Dr. Duncan McCollum, D.C
Phone: 831-459-9990 Email:info@mccollumfamilychiropractic.com
3555 Clares St. Ste. WW Capitola, CA 95010

| Name: | | Date: | |
|---|---|---|---|
| Address: | | Unit: | |
| City: | | State: | | Zip: | |
| PHONE | Home: | | Mobile: | | Work: | |
| Email Address: | | | |

| Date of Birth: | | Gender: ☐ Male ☐ Female |
|---|---|---|

| Age: | | Height: | | Weight: | |
|---|---|---|---|---|---|

*Status:*
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Widowed
- ☐ Single
- ☐ Partnership

*Live with:*
- ☐ Spouse
- ☐ Partner
- ☐ Parents
- ☐ Children
- ☐ Friends
- ☐ Alone

Education: ____________________

Occupation: ____________________ Hours per week: ________ ☐ Retired

| Employer | Work Address |
|---|---|
| | |

In case of emergency, whom should we contact?

| Name | Relationship | Address | Phone |
|---|---|---|---|
| | | | |

How did you hear about our Chiropractic Wellness Center and Nutrition Program?

______________________________________________
______________________________________________
______________________________________________

What is your major complaint? Please list when each symptom began and be as descriptive as possible:

______________________________________________
______________________________________________
______________________________________________
______________________________________________

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What are your current medications?

What are your current vitamins and/or supplements?

Please list your current and past health conditions (i.e. Diabetes Mellitus, etc.):

Is there anything else in your medical history that you consider to be relevant? (Even from childhood)

What is your employment history? Please provide brief summary including dates if possible.

Please list your past or present Hobbies that could be sources of toxicity or chemicals:

How often are you involved in these Hobbies currently?

Please list past or present allergies, including allergies to medications.

Please list all past surgeries and the condition each surgery was for, including dates.

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please explain your housing history (type of homes, where and when).

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

## Patient History

Answer the following questions to the best of your ability. If you don't know the answer, simply leave it blank.

**Mercury**

☐ Yes ☐ No Do you have amalgam (silver) fillings in your teeth? If so, How many? ________
☐ Yes ☐ No Have you ever had an amalgam removed? If Yes, How many______ Date? _________
☐ Yes ☐ No If you had amalgams removed, was it done by a biological dentist using a safe protocol?
☐ Yes ☐ No Did your mother have amalgam when pregnant with you?
☐ Yes ☐ No Have you ever worked in a dental office? If so, how long? _____________
☐ Yes ☐ No Have you had any dental crowns? If yes, how many_____
☐ Yes ☐ No Have you had any bridges?
☐ Yes ☐ No Have you had any root canals?
☐ Yes ☐ No Have you had any tooth extractions?
☐ Yes ☐ No Do you have any dental implants, retainers or other metal in your mouth? Explain:________
☐ Yes ☐ No Did you wear contact lenses during the 1980's or early 1990's?
☐ Yes ☐ No Did you take oral contraceptives during the 1980's or early 1990's?
☐ Yes ☐ No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
☐ Yes ☐ No Have you noticed any adverse reactions to these shots?
☐ Yes ☐ No Do you have any tattoos with red ink?
☐ Yes ☐ No Do you eat large amounts (more than twice a week) of tuna, shark, swordfish or Atlantic Salmon?

**Lead**

☐ Yes ☐ No Does your occupation involve soldering or metal salvage?
☐ Yes ☐ No Have you done any old home repair or sandblasting? If so, When________
☐ Yes ☐ No Do you do a lot of painting?
☐ Yes ☐ No Was your home built before 1978?
☐ Yes ☐ No Have you ever worn cosmetics containing kohl? (make-up with dark black or deep red pigment)
☐ Yes ☐ No Are you around a lot of fake leather, or vinyl?
☐ Yes ☐ No Do you get stomach aches in the morning?

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## General Toxicity

☐ Yes ☐ No Have you ever lived near, on or by a golf course, freeway or tension wires? If yes, please explain.
☐ Yes ☐ No Have you ever had any chemical exposures? (i.e. cleaning chemical spills, working in a beauty salon, etc.)
☐ Yes ☐ No Do you have your house sprayed with pesticides for pest control?
☐ Yes ☐ No Do you spray herbicide (weed killers) in or around your home?
☐ Yes ☐ No Do you use conventional insect repellants on yourself or family?
☐ Yes ☐ No Do you use conventional sunscreen?
☐ Yes ☐ No Do you use conventional perfume or cologne every day?
☐ Yes ☐ No Do you get your hair colored? If so, is it on the scalp?
☐ Yes ☐ No Do you use aerosol hairspray?
☐ Yes ☐ No Do you get your nails done? If so, how often? ______________
☐ Yes ☐ No Do you use air freshener in your house, work or car?
☐ Yes ☐ No Do you drink filtered water? If so, what type of filter do you have?__________
☐ Yes ☐ No Do you drink bottle water if so what kind?
☐ Yes ☐ No Do you have a water filtration system for your entire house or shower filtration? If so, what type?_________
☐ Yes ☐ No Does your spouse or other family members work around chemicals?
☐ Yes ☐ No Can you think of any other toxic exposures you may have had?

