Fitness Genome Tayebjee Chiropractic Neurology Center
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Welcome to Fitness Genome Tayebjee Chiropractic Neurology Center. Carefully complete all of the following health history questionnaires. The accuracy of your answers will help us better diagnose and treat your conditions. Thank you for your patience with what may appear to be some duplication in questions in different areas. Each questionnaire has been carefully designed to identify your specific condition.

Patient Name: ____________________________ Age: _______ DOB: _____/_____/______
Patient Guardian/Representative: ____
Handed:
❑ Right ❑ Left ❑ Ambidextrous
Gender:
❑ Female ❑ Male
SSN: _____/_____/______
Street address: ____ Unit/APT: _______
City: __________________________ State: _____________ ZIP: _____________________
Home Phone: ____________________________ Cell Phone: _________________________
Email address: ____
Occupation: _____________________________ Employer: __________________________
Street address: ____ Unit/APT: _______
City: __________________________ State: _____________ ZIP: _____________________
Work Phone: ____________________________ Work Fax: __________________________
How did you hear about Fitness Genome and/or Dr. Nisreen?_______________________
Emergency Contact Information: Contact Name: _____________________________________
Phone: (_____)___________________ Alternate Phone: (_____)___________________
Relationship to Patient: ____

Primary Physician: Name: ____
Clinic Name: ____
Street Address: ____
City: ________________________ State: _______________ ZIP:______________________

Primary Pharmacy: Name: ____
Street Address: ____
City: ________________________ State: _______________ ZIP:______________________

Primary Chiropractor: Name: ____
Clinic Name: ____
Street Address: ____
City: ________________________ State: _______________ ZIP:______________________
When? _____________________________ How long were you under care?_____________

Have you consulted or do you regularly consult any of the following providers? (Check all that apply.)

❑ Medical Physician	❑Acupuncturist	❑Massage Therapist	❑Energy Healer
❑Naturopath	❑Homeopath	❑Psychotherapist	❑Dentist

Values: Please list your interest in order of importance from 1 to 7 (1=most important, 7=least important)

_____ Family ______ Financial _____ Social _____ Physical
_____ Mental ______ Spiritual _____ Work

Quality of Life Rank: Please rate your current quality of life.

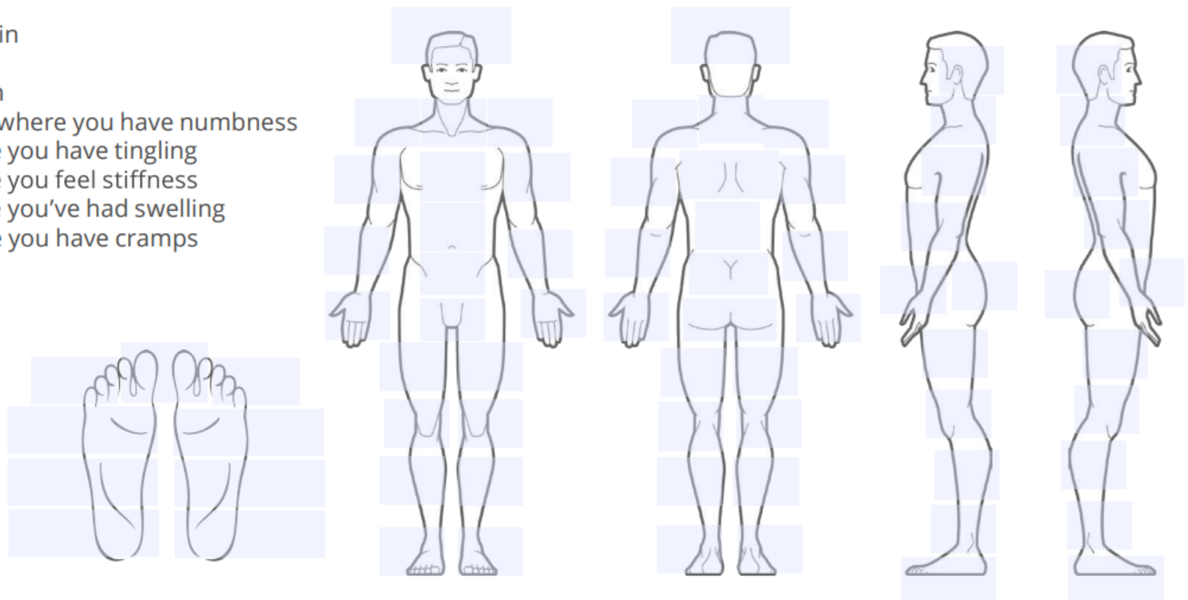
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

What are the 3 greatest concerns about your present state of health?

