Ballard Family Chiropractic

Functional Nutrition Patient Information

Please keep the first two pages for your records. They DO NOT need to be returned.

FUNCTIONAL MEDICINE CONSULTATION FEES

Initial consultation with Dr. Ballard: $200
Follow up appointments are time dependent as follows:

- 20 Minutes - $55
- 30 Minutes - $70
- 40 Minutes - $85
- 50 Minutes - $100

PAYMENT OPTIONS

Cash, checks, or credit cards (MasterCard, Visa, Discover) are all accepted methods of payment for services. When you schedule the initial visit, we request a credit card on file to hold the appointment for you. No charges will be applied to your credit card unless you miss or cancel an appointment without proper notice. On the day of your scheduled appointment, all charges for consultations, laboratory testing and nutritional supplements will be itemized, and payment is due on day of service.

Follow-up phone, or in person consultations will be billed to your credit card on file unless you provide other payment information and instructions prior to your appointment. If additional lab tests are required and our office sends test kits, the appropriate fees will be charged to your account. **The credit card on file will also be used for supplements mailed unless otherwise specified.**

INSURANCE

Medical insurance is not accepted, and our office cannot assist you with claim resolution. Functional Medicine is considered preventative care and therefor not a covered service for most insurance providers. Charges are typically HSA eligible.

MEDICAL RECORDS

Medical records can only be released with your authorization. Please fill out a Records Release form for each provider you have seen in the last 3 ***years*** and make sure that we have received them ***at least 5 DAYS*** prior to your initial appointment.

Your medical records should be faxed to our office:
Fax #: (866) 849-1536

Ballard Family Chiropractic

Functional Nutrition Patient Information

OFFICE HOURS

Our office hours are Monday, Wednesday, and Friday:
8:30 am – 12:00 pm & 2:00 pm - 5:30 pm CST.

CONTACT INFORMATION

- **Phone messages left will be responded to within 24 hours (during business hours)**
- To reach the office, please call or text (217) 347-5010
- If you call or text after hours, the office staff will respond to your request on the next business day
- When leaving a message, please be brief and include the following information:
  - ✓ Full name
  - ✓ Reason for call
  - ✓ Preferred contact method

Email contact information:
Tammie (appointment scheduling and supplements)
info@ballardfamilychiro.com

LATE ARRIVALS, CANCELLATIONS AND RESCHEDULES

We are committed to being on time with patients' appointments in order to prevent clients from waiting. If you arrive late to the office for your consult, your appointment will end at the scheduled time, and you will be charged for the length of the originally scheduled visit.

Due to the dedicated nature of the appointment time, we require notice of cancellation or reschedule of your visit **by 2:30 pm on our office working day before your appointment**. If you do not notify our office, you will be charged **a $50 fee**. If you reschedule, that $50 fee will be applied to your next visit.

RETURNS

Due to the individualized nature of products ordered and lack of quality control once supplements leave the office, we are unable to accept returns of supplements.

ORDERING SUPPLEMENTS

Supplement orders are placed every Monday and typically arrive Wednesday. Ask about our Patient Direct Program to have your supplements drop shipped to you directly.

Ballard Family Chiropractic

Functional Nutrition Health History Questionnaire *TO BE FILLED OUT BY PATIENT*

Please fill out the Health History Questionnaire as accurately as you can. The more information you can provide, the better.

Be sure to return this portion to our office, along with your consult fee of $200, as soon as possible to secure your tentatively scheduled appointment date and time.

We would like to take the time to thank you for choosing our office to assist you with your journey to optimal health. Our ability to draw effective conclusions about your state of health and how to optimize its improvement depends largely on the accuracy of the information you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation.

Name: _____ Date: _____

Email: _____ Phone: _____

Address: _____ City: _____

State: _____ Zip: _____

Age: _____ Date of Birth: _____ Height: _____ Weight: _____

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Long Term Partnership

Occupation: Hours Per Week: ☐ Retired

Genetic Background:
☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian ☐ Native American

☐ Caucasian ☐ Northern European ☐ Other (Please describe): _____

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems.

