

Waterman Chiropractic | Nutrition Response Testing

NEW CLIENT INFORMATION FORM

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Please print clearly:

Name _____ Date _____

Home Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address (if different from home address) _____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Appt. reminder, call phone number: ☐ C ☐ H ☐ W

Email address: _____ **REFERRED BY:** _____

Genetic Background: ☐ African American ☐ Native American ☐ Hispanic ☐ Caucasian
☐ Mediterranean ☐ Northern European ☐ Asian ☐ Other: _____

Occupation _____ Employer _____ # of hours work/week _____

Date of Birth _____ Age _____ Sex: ☐ M ☐ F Height _____ Weight _____

Overall health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint _____

Other complaints or problems: (use separate sheet if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals? (If yes, please give name and date of last visit): _____

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (If yes, indicate how much or how often and what kind)

Cigarettes _____ Coffee _____ Alcohol _____

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HEALTH HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operations (with approx. dates): _____

Past Accidents or injuries: _____

=====

Emergency Contact (Name/Relationship) _____ Phone: _____

Marital Status: ☐ Married ☐ Partnered ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
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_____	____	☐ M ☐ F	_____
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_____	____	☐ M ☐ F	_____
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_____	____	☐ M ☐ F	_____
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_____	____	☐ M ☐ F	_____
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_____	____	☐ M ☐ F	_____
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Any family history of serious illnesses (circle those which apply): ☐ Cancer ☐ Diabetes ☐ Heart Disease

Any household pets or other animals you or family members are in close contact with:

What can we do to make you happier? _____

Signature: _____ Date: _____

Systems Assessment Form

Name: _____ Age: _____ Sex: _____ Date: _____

List your 5 main health complaints in the order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Weight: _____

☐ Vegetarian

☐ Vegan

Height: _____

☐ Gluten-free

☐ Dairy-free

Organs Removed:

☐ Gallbladder

☐ Thyroid

☐ Colon

☐ Spleen

☐ Uterus

☐ Ovaries

☐ Breast

☐ Prostate

☐ Tonsils

☐ Appendix

☐ Other: _____

Circle the appropriate number that applies on all questions below. 0 is the least/never to 3 as the most/always

Group 1

1. Acid foods upset 0 1 2 3
2. Get the chills often 0 1 2 3
3. "Lump" in throat 0 1 2 3
4. Dry mouth, eyes, or nose 0 1 2 3
5. Pulse increases after a meal 0 1 2 3
6. Keyed up, difficult to calm down 0 1 2 3
7. Cuts or scratches heal slowly 0 1 2 3
8. Gag easily 0 1 2 3
9. Unable to relax; startle easily 0 1 2 3
10. Clammy or cold hands/feet 0 1 2 3
11. Irritated by strong light 0 1 2 3
12. Urine amount reduced 0 1 2 3
13. Heart pounds after retiring 0 1 2 3
14. "Nervous" stomach 0 1 2 3
15. Forgets to eat meals 0 1 2 3
16. Cold sweats 0 1 2 3
17. Temperature raises easily, fevers 0 1 2 3
18. Skin sensitive or painful if touched 0 1 2 3
19. Eyes lock in fixed stare (few seconds) 0 1 2 3
20. Queasy or sour stomach 0 1 2 3

Group 2

21. Joint stiffness on arising 0 1 2 3
22. Muscle, leg, or toe cramps at night 0 1 2 3
23. "Butterfly" stomach, cramps 0 1 2 3
24. Eyes or nose watery 0 1 2 3
25. Eyes blink rapidly 0 1 2 3
26. Eyelids swollen or puffy 0 1 2 3
27. Indigestion soon after meals 0 1 2 3
28. Always feel hungry; "lightheaded" often 0 1 2 3
29. Digestion is rapid 0 1 2 3
30. Occasional nausea or vomiting 0 1 2 3
31. Voice gets hoarse or raspy 0 1 2 3
32. Slow or Irregular breathing pattern 0 1 2 3
33. Pulse skips or feels "irregular" 0 1 2 3
34. Excessive saliva production 0 1 2 3
35. Difficulty swallowing food or pills 0 1 2 3
36. Alternating constipation & diarrhea 0 1 2 3
37. Slow starter in the morning 0 1 2 3
38. Ears get hot or red 0 1 2 3
39. Sweat easily 0 1 2 3
40. Feel cold – hands, feet, all over 0 1 2 3
41. Colds or respiratory infections 0 1 2 3

Group 3

42. Eat when nervous or anxious 0 1 2 3
43. Excessive appetite 0 1 2 3
44. Hungry between meals 0 1 2 3
45. Irritated before meals (hangry) 0 1 2 3
46. Get "shaky" or "jittery" if hungry 0 1 2 3
47. Fatigue after meals (food coma) 0 1 2 3
48. "Lightheaded" if meals delayed 0 1 2 3
49. Can feel heart beat, palpitates 0 1 2 3
50. Afternoon Headaches 0 1 2 3
51. Bloating after eating fiber, starch, sugar 0 1 2 3
52. Insomnia: Cannot stay asleep 0 1 2 3
53. Crave candy or coffee during the day 0 1 2 3
54. Depression, lack of motivation 0 1 2 3
55. Crave sweets or snacks during the day 0 1 2 3

