

## 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?

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**Ballas Chiropractic and Nutrition Centre**

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

# NUTRITIONAL EVALUATION

*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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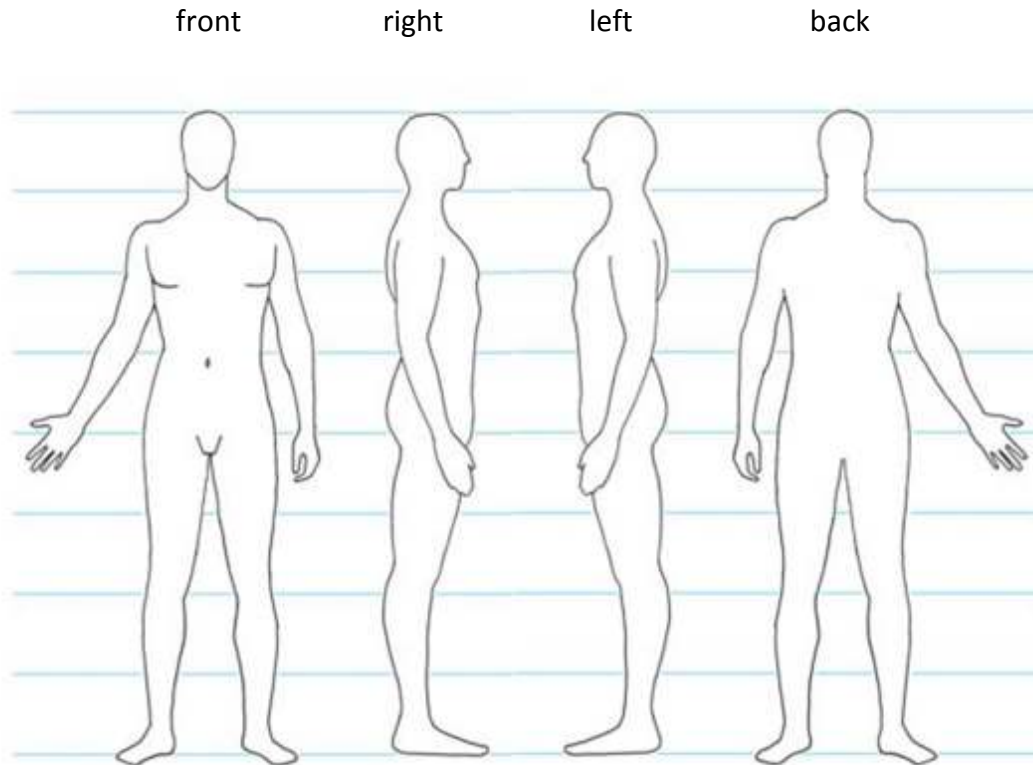
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## NUTRITIONAL EVALUATION

**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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## PATIENT QUESTIONNAIRE

Please use the following key to indicate your responses to the following questions:

1 = Never      2 = Rarely      3 = Sometimes      4 = Frequently      5 = Daily

Please give one rating for each question.

Circle all symptoms that apply to you within each question.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Location	Organ System	Meridian	Question	Rating
RH	Lymphatic	LY – 1-2	Do you experience recurrent infections, sinusitis, postnasal drip or swollen lymph nodes, etc?	
RH	Lungs	LU – 10c	Do you experience recurrent respiratory infections, coughs bronchitis, pneumonia, asthma, etc?	
RH	Large Intestine Kidneys	LI – 1b K1 – 1-3	Do you experience bouts of diarrhea or constipation, gas, bloating, etc?	
RH	Nervous	NE – 1b	Do you experience irritability, nervous, trembling, anxiety or memory problems?	
RH	Circulation	CI – 8d	Do you have cold fingers or toes, blood pressure problems, varicose veins, arteriosclerosis, etc?	
RH	Allergy	AL – 1	Do you react to pollens, molds, foods, season irritants, perfumes, animal dander, etc?	
RH	Organ System	OR – 1b	Do you have slow metabolism, are you always hungry, have low energy at specific times of the day?	
RH	Endocrine	TW – 1b	Do you have mood swings, problems sleeping, are you always cold, have chemical imbalances, etc?	
RH	Heart	HT – 8c	Do you experience palpitations, arrhythmia, impairments from prior infections, weak valves, etc?	
RH	Small Intestine	SI – 1b	Do you have recurrent yeast infections, frequent antibiotic use, poor diet, gas, bloating, etc?	
RH	Pituitary Pineal	TW – 3	Do you experience spinal stiffness or pain, headaches, mental confusion, depression, etc?	
RH	Endocrine	TW – 1b	Do you have diabetes, hypoglycemia, irritability, shaking if you skip a meal, etc?	
RH	Adrenal Gland	TW – 1b	Do you experience fatigue, chronic fatigue, recurring infections, stress, low immune system and abdominal weight gain?	
RF	Liver	LV – 1a	Do you experience jaundice, high cholesterol, discomfort in the liver region, blood disorder, etc?	
RF	Joints	JO – 1b	Do you have arthritis, back pain, discomfort when moving, weather triggered ailments, etc?	
RF	Stomach	ST – 44b	Do you experience digestive disturbances, acid reflux, burping or upper digestive bloating after meals, etc?	
RF	Fibroid Tissue	FI – 1b	Do you have fibromyalgia, rheumatism, carpal tunnel, slow recovery to exercise, etc?	
RF	Skin	SK – 1-3	Do you have rashes, dryness or cracking, scaly patches, eczema, acne, psoriasis, etc?	

Please continue questions on next page

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Circle all symptoms that apply to you within each question.

Location	Organ System	Meridian	Question	Rating
RF	Fatty Tissue	FA – 1b	Do you have lymphomas, degenerative liver disease, breast tumors, problems burning fat, etc?	
RF	Gall Bladder	GB – 43b	Do you have a history of gallstones, discomfort after eating rich foods, low fat metabolism, etc?	
RF	Urogenital Uterus Prostrate	CV – 65	Do you experience impotence, miscarriages, sterility, gynecologic or genital disorders, etc?	
RF	Kidneys	KI – 1-3	Do you experience edema, gout, pain in the lower back, burning urination, kidney stones, etc?	
RF	Urogenital Bladder	UB – 66B	Do you have recurring infections, itching or yeast problems, painful urination, “leaking”, etc?	
RF	Uterus	UB – 65	Do you have PMS, menstrual pains or discomfort, irregular periods, mood swings, hot flashes, menopausal symptoms, etc?	
RF	Prostate	UB – 65	Do you experience urinary discomfort, frequency of urination, etc?	
RF	Lymphatic	LY – 2	Do you have sensitive teeth or experience pain or discomfort in the teeth, gums or low jaw region?	
RH	Nervous	NE – 1b	Do you experience stress from work, finances, society or relationships that you feel cause physical ailments?	
RH	Endocrine	TW – 1b*	Do you lack motivation, drive, perseverance, stamina or endurance?	
RH	Nervous	NE – 1b	Do you lack a sense of happiness, joy, feelings of fulfillment, a positive outlook on life?	
LF	Spleen	SP – 1aL	Are you susceptible to infections, allergies, or sensitive to pollution or work environment?	
RH	Thyroid Hypo	TW2	Are you mostly tired with a low energy, lacking motivation, stamina, drive and endurance? Do you have a slow metabolism, gain weight easily or difficulty losing weight? Do you crave carbs, starches or sugars?	
RH	Thyroid Hyper	TW2	Are you prone to mood swings, sleeping difficulties, always cold, cold hands, cold feet, concentration or learning challenges or chemical imbalances? Difficulties gaining or losing weight?	

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