Problem	Date of Onset	Severity/Frequency	Treatment	Success
Example: Headaches	*May 2006*	*2 times/week*	*Acupuncture/Aspirin*	*Mild improvement*

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions?

What treatments/tests were recommended?

Do you have copies of your testing? Y / N
If yes, please include when sending this questionnaire to the office.
If no, please fill out a records release for ***each*** provider you saw and include them when sending this questionnaire to the office.

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when, or how often under comments. Please feel free to use additional paper for any other information if needed.

Illness	When/Onset	Comments
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer (Specify type)		
Chicken Pox		
Chronic Fatigue Syndrome		
Chron's Disease or Ulcerative Colitis		
Diabetes (Specify type)		
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis or EBV		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Thyroid disease, Whooping Cough		

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when, or how often under comments. Please feel free to use additional paper any other information if needed.

Injuries	When	Comments
Back injury		
Broken bones or fractures (describe)		
Neck injury		
Other (describe)		
Other (describe)		
Diagnostic Studies	**When**	**Comments**
Blood Tests		
Bone Density Test		
Carotid Artery Ultrasound		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
Surgeries	**When**	**Comments**
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes In Ears		
Other (describe)		
Other (describe)		

HOSPITILIZATIONS

Where	When	Reason

MEDICATIONS

How often have you taken antibiotics	< 5 Times	> 5 Times	Comments
Infancy/Childhood			
Teen			
Adult			

How often have you taken oral steroids? (e.g., Prednisone, Cortisone, etc.)	< 5 Times	> 5 Times	Comments
Infancy/Childhood			
Teen			
Adult			

List all medications you are currently on. Include bio-identical hormones and over the counter. Please use additional sheets of paper if necessary.

Type & Brand	Start Date	End Date	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. Please use additional sheets of paper if necessary.

Type & Brand	Start Date	End Date	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement?

☐ Yes ☐ No

If yes, please list: _____

_____

_____

FAMILY HEALTH HISTORY

Check all family members that apply:	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (If still living)									
Age at death (If deceased)									
Heart Attack									

FAMILY HEALTH HISTORY

Check all family member that apply:	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Disease									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Autism									
Autoimmune Diseases									
Bipolar Disease									
Bladder Disease									
Blood Clotting Problems									
Celiac Disease									
Dementia									
Depression									

FAMILY HEALTH HISTORY

Check all family member that apply:	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Flu									
Genetic Disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing, Spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Disease									
Kidney Disease									
Multiple Sclerosis									
Nervous Breakdown									
Obesity									

FAMILY HEALTH HISTORY

Check all family member that apply:	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Osteoporosis									
Parkinson's									
Pneumonia									
Psoriasis									
Psychiatric Disorders									
Schizophrenia									
Sleep Apnea									
Smoking Addiction									
Substance Abuse									
Ulcers									
Please use the space below to list any other conditions not mentioned above.									

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Were you a full-term baby?				
A premature birth ('Preemie')?				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription meds?				

IMMUNIZATION HISTORY **Please indicate if you have been vaccinated against any of the following diseases:**	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (Oral)				
Polio (Injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				
Influenza				

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

CHILDHOOD DIET **Was your childhood diet high in:**	**Yes**	**No**	**Don't Know**	**Comment**
Sugar (Sweets, candy, cookies, etc.)				
Soda				
Fast food, pre-packaged foods, artificial sweeteners				
Milk, cheeses, other dairy products				
Meat, vegetables, and potato diet				
Vegetarian diet				
Diet high in white breads				

As a child, were there foods that you had to avoid because they gave you symptoms?