Group 4

56. Hands or feet go to sleep, numbness 0 1 2 3
57. Sigh frequently, "Air hunger" 0 1 2 3
58. Aware of "breathing heavily" 0 1 2 3
59. High-Altitude discomfort 0 1 2 3
60. Feel must open windows in closed rooms 0 1 2 3
61. Easily gets colds or fevers 0 1 2 3
62. Afternoon "yawner" 0 1 2 3
63. Feel "drowsy" 0 1 2 3
64. Ankle or wrist swelling, fluid retention 0 1 2 3
65. Muscle cramps 0 1 2 3
66. Shallow, rapid breathing 0 1 2 3
67. Chest tightness, pressure or pain 0 1 2 3
68. Bruise easily, "black and blue" spots 0 1 2 3
69. Tendency to Anemia 0 1 2 3
70. "Nose bleeds" 0 1 2 3
71. Noises in head, or "ringing in ears" 0 1 2 3
72. Shortness of breath upon exertion 0 1 2 3

Group 5

73. Dizziness 0 1 2 3
74. Dry or flaky skin (scalp, feet, anywhere) 0 1 2 3

75. Burning or itching feet 0 1 2 3
76. Blurred vision 0 1 2 3
77. Unexplained itching skin or rash anywhere 0 1 2 3
78. Excessive falling hair 0 1 2 3
79. Reddened skin, especially palms or feet 0 1 2 3
80. Bitter or metallic taste in mouth in mornings 0 1 2 3
81. Bowel movements painful or difficult 0 1 2 3
82. Worrier, feel insecure 0 1 2 3
83. Tightness/headache over eyes 0 1 2 3
84. Greasy or high-fat foods cause distress 0 1 2 3
85. Stool color is pale, white or light colored 0 1 2 3
86. Perfume/fragrance sensitivity 0 1 2 3
87. Muscle tightness between shoulder blades 0 1 2 3
88. Occasional constipation 0 1 2 3
89. Stools alternate from soft to watery 0 1 2 3
90. History of gallbladder spasms or stones 0 1 2 3
91. Sneezing attacks 0 1 2 3
92. Nightmare-type dreams or terrors 0 1 2 3
93. Bad breath (halitosis) 0 1 2 3
94. Dairy, Milk products cause distress or lactose intolerant 0 1 2 3
95. Sensitive to hot weather 0 1 2 3
96. Itching or burning anus 0 1 2 3
97. Sweet and sour cravings 0 1 2 3

Group 6

98. Loss of interest to eat meat 0 1 2 3
99. Use antacids 0 1 2 3
100. Burning stomach relieved by eating 0 1 2 3
101. White coating on tongue 0 1 2 3
102. Pass large amounts of foul-smelling gas 0 1 2 3
103. Bloating lasts hours after eating 0 1 2 3
104. Unpredictable urgency to defecate 0 1 2 3
105. Pass large amounts of gas: No odor 0 1 2 3
106. Heartburn when lying down 0 1 2 3

Group 7A

107. Insomnia: Hard to fall asleep	0 1 2 3
108. Nervousness, feel on edge	0 1 2 3
109. Difficult to gain weight	0 1 2 3
110. Intolerance to heat	0 1 2 3
111. Highly emotional	0 1 2 3
112. Face or skin flushes easily	0 1 2 3
113. Night sweats	0 1 2 3
114. Thin, moist skin	0 1 2 3
115. Inward trembling	0 1 2 3
116. Can hear heartbeat on pillow	0 1 2 3
117. Increased appetite but can't gain weight	0 1 2 3
118. Increased or rapid pulse at rest	0 1 2 3
119. Eyelids or face twitch	0 1 2 3
120. Irritable and restless	0 1 2 3
121. Difficulty working under pressure	0 1 2 3

Group 7B

122. Increase in weight	0 1 2 3
123. Decrease in appetite	0 1 2 3
124. Fatigue easily	0 1 2 3
125. Ringing in ears (Pitch: ☐ High ☐ Low)	0 1 2 3
126. Sleepy during day	0 1 2 3
127. Sensitive to cold	0 1 2 3
128. Dry or scaly skin	0 1 2 3
129. Use laxatives	0 1 2 3
130. Mental sluggishness	0 1 2 3
131. Hair coarse or falling out	0 1 2 3
132. Headaches in mornings, wear off during the day	0 1 2 3
133. Slow pulse, below 65	0 1 2 3
134. Frequent urination	0 1 2 3
135. Impaired or loss of hearing	0 1 2 3
136. Reduced initiative or motivation	0 1 2 3

Group 7C

137. Failing memory	0 1 2 3
138. Low blood pressure	0 1 2 3
139. Increased sex drive	0 1 2 3
140. "Splitting or rending" headache near the temple	0 1 2 3
141. Cannot handle sugar well	0 1 2 3

