SYSTEMS SURVEY FORM

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Sex: Male ·· Female ··

Pulse: Recumbent _____ Standing _____ Vegetarian ·· Gluten-free ··

Blood pressure: Recumbent _____/_____ Standing _____/_____ Ragland's Test is Positive ··

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurs rarely).
○ ● ○ MODERATE symptoms (occurs several times a month).
○ ○ ● SEVERE symptoms (occurs almost constantly)
○ ○ ○ **Leave circles BLANK if they don't apply to you!**

	1	2	3	
				GROUP 1
1	○	○	○	Acid foods upset
2	○	○	○	Get chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meal
6	○	○	○	Keyed up - fail to calm
7	○	○	○	Cut heals slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold, clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Fever easily raised
18	○	○	○	Neuralgia-like pains
19	○	○	○	Staring, blinks little
20	○	○	○	Sour stomach often
				GROUP 2
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				GROUP 3
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
	1	2	3	
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				GROUP 4
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion
				GROUP 5
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter, metallic taste in mouth in mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Worrier, feels insecure
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upset
85	○	○	○	Stools light colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Use laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmare type bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				GROUP 6
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul-smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucous colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

	1	2	3	
				GROUP 7A
107	○	○	○	Insomnia
108	○	○	○	Nervousness
109	○	○	○	Can't gain weight
110	○	○	○	Intolerance to heat
111	○	○	○	Highly emotional
112	○	○	○	Flush easily
113	○	○	○	Night sweats
114	○	○	○	Thin, moist skin
115	○	○	○	Inward trembling
116	○	○	○	Heart palpitates
117	○	○	○	Increased appetite without weight gain
118	○	○	○	Pulse fast at rest
119	○	○	○	Eyelids and face twitch
120	○	○	○	Irritable and restless
121	○	○	○	Can't work under pressure
				GROUP 7B
122	○	○	○	Increase in weight
123	○	○	○	Decrease in appetite
124	○	○	○	Fatigue easily
125	○	○	○	Ringing in ears
126	○	○	○	Sleepy during day
127	○	○	○	Sensitive to cold
128	○	○	○	Dry or scaly skin
129	○	○	○	Constipation
130	○	○	○	Mental sluggishness
131	○	○	○	Hair coarse, falls out
132	○	○	○	Headaches upon arising, wear off during day
133	○	○	○	Slow pulse, below 65
134	○	○	○	Frequency of urination
135	○	○	○	Impaired hearing
136	○	○	○	Reduced initiative
				GROUP 7C
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance
				GROUP 7D
142	○	○	○	Abnormal thirst
143	○	○	○	Bloating of abdomen
144	○	○	○	Weight gain around hips or waist
145	○	○	○	Sex drive reduced or lacking
146	○	○	○	Tendency to ulcers, colitis
147	○	○	○	Increased sugar tolerance
148	○	○	○	Women: menstrual disorders
149	○	○	○	Young girls: lack of menstrual function
				GROUP 7E
150	○	○	○	Dizziness
151	○	○	○	Headaches
152	○	○	○	Hot flashes
153	○	○	○	Increased blood pressure
154	○	○	○	Hair growth on face or body (female)
155	○	○	○	Sugar in urine (not diabetes)
156	○	○	○	Masculine tendencies (female)
				GROUP 7F
157	○	○	○	Weakness, dizziness
158	○	○	○	Chronic fatigue
159	○	○	○	Low blood pressure
160	○	○	○	Nails weak, ridged
161	○	○	○	Tendency to hives
162	○	○	○	Arthritic tendencies
163	○	○	○	Perspiration increase
164	○	○	○	Bowel disorders
165	○	○	○	Poor circulation
166	○	○	○	Swollen ankles
167	○	○	○	Crave salt
168	○	○	○	Brown spots or bronzing of skin
169	○	○	○	Allergies - tendency to asthma