☐ Yes ☐ No

If yes, please explain (Example: Milk = Diarrhea): _____

_____

_____

CHILDHOOD ILLNESS **Please indicate which of the following problems/conditions you experienced as a child and the approximate age of onset.**	**Yes**	**Age**	**Comment**
Asthma			
Chicken Pox			
Colic			
Congenital problems			
Ear infections			
Fever blisters			
Frequent colds or flu			
Frequent headaches			
Hyperactivity			
Jaundice			
Measles			
Mumps			
Pneumonia			
Seasonal allergies			
Skin disorders (e.g., dermatitis)			
Upset stomach, digestive problems			
Whooping cough			
Other (describe)			

As a child, did you have a high absence from school?

☐ Yes ☐ No

If yes, please explain: _____

_____

_____

As a child, did you experience chronic exposure to secondhand smoke in your home? Y / N

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Y / N

If yes, what type? Cigarette ___ Smokeless ___ Cigar ___ Pipe ___ Patch/Gum ___

How much? _____ Number of years? ___ If not a current user, year you quit? ___

Attempts to quit: ___

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

_____

_____

ALCOHOL INTAKE

Have you ever used alcohol? Y / N

If yes, how often do you drink alcohol now? Please check one:

No longer drink alcohol ☐

Average 1 - 3 drinks per week ☐

Average 4 - 6 drinks per week ☐

Average 7- 10 drinks per week ☐

Average > 10 drinks per week ☐

Do you notice a tolerance to alcohol? (Can you "hold" more than other?) Y / N

OTHER SUBSTANCES (NO judgement. Please answer honestly.)

Do you currently, or have you previously used recreational drugs? Y / N

If yes, please describe what type(s), method(s), and frequency: _____

_____

_____

To your knowledge, have you ever been exposed to toxic metals in your job or home? Y / N
If yes, please select all that apply:

Lead ☐
Arsenic ☐
Aluminum ☐
Cadmium ☐
Mercury ☐

SLEEP AND REST HISTORY

Average number of hours that you sleep at night? < 6 ___ 6 - 8 ___ 8 - 10 ___ > 10 ___

Do you experience any of the following (select all that apply):

Have trouble falling asleep ☐

Feel rested upon wakening ☐

Have problems with insomnia ☐

Have trouble staying asleep ☐

Snore ☐

CPAP ☐

Use a sleeping aid ☐

Please describe: _____

NUTRITION HISTORY

Have you made any changes in your eating habits because of your health? Y / N

If yes, when did you make these changes?

How much of the following do you consume each week?

Candy _____

Cheese _____

Chocolate _____

Cups of coffee containing caffeine _____

Cups of decaffeinated coffee or tea _____

Cups of hot chocolate _____

Cups of tea containing caffeine _____

Ice Cream _____

Salty Foods _____

Slices of white bread (rolls, bagels, etc.) _____

Soda with caffeine _____

Soda without caffeine _____

Diet soda _____

Do you currently follow a special diet or nutritional program? Y / N

Ovo-lacto	☐	Vegetarian	☐
Diabetic	☐	Vegan	☐
Dairy restricted	☐	Blood type diet	☐

Other: _____

NUTRITION HISTORY

Is there anything special about your diet that we should know? Y / N

If yes, please describe: _____

Do you have symptoms ***immediately after*** eating such as belching, bloating, sneezing, hives, etc.? Y / N

If yes, are these symptoms associated with any food or supplement? Y / N

If yes, please name the food or supplement and symptoms: _____

_____

_____

Do you have ***delayed*** symptoms after eating certain foods such as fatigue, muscle ache, sinus congestion, etc.?

Symptoms may not be evident for 24 hours or more. Y / N

If yes, please describe the food and symptoms: _____

_____

Do you fee ***worse*** when you eat a lot of:

High fat foods	☐	Refined sugar (junk food)	☐
High protein foods	☐	Fried foods	☐
High carbohydrate foods	☐	1 or 2 alcoholic drinks	☐
Other	☐	Describe:	_____

Do you fee ***better*** when you eat a lot of:

High fat foods	☐	Refined sugar (junk food)	☐
High protein foods	☐	Fried foods	☐
High carbohydrate foods	☐	1 or 2 alcoholic drinks	☐
Other	☐	Describe:	_____