1. ________________ 2. ________________ 3. ________________

Please label any areas where you are experiencing the following symptoms:

"//"	stabbing pain
"B"	for burning pain
"D"	for dull pain
"A"	for aching pain
"N"	on or in areas where you have numbness
"T"	in areas where you have tingling
"St"	in areas where you feel stiffness
"Sw"	in areas where you've had swelling
"C"	In areas where you have cramps
"W"	for weakness
"Tr"	for tremor



What are activities or responsibilities are being or have been affected by the above issues?

____

What are your goals for care?

1. ________________ 2. ________________ 3. _______________

What would you like to regain in your life by becoming healthier?
____
Have you seen anyone else for this condition? _____ If yes, who? ____________________ Have you lost work days because of this condition? _____ If yes, how many?____________ How long has this problem been present? ____ What do you think is causing/triggering your present condition?
____
Have you had any diagnostic testing for this condition? (Describe test/lab and dates)
____
Indicate any other symptoms you may think may be important: ________________________

Do you now or have you ever suffered from:

- ❏ Dizziness
- ❏ Heart Disease
- ❏ Diabetes
- ❏ Frequent UTIS
- ❏ Asthma
- ❏ High Blood Pressure
- ❏ Neuritis
- ❏ Digestive disorder or troubles
- ❏ Heartburn
- ❏ Headaches
- ❏ Arthritis
- ❏ Sinus pain/Congestion
- ❏ Cancer
- ❏ Anxiety
- ❏ Brain Fog
- ❏ Low Energy
- ❏ Poor circulation
- ❏ Constipation
- ❏ Diarrhea
- ❏ Menstrual Pain or Difficulties
- ❏ Allergies
- ❏ Tire Easily
- ❏ Kidney Stones
- ❏ Cold/Tingling/ Numbness in Hands/Feet
- ❏ Muscle Aches
- ❏ Arthritis
- ❏ Irritability
- ❏ Depression
- ❏ Mood Swings
- ❏ Skin Irritations
- ❏ Frequent Colds
- ❏ PCOS
- ❏ Adrenal Dysfunction
- ❏ Cognitive Changes
- ❏ Concentration difficulty
- ❏ Balance or Coordination Decline
- ❏ Heart Palpitation
- ❏ Arrhythmia
- ❏ Autoimmune Condition
- ❏ Thyroid Dysfunction
- ❏ Hormone Dysfunction
- ❏ Difficulty Sleeping
- ❏ Memory Decline
- ❏ Acne
- ❏ Speech Changes
- ❏ Reflux
- ❏ Frequent Cravings
- ❏ Hyperactivity
- ❏ Restlessness

Do you have a:

- ❏ Pacemaker _____ Explain: ____________
- ❏ Artificial Joint _____ Explain: ____________
- ❏ Artificial Heart Valve ______ Explain: __________
- ❏ Stent _____ Explain: _________

Have you ever been diagnosed with a tumor, cancer or neoplasia? _____ When?__________
Have you ever been diagnosed with diabetes? _____ When? _________________________
Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure? ______

When?____
Have you ever had a stroke? _____ When? ______________________________________
Have you ever had a heart attack? ____ When? ___________________________________
Have you ever had a spinal cord injury? _____ When? ______________________________

Medication List

Medications (Include over-the-counter medications)	Dose (e.g. Strength, # of pills or drops)	Route (e.g. by mouth, inhaled or transdermal)	Frequency (how often)

Supplements/Herbals

Supplement/herbal Name	Dose (e.g. Strength, # of pills or drops)	Route (e.g. by mouth, inhaled or transdermal)	Frequency (how often)

Physical Stressors:

List any accidents, traumas or injuries: (Dates & Description)
____
List all operations/surgeries and/or hospitalizations: (Dates)
____
List all fractures/broken bones or dislocations: (Dates)
____
List any major illness: (Dates):
____
Have you suffered a head injury or concussion? Did you lose consciousness? How long?
____