	1	2	3	
170	○	○	○	Weakness after colds, influenza
171	○	○	○	Exhaustion - muscular and nervous
172	○	○	○	Respiratory disorders
				GROUP 8
173	○	○	○	Muscle weakness
174	○	○	○	Lack of Stamina
175	○	○	○	Drowsiness after eating
176	○	○	○	Muscular soreness
177	○	○	○	Rapid heart beat
178	○	○	○	Hyper-irritable
179	○	○	○	Feeling of a band around your head
180	○	○	○	Melancholia (feeling of sadness)
181	○	○	○	Swelling of ankles
182	○	○	○	Diminished urination
183	○	○	○	Tendency to consume sweets or carbohydrates
184	○	○	○	Muscle spasms
185	○	○	○	Blurred vision
186	○	○	○	Loss of muscular control
187	○	○	○	Numbness
188	○	○	○	Night sweats
189	○	○	○	Rapid digestion
190	○	○	○	Sensitivity to noise
191	○	○	○	Redness of palms of hands and bottom of feet
192	○	○	○	Visible veins on chest and abdomen
193	○	○	○	Hemorrhoids
194	○	○	○	Apprehension (feeling that something bad will happen)
195	○	○	○	Nervousness causing loss of appetite
196	○	○	○	Nervousness with indigestion
197	○	○	○	Gastritis
198	○	○	○	Forgetfulness
199	○	○	○	Thinning hair
				FEMALE ONLY
200	○	○	○	Very easily fatigued
201	○	○	○	Premenstrual tension
202	○	○	○	Painful menses
203	○	○	○	Depressed feelings before menstruation
204	○	○	○	Menstruation excessive and prolonged
205	○	○	○	Painful breasts
206	○	○	○	Menstruate too frequently
207	○	○	○	Vaginal discharge
208			○	Hysterectomy / ovaries removed
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Depression of long standing
				MALE ONLY
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Night urination frequent
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Tire too easily
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

List the five main complaints you have in the order of their importance:

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

WEISS CHIROPRACTIC

DR. KEITH A. WEISS

133 LOUDON RD. CONCORD NH 03301
WWW.WEISSCHIRO.COM 603 224 1846

NUTRITION PATIENT INFORMATION FORM

PATIENT INFORMATION

Last Name _____ First Name _____Middle _____
Gender M F Date of Birth ____ / ____ / ____ Age _____
Home Address _____
City _____State _____ Zip_____
Home Phone #_____ cell phone #_____Email_____
Work Phone #_____ Preferred method of contact_____
Employer Name _____Occupation _____
SPOUSE /PARTNER OR GUARDIAN
Last Name _____ First Name _____
Referred by_____

PURPOSE OF VISIT

What brings you to the office today?_____
_____
_____
_____

What have you done to treat these symptoms?_____
_____
_____

When did the symptoms begin?_____

MY PRIVACY

I have reviewed a copy of the Notice of Privacy Practices. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan and direct my treatment and follow-up among the healthcare providers who may be directly and indirectly involved in providing my treatment; Obtain payment from third party payers; Conduct normal healthcare operations such as quality assessments and accreditation.

X _____ _____
Signature of patient or person acting on patient's behalf Date

I certify that the above information is correct. I understand that I am personally financially responsible for all services provided.

X _____ _____
Signature of patient or responsible party Date

_____
Please print name above

WEISS CHIROPRACTIC

DR. KEITH A. WEISS

133 LOUDON RD. CONCORD NH 03301
WWW.WEISSCHIRO.COM 603 224 1846

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean:
"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) Chemical components of the VSC (Vertebral Subluxation Complex).

I have read and understand the above:

_____ _____

Signature Date

WEISS CHIROPRACTIC

DR. KEITH A. WEIS

133 LOUDON RD. CONCORD NH 0330
WWW.WEISSCHIRO.COM 603 224 184

FAMILY HISTORY

Please tell us about the health of your parents. Circle everything that applies. If someone is deceased, please circle and write in the cause.

Deceased M/F cause:_____

Heart disease M/F Stroke M/F Cancer Diabetes M/F Rheumatoid Arthritis M/F

Multiple Sclerosis M/F Lung Disease M/F Bone Disease M/F

PAST AND SOCIAL HISTORY

Are you employed Y N Where_____

How is your general health?_____

Do you drink alcohol Y N Use tobacco Y N Use recreational drugs Y N

Have you had any illnesses? (This includes, but is not limited to: heart disease, high cholesterol, high blood pressure, diabetes, cancer, etc)

_____

_____

_____

Have you had any injuries? (car accidents, broken bones, etc)

_____

_____

_____

Have you been hospitalized? (Explain)

_____

_____

_____

Have you had any surgeries? (Explain)

_____

_____

_____

List any medications that you are taking and WHY (continue on back if necessary).

_____

_____

_____

_____

_____

I certify that the information that the information that I have given here is true and accurate to the best of my knowledge.

Patient Signature_____Date_____

Print_____