Sheehan Chiropractic & Nutritional Wellness
NEW PATIENT INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

_____

Home Phone (___) ___-_____ Work Phone (___) ___-_____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): 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)

Cigarettes _____ Coffee _____ Alcohol _____

What is your stress level on a scale of 1-10? _____

What is the quality of your sleep? ☐Good ☐Fair ☐Poor How many hours? _____

How many bowel movements do you have per day? ____ week?____

How many hours a week do you exercise? ____ What type of exercise? _____

Office Use Only:

Sheehan Chiropractic & Nutritional Wellness
NEW PATIENT INFORMATION FORM

Name: _____ Date_____

HISTORY:

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

_____

List any surgery or operations with approx. date:_____

_____

Past Accidents or injuries: _____

_____

Marital Status: S M D W Name of Spouse _____

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

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	___	M/F	_____
_____	___	M/F	_____
_____	___	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

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

_____

What can we do to make you happier?_____

_____

SIGNED:_____ DATE _____

SYMPTOM SURVEY FORM

Maestro

Patient _____ Doctor _____ Date _____

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

Pulse: Recumbent _____ Standing _____ Vegetarian: Yes ☐ No ☐

Blood pressure: Recumbent ___/___ Standing ___/___ Ragland's Test is Positive ☐

INSTRUCTIONS: Fill in only the circles which apply to you.
● ○ ○ MILD symptoms (occurred once or twice last 6 months).
○ ● ○ MODERATE symptoms (occurred once or twice last month).
○ ○ ● SEVERE symptoms (chronic, occurred once or twice last week).
○ ○ ○ **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	O	O	O	Insomnia
108	O	O	O	Nervousness
109	O	O	O	Can't gain weight
110	O	O	O	Intolerance to heat
111	O	O	O	Highly emotional
112	O	O	O	Flush easily
113	O	O	O	Night sweats
114	O	O	O	Thin, moist skin
115	O	O	O	Inward trembling
116	O	O	O	Heart palpitates
117	O	O	O	Increased appetite without weight gain
118	O	O	O	Pulse fast at rest
119	O	O	O	Eyelids and face twitch
120	O	O	O	Irritable and restless
121	O	O	O	Can't work under pressure
				GROUP 7B
122	O	O	O	Increase in weight
123	O	O	O	Decrease in appetite
124	O	O	O	Fatigue easily
125	O	O	O	Ringing in ears
126	O	O	O	Sleepy during day
127	O	O	O	Sensitive to cold
128	O	O	O	Dry or scaly skin
129	O	O	O	Constipation
130	O	O	O	Mental sluggishness
131	O	O	O	Hair coarse, falls out
132	O	O	O	Headaches upon arising, wear off during day
133	O	O	O	Slow pulse, below 65
134	O	O	O	Frequency of urination
135	O	O	O	Impaired hearing
136	O	O	O	Reduced initiative
				GROUP 7C
137	O	O	O	Failing memory
138	O	O	O	Low blood pressure
139	O	O	O	Increased sex drive
140	O	O	O	Headaches, "splitting or rending" type
141	O	O	O	Decreased sugar tolerance
				GROUP 7D
142	O	O	O	Abnormal thirst
143	O	O	O	Bloating of abdomen
144	O	O	O	Weight gain around hips or waist
145	O	O	O	Sex drive reduced or lacking
146	O	O	O	Tendency to ulcers, colitis
147	O	O	O	Increased sugar tolerance
148	O	O	O	Women: menstrual disorders
149	O	O	O	Young girls: lack of menstrual function
				GROUP 7E
150	O	O	O	Dizziness
151	O	O	O	Headaches
152	O	O	O	Hot flashes
153	O	O	O	Increased blood pressure
154	O	O	O	Hair growth on face or body (female)
155	O	O	O	Sugar in urine (not diabetes)
156	O	O	O	Masculine tendencies (female)
				GROUP 7F
157	O	O	O	Weakness, dizziness
158	O	O	O	Chronic fatigue
159	O	O	O	Low blood pressure
160	O	O	O	Nails weak, ridged
161	O	O	O	Tendency to hives
162	O	O	O	Arthritic tendencies
163	O	O	O	Perspiration increase
164	O	O	O	Bowel disorders
165	O	O	O	Poor circulation
166	O	O	O	Swollen ankles
167	O	O	O	Crave salt
168	O	O	O	Brown spots or bronzing of skin
169	O	O	O	Allergies - tendency to asthma