Does skipping meals greatly affect your symptoms? Y / N

Has there ever been a food that you have craved or "binged" on over a period of time? Y / N

If yes, please list what food(s): _____

_____

NUTRITION HISTORY

Please check all that apply as it relates to your bowel movements:

FREQUENCY:

- More than 3x/day ☐
- 1 - 3x/day ☐
- 4 - 6x/week ☐
- 2 - 3x/week ☐
- 1 or fewer x/week ☐

CONSISTENCY:

- Soft and well formed ☐
- Often floats ☐
- Difficult to pass ☐
- Diarrhea ☐
- Thick, long, or narrow ☐

COLOR:

- Medium brown consistently ☐
- Very dark or black ☐
- Greenish ☐
- Blood is visible ☐
- Varies a lot ☐
- Dark brown consistently ☐
- Yellow, light brown ☐
- Greasy, shiny ☐

COMMENTS:

_____

_____

_____

_____

_____

_____

_____

_____

DENTAL HISTORY

Please check all that apply:

- Problems with sore gums (gingivitis)? ☐
- Ringing in the ears (Tinnitus)? ☐
- Have TMJ (Temporal Mandibular Joint) problems? ☐
- Metallic taste in mouth? ☐
- Problems with bad breath (Halitosis) or white tongue (thrush)? ☐
- Previously or currently wear braces? ☐
- Problems chewing? ☐
- Floss regularly? ☐
- Amalgam (silver) fillings? If yes, how many? ☐
- Did you receive these fillings as a child? ☐

DENTAL HISTORY

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work	Describe any health problems that followed dental work:

EXERCISE HISTORY

Do you exercise regularly? Y / N If yes, please indicate:	Times/Week				Length of session (Min.)			
TYPE OF EXERCISE								
Jogging/walking								
Aerobics								
Strength training								
Pilates/Yoga/Tai Chi								
Sports (Tennis, golf, water, etc.)								
Other:								

If you do not exercise regularly, please indicate what problems limit your activity (low motivation, fatigue after exercising, etc.): _____

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system disfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Y / N

Do you feel you can easily handle the stress in your life? Y / N

If no, do you believe that stress is presently reducing the quality of your life? Y / N

If yes, do you believe that you know the source of your stress? Y / N

If yes, what do you believe it to be? _____

Have you ever contemplated suicide? Y / N

If yes, how often? _____

When was the last time?_____

Have you ever sought help through counseling? Y / N

If yes, what type? (e.g., pastor, psychologist, etc.) _____

Did it help? Y / N

How satisfied are you with:	Perfect	Satisfied	Just OK	Dissatisfied	Terrible	Doesn't apply
School life						
Your job						
Your social life						
Close friends						
Quality of sex						
Quantity of sex						
Your significant other						
Your children						
Your parents						

Which of the following provide you emotional support? Circle all that apply:

Spouse Family Friends Religion/Spirituality Pets Other_____

SOCIAL HISTORY

Have you ever been involved in abusive relationships (physical and/or emotional)? Y / N

Have you ever been a victim of a crime, or experienced a significant trauma? Y / N

Is alcoholism or substance abuse present in your relationships now? Y / N

If yes, do you need resources to help you/your loved one? Y / N

How important is religion/spirituality for you and your family's life?

Not at all important ____ Somewhat important ___ Extremely important ___

Do you practice meditation or relaxation techniques? Y / N

If yes, how often?_____

Circle all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other_____

What hobbies and leisure activities do you do for fun?

Is there anything that you would like to discuss with the doctor today that you feel was not covered? Y / N

If yes, please list your comments below:

FEMALE MEDICAL HISTORY

Age at onset of first period: _____ Approximate date of onset: _____

What are you using for contraception now? _____

Have you ever used oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception?

Y / N If yes, when? From _____ to _____

Do you suffer from any side effects?

Y / N Explain: _____

Are you now, or have you ever used an IUD? Y / N What type? (Paraguard, Mirena, etc.) _____

When? _____ For how long? _____

While under the use of any birth control method, did you experience the following? Check all that apply:

Yeast	☐	Sweet cravings	☐
Heavy/light bleeding	☐	Fatigue	☐
Mood	☐	Depression	☐
Weight gain	☐	Palpitations	☐
Acne	☐	Other (describe)	_____

Please use the space below for any additional explanation:

_____

_____

Are you currently, or have you ever used fertility treatment?

Y / N Explain: _____

Do you have any history of abnormal Pap tests? _____

Y / N Explain: _____

Do you have any history of vaginal infections?

Y / N Explain: _____

Please describe any treatment and/or medication for this: _____

Do you have any history of the following conditions? Check all that apply:

Ovarian Cysts	☐	Endometriosis	☐
Fibrocystic Breasts	☐	Lichen Sclerosis	☐
Polycystic Ovarian Syndrome	☐	Vulvodynia	☐
Uterine Fibroids	☐	Other (describe)	_____

FEMALE MEDICAL HISTORY

DIAGNOSTIC TESTING

Please list the most recent date and results for the following:

PAP	___/___/___	Normal ___	Abnormal ___	
Mammogram	___/___/___	Normal ___	Abnormal ___	
Breast biopsy	___/___/___	Normal ___	Abnormal ___	
Breast thermography	___/___/___	Normal ___	Abnormal ___	
Bone density	___/___/___	High ___	Low ___	Within Normal Range ___

PREGNANCY HISTORY (to be completed by all women, if applicable)

Have you ever been pregnant before? Y / N

Please list the age(s) of your children: _____

Number of pregnancies: _____

Number of live births: _____

Number of miscarriages: _____

How many weeks gestation at the time of miscarry: _____

Number of premature births: _____

Number of cesarean births: _____

Number of stillbirths: _____

Number of ectopic pregnancies: _____

Number of terminated pregnancies: _____

CYCLE HISTORY (to be completed by all women, if applicable)

What was the date of your last menstrual period? ___/___/___

Have you ever had tubal ligation surgery? Y / N Have you had an ablation? Y / N If yes, when? ___/___/___

If so, please list the date and specific details: _____

_____

_____

_____

How many days is your current cycle (counting from the first day of bleeding to the first day of your next cycle)?

< 20 Days 20 - 30 Days 30 - 40 Days 40 - 50 Days > 50 Days

How many days does your menstruation typically last? _____

Would you describe your menstruation as: Easy Uncomfortable/Difficult Debilitating

FEMALE MEDICAL HISTORY

CYCLE HISTORY CONTINUED

What is/was your typical menstrual flow? Light Medium Heavy

When you are or were cycling, would you describe your cycles as regular? Y / N

If no, please give explanation: _____

_____

If you have received any type of "treatment" for any cycle issues, please provide details below:

_____

_____

_____

_____

What type of product do you use during your cycle? Circle all that apply:

Pads Tampons Menstrual Cup Other _____

How many pads and/or tampons do you use on heavy days? _____

How often do you empty your cup? _____

During menstruation, do you pass blood clots? Y / N How often? _____

How would you describe your cramping? None Mild Moderate Severe

At what point in your cycle do you experience cramping? _____

Have you noticed any recent changes to your cycle? Y / N

If yes, please explain: _____

_____

Do you experience any unusual or excessive vaginal discharge throughout the month? Y / N

If yes, when? _____

Do you experience itching or odor in the vaginal area? Y / N

If yes, when? _____

Do you experience any breast tenderness? None Mild Moderate Severe

If yes, at what point in your cycle? _____

Do you have nipple discharge at any point in your cycle? Y /N

If yes, when? _____

FEMALE MEDICAL HISTORY

MENOPAUSAL WOMEN

Menopause is reached after 1 full year without a menstrual cycle or after a hysterectomy.

