Cascade CHIROPRACTIC HEALTH AND NUTRITION

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Hello, and welcome to the first step towards a healthier you!

In order to best serve you, please fill out all three forms that follow. You will find:

- A Systems Assessment Form
- A Toxicity Questionnaire
- A Food Log

For the Food Log, just put what you ate for a few days, how much is not important.

In addition to these forms, please also bring to your appointment:

- Any recent lab work
- All vitamins and medications you are currently taking

If you have any questions, please give our office a call.

In Health,

Dr. Virginia Irby D.C., ACN

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

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.

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. Dizzy after standing up quickly 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. Masculine tendencies (female) 0 1 2 3

Group 7F

157. Weakness, dizziness 0 1 2 3
158. Chronic fatigue 0 1 2 3
159. Low blood pressure 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

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: _____

SpO_2: _____%

Calcium Cuff Test:

Before: _____ After: _____

The Nutritional Exam:

❑ HCL ❑ Ascending
❑ Enzyme ❑ Transverse
❑ Murphy's Sign ❑ Descending

Notes:

Symptoms listed on this form are not intended to be used as a diagnosis of any disease or condition.

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a detoxification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Stiffness or limited movement	0 1 2 3 4
c. Pain or aches in muscles	0 1 2 3 4
d. Recurrent back aches	0 1 2 3 4
e. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

g. How often do you consume nonorganic foods? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a detoxification program.

Daily Record of Food Intake | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

Standard Process®
WHOLE FOOD NUTRIENT SOLUTIONS

Name:

Day 1—Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK *Time:*	**MIDDAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel movements *(number and consistency):*	**Hours of sleep:**	**Quality of sleep:** *(good)* 1 2 3 4 5 *(poor)*

Day 2—Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK *Time:*	**MIDDAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel movements *(number and consistency):*	**Hours of sleep:**	**Quality of sleep:** *(good)* 1 2 3 4 5 *(poor)*

Day 3—Date:

BREAKFAST *Time:*	**LUNCH** *Time:*	**DINNER** *Time:*
Meat and dairy:		
Vegetables and fruits:		
Breads, cereals, and grains:		
Fats (butter, margarine, oil, etc.):		
Candy, sweets, and junk food:		
Water intake (fl. oz.):		
Other drinks:		
MIDMORNING SNACK *Time:*	**MIDDAY SNACK** *Time:*	**NIGHTTIME SNACK** *Time:*
Snack:		
Bowel movements *(number and consistency):*	**Hours of sleep:**	**Quality of sleep:** *(good)* 1 2 3 4 5 *(poor)*

Notes: