

NUTRITIONAL EVALUATION

Purpose: To Find Any Health Issues That Could Be Helped With Nutrition

Name: _____ Date: _____

Address: _____ Age: _____ DOB: _____

City: _____ State: _____ Zip: _____

Phone (cell) _____ Phone (home) _____

Phone (work) _____ E-mail: _____

MEDICATIONS: _____

HEALTH CONDITIONS: _____

Please Circle Y-Yes or N-No

- Y N** Do you have or have you ever had any metal dental work such as;
Mercury Amalgam (silvered colored) dental fillings, Metal tooth bridges
Silver or Gold Tooth Crowns, Dental implants (metal posts), Dental Plates
Partials, Dentures made from metal, Metal Tooth Braces?
- Y N** Do you have any metal surgical parts such as; metal joint replacements, rods,
posts, screws, staples, or wires?
- Y N** Do you wear any electronic devices such as; heart pacemaker, defibrillator,
batteries, etc?
- Y N** Are you or have you ever been exposed to any hazardous or potentially
hazardous chemical such as pesticides, fertilizers, industrial chemicals, agent orange?
- Y N** Have you ever been treated for parasites, been exposed to parasites, been
bitten by a parasite or suspected that you might have a parasite? (def: parasite
a bug or worm that can live and thrive inside the human body)
- Y N** Are you prone to cold sores, herpes, shingles or virus infections of the skin/mouth,
lungs or digestive tract?
- Y N** Are you prone to bacterial infections?
- Y N** Do you have food allergies?
- Y N** Do you have allergies to dust, mold, pollen, plants, animals or seasonal allergies?

Ballas Chiropractic and Nutrition Centre

11639 Studt Avenue * Creve Coeur * MO * 63141 * 314-872-7797
www.wippermanchiropractic.com * ballaschiropractic@charter.net

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Please Check All Areas You Would Like To Improve if Possible

- | | |
|--|---|
| <input type="checkbox"/> Low Energy/Fatigue | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Weight | <input type="checkbox"/> Hot Flashes |
| <input type="checkbox"/> Infections: _____ | <input type="checkbox"/> Feeling Cold – Cold Hands, Cold Feet |
| <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Concentration/Focus |
| <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Sleeping Difficulties |
| <input type="checkbox"/> Sinus Drip/Congestion | <input type="checkbox"/> Breathing Difficulties |
| <input type="checkbox"/> Pain: _____ | <input type="checkbox"/> Skin Breakouts/Rashes/Patches |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Acid Reflux |
| <input type="checkbox"/> Blood Sugar | <input type="checkbox"/> Digestive Issues |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Memory |
| <input type="checkbox"/> Anxiety/Nervous/Hyper | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Difficulty Walking/Moving | <input type="checkbox"/> Heart Palpitations |
| <input type="checkbox"/> Fluid Retention/Bloating/Swelling | <input type="checkbox"/> Female PMS/Menopause |
| <input type="checkbox"/> Male Prostrate Issues | |

ANY OTHERS NOT LISTED? _____

PLEASE LIST YOUR TOP THREE – MOST PRESSING HEALTH RELATED ISSUES THAT YOU WOULD LIKE HELP WITH:

1. _____
2. _____
3. _____

ENERGY LEVELS: (Scale: Worst = 1, Best = 10) 1 2 3 4 5 6 7 8 9 10

Notes:

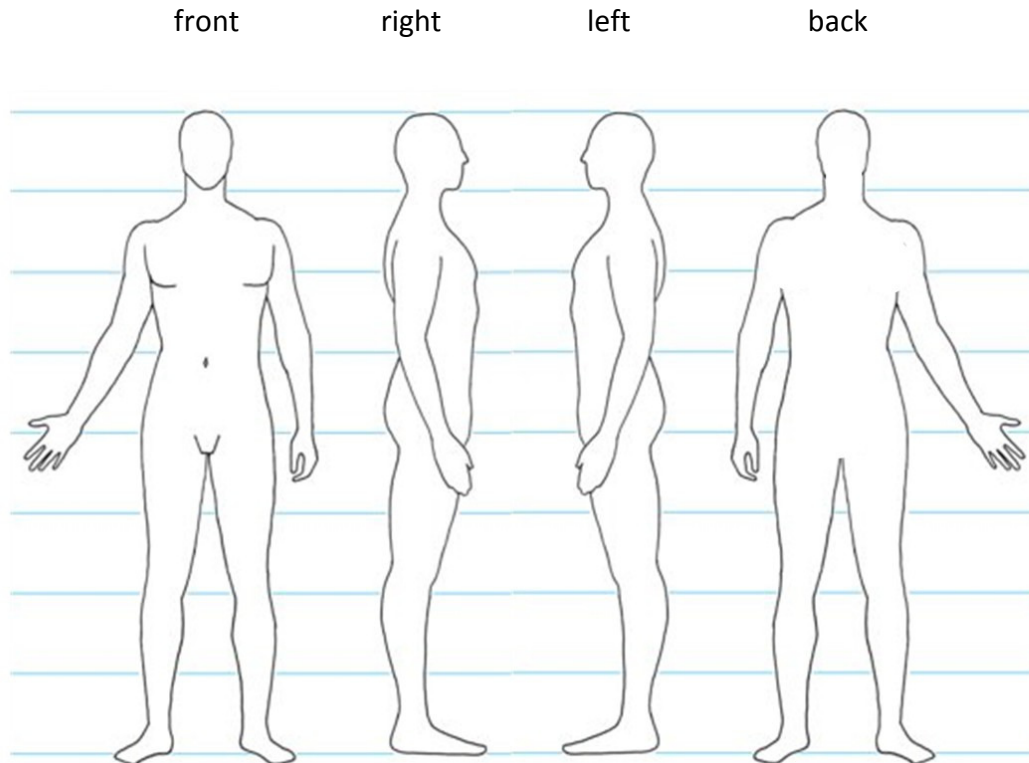
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SCARS: Scars can slow the body's healing process by interfering with electrical nerve transmission. Please indicate any injury or surgery scars that you may have by marking their locations on the body figures below. (Use an "S")

PIERCINGS: Piercings can become scars in time and set off allergic-type symptoms or slow the healing process of the body. Please mark all piercings you may have on the body figures below. (Use a "P")



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