	1	2	3	
170	O	O	O	Weakness after colds, influenza
171	O	O	O	Exhaustion - muscular and nervous
172	O	O	O	Respiratory disorders
				GROUP 8
173	O	O	O	Apprehension
174	O	O	O	Irritability
175	O	O	O	Morbid fears
176	O	O	O	Never seems to get well
177	O	O	O	Forgetfulness
178	O	O	O	Indigestion
179	O	O	O	Poor appetite
180	O	O	O	Craving for sweets
181	O	O	O	Muscular soreness
182	O	O	O	Depression; feelings of dread
183	O	O	O	Noise sensitivity
184	O	O	O	Acoustic hallucinations
185	O	O	O	Tendency to cry without reason
186	O	O	O	Hair is coarse and/or thinning
187	O	O	O	Weakness
188	O	O	O	Fatigue
189	O	O	O	Skin sensitive to touch
190	O	O	O	Tendency toward hives
191	O	O	O	Nervousness
192	O	O	O	Headache
193	O	O	O	Insomnia
194	O	O	O	Anxiety
195	O	O	O	Anorexia
196	O	O	O	Inability to concentrate; confusion
197	O	O	O	Frequent stuffy nose; sinus infections
198	O	O	O	Allergy to some foods
199	O	O	O	Loose joints
				FEMALE ONLY
200	O	O	O	Very easily fatigued
201	O	O	O	Premenstrual tension
202	O	O	O	Painful menses
203	O	O	O	Depressed feelings before menstruation
204	O	O	O	Menstruation excessive and prolonged
205	O	O	O	Painful breasts
206	O	O	O	Menstruate too frequently
207	O	O	O	Vaginal discharge
208			O	Hysterectomy / ovaries removed
209	O	O	O	Menopausal hot flashes
210	O	O	O	Menses scanty or missed
211	O	O	O	Acne, worse at menses
212	O	O	O	Depression of long standing
				MALE ONLY
213	O	O	O	Prostate trouble
214	O	O	O	Urination difficult or dribbling
215	O	O	O	Night urination frequent
216	O	O	O	Depression
217	O	O	O	Pain on inside of legs or heels
218	O	O	O	Feeling of incomplete bowel evacuation
219	O	O	O	Lack of energy
220	O	O	O	Migrating aches and pains
221	O	O	O	Tire too easily
222	O	O	O	Avoids activity
223	O	O	O	Leg nervousness at night
224	O	O	O	Diminished sex drive

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

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

THE FOUR-PART MOOD-TYPE QUESTIONNAIRE

Circle the number next to each symptom that you identify with. Total your score in each section and compare it to the cut-off score. If your score is over the cut-off, or if you have only a few of the symptoms described in a section but they bother you (or those close to you) on a regular basis, turn to the chapter indicated.

Type 1. Under a Dark Cloud: Low in Antidepressant Serotonin

3 Do you have a tendency to be negative, to see the glass as half-empty rather than half-full? Do you have dark, pessimistic thoughts?
3 Are you often worried and anxious?
3 Do you have feelings of low self-esteem and lack confidence? Do you easily get to feeling self-critical and guilty?
3 Do you have obsessive, repetitive, angry, or useless thoughts that you just can't turn off—for instance, when you're trying to get to sleep?
3 Does your behavior often get a bit, or a lot, obsessive? Is it hard for you to make transitions, to be flexible? Are you a perfectionist, a neatnik, or a control freak? A computer, TV, or work addict?
3 Do you really dislike the dark weather or have a clear-cut fall/winter depression (SAD)?
2 Are you apt to be irritable, impatient, edgy, or angry?
3 Do you tend to be shy or fearful? Do you get nervous or panicky about heights, flying, enclosed spaces, public performance, spiders, snakes, bridges, crowds, leaving the house, or anything else?
2 Have you had anxiety attacks or panic attacks (your heart races, it's hard to breathe)?
2 Do you get PMS or menopausal moodiness (tears, anger, depression)?
3 Do you hate hot weather?

continued

2 Are you a night owl, or do you often find it hard to get to sleep even through you want to?
2 Do you wake up in the night, have restless or light sleep, or wake up too early in the morning?
3 Do you routinely like to have sweet or starchy snacks, wine, or marijuana in the afternoons, evenings, or in the middle of the night (but not earlier in the day)?
2 Do you find relief from any of the above symptoms through exercise?
3 Have you had fibromyalgia (unexplained muscle pain) or TMJ (pain, tension, and grinding associated with your jaw)?
4 Have you benefitted from serotonin-targeted antidepressant drugs?

Total _____ *If your score is more than 12 in part 1, turn to chapter 3, page 25.*

Type 2. Suffering from the Blahs: Low in Stimulating Catecholemines or Thyroid or Low in Natural Stimulants Like Noradrenalin or Thyroid

3 Do you often feel depressed—the flat, bored, apathetic kind?
2 Are you low on physical or mental energy? Do you feel tired a lot, have to push yourself to exercise?
2 Is your drive, enthusiasm, and motivation quota on the low side?
3 Do you have difficulty focusing or concentrating?
3 Do you need a lot of sleep? Are you slow to wake up in the morning?
3 Are you easily chilled? Do you have cold hands or feet?
2 Do you tend to put on weight too easily?
3 Do you feel the need to get more alert and motivated by consuming a lot of caffiene or other "uppers" like chocolate, diet pills, or cocaine?