Chemical Stressors:

Do you currently use any tobacco products? _____ What kind, how often and how long?________________________

Have you used tobacco products in the past?_____ What kind, how long and when did you quit? ___________________________
Do you drink alcoholic beverages? _____ What kind and how many a week?____________
Have you had issues with alcohol in the past? ______ How long ago and for how long?_______
Do you drink caffeinated beverages? ______ What kind and how many/day? ____________
Do you currently use recreational drugs? ______What type, how often, and how long?____________
Have you used recreational drugs in the past? ____ What kind, how long, and for how long?____________
Do you have any special dietary restrictions? ______ What type? ___________________
How much water do you drink/day? (in fluid ounces) ______________________________
Do you have any food, seasonal or environmental allergies: _____________
What kind? ____
How often do they occur?____
Were you vaccinated? ________ If yes, did you have an adverse reaction? _____________
Have you been exposed to any of the following on a regular basis, (past or present)?
Toxic chemicals, Radiation, Second hand smoke, Chemotherapy, Drug therapy ___________
If yes, please list: ____

Emotional Stressors:
It is difficult to separate the emotional stress in our life from the physical response that often occurs. Please indicate if you have experienced any of the emotional stresses below:

Childhood Trauma Y N	Loss of loved one Y N	Abuse Y N
Work or School Y N	Divorce/separation Y N	Financial Y N
Lifestyle change Y. N	Parents divorce Y N	Illness Y N

Have you had any strong emotional stressors either recently, or that has an effect on your daily life? ____
Please list any other emotional stresses you may be experiencing (anxiety, nervousness, depression,
etc.)____

Marital Status:
❏ Single
❏ Married - Spouse’s Name: ____
❏ Widowed
❏ Divorced
❏ Partnered

How many Children do you have?

❑ None ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ Other:____

Occupation: ____________________________ How many hours a week? _______________ Describe your work environment: ____ Describe your home life: ____ What is your highest level of education? ____ What are your hobbies? ____ Do you Exercise? _________ What type and how often? ______________________________ Are you sexually active? _____ Have you ever been diagnosed with an STD or VD? _______

Females ONLY:

❑ Menstruating ❑ Non-menstruating

First day of last menstrual cycle date: __ / __/ __Are you pregnant: Yes ______ No ______

Pregnancy Release: This is to certify that to the best of my knowledge I am not pregnant and the above practice and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child.

Signature: ________________________________ Date: ___________________________

Are there any other concerns or interests you have about your health that you would like us to address? (You may describe any other concerns or questions in this space:

Patient Authorization:

Thank you for taking the time to fill out this health history questionnaire. This information is important to the doctor obtaining an accurate clinical picture. Please sign below authorizing that the information in this form has been read and filled out completely and accurately to the best of your understanding and you agree to allow this office to examine you for further evaluation.

_____________________________________ _________________________

Patient’s (or guardian’s) signature Date

_____________________________________ _________________________

Patient’s (or guardian’s) printed name Date

Privacy Act:

I consent to the use of my protected health information by Dr. Nisreen Tayebjee DC for the purpose of analyzing, assessing and providing treatment recommendations to me, obtaining payment for my health care bills or conduct health care operations. HIPAA Compliance. Furthermore, I understand that the information in this form is considered confidential and for use by your doctor at Fitness Genome Tayebjee Chiropractic Neurology Center.

_____________________________________ _________________________

Patient’s (or guardian’s) signature Date

_____________________________________ _________________________

Patient’s (or guardian’s) printed name Date

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Category I

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools	0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category VI

Difficulty digesting roughage and fiber	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0 1 2 3
Frequent loss of appetite	0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0 1 2 3
Abdominal distention after certain probiotic or natural supplements	0 1 2 3
Decreased gastrointestinal motility, constipation	0 1 2 3
Increased gastrointestinal motility, diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Suspicion of nutritional malabsorption	0 1 2 3
Frequent use of antacid medication	0 1 2 3

Category VIII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	*YES NO*

Category IX

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

Category X

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful between meals	0 1 2 3
Blurred vision	0 1 2 3

Category XI

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3
Increased thirst and appetite	0 1 2 3
Difficulty losing weight	0 1 2 3

Category XII

Symptom	Rating
Cannot stay asleep	0 1 2 3
Crave salt	0 1 2 3
Slow starter in the morning	0 1 2 3
Afternoon fatigue	0 1 2 3
Dizziness when standing up quickly	0 1 2 3
Afternoon headaches	0 1 2 3
Headaches with exertion or stress	0 1 2 3
Weak nails	0 1 2 3

Category XIII

Symptom	Rating
Cannot fall asleep	0 1 2 3
Perspire easily	0 1 2 3
Under a high amount of stress	0 1 2 3
Weight gain when under stress	0 1 2 3
Wake up tired even after 6 or more hours of sleep	0 1 2 3
Excessive perspiration or perspiration with little or no activity	0 1 2 3

Category XIV

Symptom	Rating
Edema and swelling in ankles and wrists	0 1 2 3
Muscle cramping	0 1 2 3
Poor muscle endurance	0 1 2 3
Frequent urination	0 1 2 3
Frequent thirst	0 1 2 3
Crave salt	0 1 2 3
Abnormal sweating from minimal activity	0 1 2 3
Alteration in bowel regularity	0 1 2 3
Inability to hold breath for long periods	0 1 2 3
Shallow, rapid breathing	0 1 2 3

Category XV

Symptom	Rating
Tired/sluggish	0 1 2 3
Feel cold—hands, feet, all over	0 1 2 3
Require excessive amounts of sleep to function properly	0 1 2 3
Increase in weight even with low-calorie diet	0 1 2 3
Gain weight easily	0 1 2 3
Difficult, infrequent bowel movements	0 1 2 3
Depression/lack of motivation	0 1 2 3
Morning headaches that wear off as the day progresses	0 1 2 3
Outer third of eyebrow thins	0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0 1 2 3
Dryness of skin and/or scalp	0 1 2 3
Mental sluggishness	0 1 2 3

Category XVI

Symptom	Rating
Heart palpitations	0 1 2 3
Inward trembling	0 1 2 3
Increased pulse even at rest	0 1 2 3
Nervous and emotional Insomnia	0 1 2 3
Night sweats	0 1 2 3
Difficulty gaining weight	0 1 2 3

Category XVII (Males Only)

Symptom	Rating
Urination difficulty or dribbling	0 1 2 3
Frequent urination	0 1 2 3
Pain inside of legs or heels	0 1 2 3
Feeling of incomplete bowel emptying	0 1 2 3
Leg twitching at night	0 1 2 3

Category XVIII (Males Only)

Symptom	Rating
Decreased libido	0 1 2 3
Decreased number of spontaneous morning erections	0 1 2 3
Decreased fullness of erections	0 1 2 3
Difficulty maintaining morning erections	0 1 2 3
Spells of mental fatigue Inability to concentrate	0 1 2 3
Episodes of depression	0 1 2 3
Muscle soreness	0 1 2 3
Decreased physical stamina	0 1 2 3
Unexplained weight gain	0 1 2 3
Increase in fat distribution around chest and hips	0 1 2 3
Sweating attacks	0 1 2 3
More emotional than in the past	0 1 2 3

Category XIX (Menstruating Females Only)

Symptom	Rating
Perimenopausal	0 1 2 3
Alternating menstrual cycle lengths	0 1 2 3
Extended menstrual cycle (greater than 32 days)	0 1 2 3
Shortened menstrual cycle (less than 24 days)	0 1 2 3
Pain and cramping during periods	0 1 2 3
Scanty blood flow	0 1 2 3
Heavy blood flow	0 1 2 3
Breast pain and swelling during menses	0 1 2 3
Pelvic pain during menses	0 1 2 3
Irritable and depressed during menses	0 1 2 3
Acne	0 1 2 3
Facial hair growth	0 1 2 3
Hair loss/thinning	0 1 2 3

Category XX (Menopausal Females Only)

Symptom	Rating
How many years have you been menopausal?	_____ *Years*
Since menopause, do you ever have uterine bleeding?	*YES NO*
Hot flashes	0 1 2 3
Mental fogginess	0 1 2 3
Disinterest in sex	0 1 2 3
Mood swings	0 1 2 3
Depression	0 1 2 3
Painful intercourse	0 1 2 3
Shrinking breasts	0 1 2 3
Facial hair growth	0 1 2 3
Acne	0 1 2 3
Increased vaginal pain, dryness, or itching	0 1 2 3