Did you enter menopause naturally or due to a hysterectomy? _____

If hysterectomy, was it full or partial? _____

What age were you at the onset of menopause? _____ Year of onset? _____

Date of your last menstrual period? _____

Please describe any recent changes and/or symptoms associated with your cycle prior to menopause:

_____

_____

MALE MEDICAL HISTORY

When was your last prostate exam? ___/___/___

What were your most recent PSA results? _____ Date: _____

Does your bladder always feel full?	YES	NO	SOMETIMES
Do you experience inconsistent pressure or pain during urination?	YES	NO	SOMETIMES
Does ejaculation cause pain?	YES	NO	SOMETIMES
Do you have premature ejaculation?	YES	NO	SOMETIMES
Have you ever been diagnosed with low testosterone?	YES	NO	SOMETIMES
Have you ever had testicular issues? (hydrocele, torsion, etc.)	YES	NO	SOMETIMES
Have you experienced infertility?	YES	NO	SOMETIMES

If yes, how was this diagnosed? _____

Please use the space below to describe any other symptoms you feel we should know about:

READINESS ASSESSMENT

In order to improve your health, please rate the following on a scale of 5 (very willing) to 1 (not willing):

Significantly modify your diet	5	4	3	2	1
Take nutritional supplements each day	5	4	3	2	1
Keep a record of everything you eat each day	5	4	3	2	1
Modify your lifestyle (e.g., work demands, sleep habits, etc.)	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic lab tests to assess progress	5	4	3	2	1

Thank you for taking the time to complete this questionnaire.

This questionnaire is an adaptation of the Comprehensive Health History created by Wayne L. Sodano, D.C., D.A.B.C.I, and Ron Grisanti, D.C., D.A.B.C.O., M.S. at the Functional Medicine University, Sequoia Education Systems, Inc.

PLEASE RETURN THESE FORMS ALONG WITH ANY MEDICAL RELEASES, YOUR 3 DAY FOOD DIARY, AND YOUR CREDIT CARD AUTHORIZATION A MINIMUM OF 5 DAYS BEFORE YOUR SCHEUDLED APPOINTMENT.

3 DAY DIET DIARY INSTRUCTIONS:

It is important to keep an accurate record of your USUAL food and beverage intake as a part of your treatment plan. Please complete your Diet Diary for **3 consecutive days, including one weekend day.**

While completing your diary, keep in mind the following:

- Do not change your eating behaviors yet, as the purpose of this food record is to analyze your present eating habits
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk - whole, 2%, nonfat; toast – whole wheat, white, buttered; chicken – fried, baked, breaded; coffee – decaffeinate with sugar and half & half, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages including water, coffee, tea, sports drinks, all sodas (diet & regular)
- Include any additional comments about your eating habits on this form. For example: craving sweets, skipped meals and why, when a meal was at a restaurant, etc.
- Please note all bowel movements and their consistency – regular, loose, firm, etc.

PLEASE COMPLETE AND SUBMIT THE FOLLOWING DIET DIARY (3pgs total) WITH THE REST OF YOUR INTAKE FORMS. DO NOT WAIT TO BRING WITH YOU TO YOUR APPOINTMENT.

Ballard Family Chiropractic | 14225 Rickelman, Effingham, IL 62565 | (217) 347-5010 | info@ballardfamilychiro.com

3 DAY DIET DIARY:

DIET DIARY:

Name: _____ Date:_____

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:

Ballard Family Chiropractic | 14225 Rickelman, Effingham, IL 62565 | (217) 347-5010 | info@ballardfamilychiro.com

3 DAY DIET DIARY:

DIET DIARY:

Name: _____ Date:_____

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:

Ballard Family Chiropractic | 14225 Rickelman, Effingham, IL 62565 | (217) 347-5010 | info@ballardfamilychiro.com

3 DAY DIET DIARY:

DIET DIARY:

Name: _____ Date:_____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel movements – number, form, color, etc.,:

Stress/Mood/Emotions:

Other Comments:

Ballard Family Chiropractic | 14225 Rickelman, Effingham, IL 62565 | (217) 347-5010 | info@ballardfamilychiro.com