Total _____ *If your score is more than 6 in part 2, turn to chapter 4, page 53.*

continued

Type 3. Overwhelmed by Stress: Low in Tranquilizing GABA

3 Do you often feel overworked, pressured, or deadlined?
1 Do you have trouble relaxing or loosening up?
1 Does your body tend to be stiff, uptight, tense?
2 Are you easily upset, frustrated, or snappy under stress?
3 Do you often feel overwhelmed or as though you just can't get it all done?
2 Do you feel weak or shaky at times?
3 Are you sensitive to bright light, noise, or chemical fumes? Do you need to wear dark glasses a lot?
3 Do you feel significantly worse if you skip meals or go too long without eating?
2 Do you use tobacco, alcohol, food, or drugs to relax and calm down?

Total _____ *If your score is more than 8 in part 3, turn to chapter 5, page 77.*

Type 4. Too Sensitive to Life's Pain: Low in Pain-Killing Endorphins

3 Do you consider yourself or do others consider you to be very sensitive? Does emotional pain or perhaps physical pain really get to you?
2 Do you tear up or cry easily—for instance, even during TV commercials?
2 Do you tend to avoid dealing with painful issues?
3 Do you find it hard to get over losses or get through grieving?
2 Have you been through a great deal of physical or emotional pain?
3 Do you crave pleasure, comfort, reward, enjoyment, or numbing from treats like chocolate, bread, wine, romance novels, marijuana, tobacco, or lattes?

Total _____ *If your score is more than 6 in part 4, turn to chapter 6, page 100.*

True-Life Stories of the Four False Mood Types

Cara had a typical case of the "dark clouds." She'd been shy and low in confidence all her life. She was a doer, though, obsessively so. Her underwear drawer was a work of art, and her boss adored her perfect projects and reports (not that she was ever satisfied herself). She worried a lot and woke up in the night feeling panicky at times. She had recently started to feel really depressed and had tried an antidepressant but hadn't liked its effects. She'd tried therapy, too, but hadn't had much to talk about—she'd come from a close, warm family, and her adult life had gone fairly well. She was out of luck till she came to our clinic and completed her mood profile, which showed that she had almost every symptom in part 1! She went home with some targeted brain repair supplements and the next day called to report the best night's sleep and the best morning mood she'd had in years.

Emma was too lethargic to clean up her underwear drawer. She had "the blahs," the kind of low-energy depression that too often made her unmotivated, unexcited, and unfocused. She was sick of being an emotional flatliner, but she had no idea what was wrong or what to do about it. We did, though. We could see that she needed our most brain-stimulating nutrient supplements. Fifteen minutes after she took them, we could see that she was feeling more like the person she was meant to be: humorous, sharp, and more alert. This became a permanent state of being for her after a few months of nutritional brain repair work and a revitalization of her thyroid function.

Rob had plenty of drive and energy, but he was a real "stress" type. Years of sixty-to-eighty-hour workweeks, too much coffee and fast food, and too many skipped meals, plus a drawn-out child custody battle, had turned him into a tense, wired, and tired mess. He was clearly sinking into adrenal burnout. On his new antistress supplements and regular meals, he was able to cut out his coffee without a backward glance, cut back his work hours, and begin to feel like a new man.

Sam was "too sensitive." He teared up whenever he talked about anything painful. He avoided hashing out problems with his wife because it was just too uncomfortable for him. Instead, he tuned out with a beer or a bowl of ice cream in front of the TV. Things started to change when we recommended some supplements that allowed him to tolerate pain more easily and enjoy life a lot more (without either the beer or the ice cream). Then, when he was no longer overly sensitive, we recommended couples therapy, which he was then able to tolerate and even enjoy.

1. Name
2. Date
3. Health Concern/Previous Diagnosis/Previous Surgery

4. Effect on Life/Work/Family

5. What have you tried in the past that has failed/Previous treatments/drugs?

6. When was the last time you didn't have this symptom/when was the last time you felt healthy?

7. What's your life going to look like if you don't handle this now (What tends to happen to people as they age)?

8. On a scale of 1-10, how important is it to you to change this health problem now?

If you are willing to make some changes, there is hope, and we can help.

Sheehan Chiropractic & Nutritional Wellness Center

1301 East King Street, Lancaster PA 17602
Phone: 717-392-6606 Fax: 509-6606

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Sheehan Chiropractic to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State ____ Zip _____

Phone: (____) _____ - _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____