Group 7D

142. Thirsty all the time	0 1 2 3
143. Bloating of abdomen	0 1 2 3
144. Weight gain around hips or waist	0 1 2 3
145. Sex drive reduced or lacking	0 1 2 3
146. Tendency to ulcers, colitis	0 1 2 3
147. Can eat and burn sugar easily	0 1 2 3
148. Increased urine output	0 1 2 3
149. Sexual dysfunction	0 1 2 3

Group 7E

150. Feel off balance, vertigo	0 1 2 3
151. Headaches that go away with caffeine	0 1 2 3
152. Hot flashes	0 1 2 3
153. Increased blood pressure	0 1 2 3
154. Thinning skin on arms or hands	0 1 2 3
155. Urine smells sweet or fruity	0 1 2 3
156. Over aggressive tendencies	0 1 2 3

Group 7F

157. Dizzy after standing up quickly	0 1 2 3
158. Chronic fatigue	0 1 2 3
159. Headaches w/ exertion, stress	0 1 2 3
160. Weak nails or have ridges	0 1 2 3
161. Tendency to hives	0 1 2 3
162. Joint pain and stiffness	0 1 2 3
163. Perspiration increase	0 1 2 3
164. Bowel inflammation	0 1 2 3
165. Poor circulation	0 1 2 3
166. Swelling of ankles (☐ Left ☐ Right)	0 1 2 3
167. Crave salt	0 1 2 3
168. Brown spots or bronzing of skin	0 1 2 3
169. Allergies	0 1 2 3
170. Weakness after colds, influenza	0 1 2 3
171. Exhaustion - muscular and nervous	0 1 2 3
172. Respiratory or breathing challenges	0 1 2 3

Group 8 | B Complex

173. Muscle weakness	0 1 2 3
174. Lack of Stamina	0 1 2 3
175. Drowsiness after eating	0 1 2 3
176. Muscular soreness	0 1 2 3
177. Rapid heart beat	0 1 2 3
178. Hyper-irritable	0 1 2 3
179. Feeling of a band around the head	0 1 2 3
180. Melancholia (feeling of sadness)	0 1 2 3
181. Difficult to concentrate	0 1 2 3
182. Diminished urination	0 1 2 3
183. Tendency to consume sweets or carbohydrates	0 1 2 3

Group 8 | G Complex

184. Muscle spasms, twitches	0 1 2 3
185. Anxiety	0 1 2 3
186. Loss of muscular control	0 1 2 3
187. Numbness	0 1 2 3
188. Night sweats	0 1 2 3
189. Rapid digestion	0 1 2 3
190. Sensitivity to noise	0 1 2 3
191. Cracking of skin, hands or bottom of feet	0 1 2 3
192. Visible veins on chest and abdomen	0 1 2 3
193. Hemorrhoids or spider veins	0 1 2 3
194. Apprehension (feeling that something bad will happen)	0 1 2 3
195. Nervousness causing loss of appetite	0 1 2 3
196. Nervousness with indigestion	0 1 2 3
197. Gastritis	0 1 2 3
198. Forgetfulness	0 1 2 3
199. Thinning hair	0 1 2 3

Notes:**FEMALE ONLY**

200. Very easily fatigued	0 1 2 3
201. Premenstrual tension	0 1 2 3
202. Painful menses or ovulation	0 1 2 3
203. Depressed feelings before menstruation	0 1 2 3
204. Menstruation excessive and prolonged	0 1 2 3
205. Painful breasts	0 1 2 3
206. Menstruate too frequently	0 1 2 3
207. Vaginal discharge	0 1 2 3
208. Hair growth on face (upper lip, chin) areola, abdomen	0 1 2 3
209. Hot flashes	0 1 2 3
210. Menses scanty or missed	0 1 2 3
211. Acne, worse at menses	0 1 2 3
212. Raised bumps on skin of arm	0 1 2 3

MALE ONLY

213. Prostate challenges	0 1 2 3
214. Urination difficult or dribbling	0 1 2 3
215. Frequent night urination	0 1 2 3
216. Depression, melancholy	0 1 2 3
217. Pain on inside of legs or heels	0 1 2 3
218. Feeling of incomplete bowel evacuation	0 1 2 3
219. Lack of energy	0 1 2 3
220. Migrating aches or pain	0 1 2 3
221. Tire too easily	0 1 2 3
222. Avoid social activity	0 1 2 3
223. Restless legs at night	0 1 2 3
224. Diminished sex drive	0 1 2 3

OFFICE USE ONLY

- ☐ Food Diary
☐ Tongue
☐ Fingernails

Zinc Test Results: _____

Postural Hypotension:

Recumbent: _____ / _____ Pulse: _____

Standing: _____ / _____ Pulse: _____

SpO₂: _____ %

Calcium Cuff Test:

Before: _____ After: _____

The Nutritional Exam:

- ☐ HCL ☐ Ascending
☐ Enzyme ☐ Transverse
☐ Murphy's Sign ☐ Descending