, please list: _____

Hours of sleep each night:	Hours exercised per week:	Alcoholic drinks per week: (1 drink = 12 oz. beer, 5 oz. wine, 1.5 oz. liquor)	Meals eaten out per week:
3-4 5-6 7-8 9+	0 1-2 3-5 6+	0 1-2 3-7 8+	0 1-2 3-5 6+

Do you have any downtime or participate in quiet mindfulness activities? (Pilates, yoga, meditation, quiet walks, personal hobbies) Yes No

Please answer the following questions based on your experience within the **last month.**	Not at All	Little Bit	Somewhat	Quite a Bit	Very Much
1. How stressful would you say your life is?	1	2	3	4	5
2. Dealing with daily stresses is negatively affecting my daily tasks.	1	2	3	4	5
3. I have a high intake of sugar and/or processed foods.	1	2	3	4	5
4. I feel worn down and/or burnt out.	1	2	3	4	5
5. I need caffeine or other energy drinks in the morning or afternoon to give me energy.	1	2	3	4	5
6. I seem to have lower than usual energy during the day.	1	2	3	4	5
7. I experience body aches and pains.	1	2	3	4	5
8. I have periods of low moods.	1	2	3	4	5
9. I feel more irritable.	1	2	3	4	5
10. My weight and metabolism have changed.	1	2	3	4	5
11. I can't seem to focus or concentrate.	1	2	3	4	5
12. I have feelings of anxiousness.	1	2	3	4	5
13. I feel totally exhausted most of the day and only have a few productive hours.	1	2	3	4	5
14. I find myself pushing through fatigue to get things done.	1	2	3	4	5
15. I seem to be sleeping a lot but never feel quite rested. I wake up feeling tired.	1	2	3	4	5
16. I have difficulty getting to sleep and/or wake up in the middle of the night.	1	2	3	4	5
17. I experience strong cravings for sweet or salty foods.	1	2	3	4	5
18. I feel overwhelmed with daily tasks and all that is on my plate.	1	2	3	4	5
19. I have a low sex drive.	1	2	3	4	5
20. I am unable to enjoy socializing with family and/or friends.	1	2	3	4	5

Add up your total score and mark where you fall on the stress scale below. **Total:** _____

Low Stress **High Stress**

20 — 40 — 60 — 80 — 100

Stress is fairly well managed in your life. It may be important to support your body to continue its healthy response.

Your body's response to stress may be getting in the way of normal activities quite frequently, leaving you feeling depleted. Consult your health care professional for an individualized program to achieve your health goals.

You may have experienced prolonged stress, and your body's stress response can no longer adapt or successfully cope. Consult your health care professional for targeted support and strategies for improvement.

Name: _____ **Date:** _____

Standard Process
WHOLE FOOD NUTRIENT SOLUTIONS

Plum Creek Chiropractic PA

Dr. Cindy Shepard

952-461-3675 *www.plumcreekchiro.com*

Child's Name (last, first. middle): _____

Mother's Name (last, first. middle):

_____

Father's Name (last, first, middle):

_____

Address:

_____

__

Home Phone: _____ Mother's work phone: _____Fathers Work phone:

_____

Cell Phone_____

email_____

Date of Birth: _____ /_____/ Age: _____

Gender: M F Social Security_____

Number of Siblings: _____

Type of Birth: Normal vaginal Suction

Drug Induced Pain Meds

Birth Weight: _____

Birth Length: _____

Current Weight_____ _

Current Length_____

Forceps

Prolonged labor

Hospital

Breech.

Short labor

Problems during pregnancy

Problems during labor/de1ivery:

APGAR Scores: _

Congenital anomalies/defects: _____

Infant feeding: Breast

Birthing Center

Was there presence at birth of Jaundice (yellow) Cyanosis (blue)

Bottle

Formula Other

Number of hours child sleeps per night: _____

Obstetrician/Midwife (name, phone number) _____

Pediatrician/Family MD (phone number): _____

Date of last visit to MD: _____Purpose: _____

Immunization History_____

Has your child ever been treated on an emergency basis: Yes No

Describe_____

_____

Quality of sleep: Good ___Fair _____Poor ____

Naps: _

Authorization for Care of a Minor

I hereby authorize this clinic and its doctor(s) to administer care as they so deem necessary to my son/daughter/ward.

Signed: _____ Witnessed: _____ Date: _

I realize that I am responsible for all fees charged by this clinic and that I will pay for all services as they are performed.

X-rays remain the property of this clinic.

Signature: _____ Date: _____

Pregnancy/
History:_____

_____

_____

_____

Delivery/
BirthHistory:_____

_____

_____

Accidents/
Injuries_____

_____

_____

Surgeries_____

_____

Medications:_____

_____

Supplements_____

_____

Family History of (circle all that apply): Heart Disease Lung Disease Diabetes Cancer Depression

Other: _____

Developmental History; At what age did this child:

Respond to Sound: _____ Follow an object with eyes: _____ Hold Head up: _____ Sit Alone: _____

Crawl: _____ Stand: _____ Walk Alone: _____

Childhood diseases (with approximate age)

Chicken Pox: _____ Rubella: _____ Mumps: _____Measles: _____

Whooping Cough: _____ Other: _____

Has this child ever suffered from?

Dizziness	Backaches	Heart Trouble	Chronic Earaches	Diabetes	Tuberculosis
Hypertension	Colds/Flu	Arthritis	Headaches	Asthma	Allergies
Neuritis	Sinus trouble	Constipation	Diarrhea	Anemia	Digestive Disorders
Poor Appetite	Hyperactivity	Bed Wetting	Convulsions	Paralysis	Rheumatic Fever
Fainting	Walking Problems	Broken Bones	Neck Problems	Arm Problems	Leg Problems
Growing Pains	Joint Problems	Behavioral Problems			

Present History:

Does anyone in your house smoke? Yes no

What are this child's favorite foods?

_____

What is this child's typical diet? _____

_____

Number of Bowel Movements a day? _____ Number of urinations a day? _____

Is there anything else I should know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____