



AFFORDABLE CHIROPRACTIC CLINIC

420 East Armour Road
North Kansas City, Missouri 64116
816-889-9800

NAME: _____

DATE: _____

ACCOUNT #: _____

SYMPTOM SURVEY

Chiro + Plus Nutritional Symptom Questionnaire

Please check any of the following conditions that you have (or have had):

- | | | |
|--|---|---|
| <input type="checkbox"/> Dry Eyes | <input type="checkbox"/> Urination Problems | <input type="checkbox"/> Hand/Foot Numbness |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Slow Wound Healing | <input type="checkbox"/> Acne |
| <input type="checkbox"/> Sterility | <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Red, Swollen Tongue | <input type="checkbox"/> Depression | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Dry, Rough Skin | <input type="checkbox"/> Irritability | <input type="checkbox"/> Bleeding Gums |
| <input type="checkbox"/> Dry, Scaly Skin | | <input type="checkbox"/> Frequent Colds |
| <input type="checkbox"/> Yellow Skin | <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Gall Stones |
| <input type="checkbox"/> Weight Gain | <input type="checkbox"/> Loss of Skin Color | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Spoon-Shaped Nails |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> White Spots on Nails |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Brittle Nails |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Graying Hair | <input type="checkbox"/> Soft Nails |
| <input type="checkbox"/> Excessive Gas | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Noise Sensitivity |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Poor Coordination | <input type="checkbox"/> Loss of Hearing |
| <input type="checkbox"/> Swelling | <input type="checkbox"/> Poor Circulation | <input type="checkbox"/> Loss of Taste |
| <input type="checkbox"/> Premenstrual Blues | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Excessive Thirst |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Muscle Tension | <input type="checkbox"/> Burning Pain |
| | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fragile Bones |

Please check any of the following conditions that you have (or have had):

- | | | |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Others: _____ |
| <input type="checkbox"/> High Blood Sugar | <input type="checkbox"/> Low Blood Pressure | _____ |

Please indicate your intake of the following:

- | | |
|------------------------|-------------------------|
| Alcohol _____ Per Week | Coffee _____ Per Week |
| Water _____ Per Day | Soda Pop _____ Per Week |

Nutritional Supplements (Types and Dosages):

Medications (Types and Dosages): (include oral contraceptives and non-prescription meds)

Doctor's Notes for Additional Screening:

- Citric Acid Cycle Urea Cycle Candida Fungus Parasite Aspirin Other: _____
- _____
- _____