## Mold

How old is the house you are living in? _____________ How long have you lived there? _____________

Have you noticed any new symptoms since moving in?_________ If so, what?______________________________

☐ Yes ☐ No Do you see mold growing at home, work or school?
☐ Yes ☐ No Have you ever had water damage at home, work or school?
☐ Yes ☐ No Does your home, workplace or school have a damp or mildew smell?
☐ Yes ☐ No Does spending time in your basement cause or worsen your symptoms?
☐ Yes ☐ No Does your basement ever get wet?
☐ Yes ☐ No Do you have a crawl space?
☐ Yes ☐ No Does your basement or crawl space have a sump pump?
☐ Yes ☐ No Does spending time in a different location for at least a few days cause a noticeable decrease in your symptoms?
☐ Yes ☐ No Does your car have a mildew smell?
☐ Yes ☐ No Does anyone in your home have asthma like symptoms?
☐ Yes ☐ No Does anyone in your family have chronic sinus infections or irritations?

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## Lyme Disease

☐ Yes ☐ No Have you ever been diagnosed with Lyme Disease?
☐ Yes ☐ No Have you had dry sockets or infected tooth extractions?
☐ Yes ☐ No Do you have small joint pain?
☐ Yes ☐ No Have you ever been bitten by a tick or recluse spider?
☐ Yes ☐ No Have you ever seen a bulls-eye rash appear on any part of your body?
☐ Yes ☐ No Did the bulls-eye rash appear shortly after following a tick, spider bite or time spent outdoors?
☐ Yes ☐ No Was your mother ever diagnosed with Lyme Disease?
☐ Yes ☐ No Have you ever been diagnosed with Chronic Fatigues Syndrome, Fibromyalgia, Lupus, Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), or an Autoimmune condition?
☐ Yes ☐ No Do you frequently go camping, hunting or are you involved in outdoor activities (specifically in wooded or grassy areas)?

## Health History

☐ Yes ☐ No Have any members of your family been diagnosed with fibromyalgia, chronic fatigue or multiple chemical sensitivities?
☐ Yes ☐ No Does anyone in your family experience similar symptoms to yours?
What is your birth order (i.e. first born, second, third, etc.)? ___________.
☐ Yes ☐ No Do you have any history of kidney dysfunction?
☐ Yes ☐ No Do you or any immediate family member have a history with cancer?
☐ Yes ☐ No Do you have any history of heart disease, myocardial infarction (heart attack), etc.?
☐ Yes ☐ No Are you currently having any thoughts of suicide?
☐ Yes ☐ No Have you ever been diagnosed with bipolar disorder, schizophrenia or depression?
☐ Yes ☐ No Do you have a history of strokes?
☐ Yes ☐ No Have you ever been diagnosed with diabetes, thyroiditis, or heart disease?
☐ Yes ☐ No Have you ever been in an auto accident, fallen or received a major physical injury?
☐ Yes ☐ No Are you in menopause?

## Microbiome Health

☐ Yes ☐ No Do you get distention, bloating, feeling full and a noisy gut after eating healthy carbohydrates such as broccoli, Brussels sprouts or other vegetables?

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☐ Yes ☐ No Do you often have gas that has a sulfur or foul smell?
☐ Yes ☐ No Are you sensitive to supplements?
☐ Yes ☐ No Have you ever been vegan or vegetarian for any length of time?
☐ Yes ☐ No Can you tolerate Meat?
☐ Yes ☐ No Do you have a history of using anti-acids, proton pump inhibitors or anything else that blocks acid?
☐ Yes ☐ No Have you taken birth control or Hormone replacement therapy for any length of time?
☐ Yes ☐ No If/When you consume alcohol, do you get brain fog or a toxic feeling even after 1 serving?
☐ Yes ☐ No Have been on antibiotics for any extended period of time or often as a child or adult?
☐ Yes ☐ No Were you caesarian delivered?
☐ Yes ☐ No Were you breast fed? If so, How long _______________
☐ Yes ☐ No Does your gut temporarily feel better after a round of antibiotics?

How many times a day are you having a bowel movement? ____________________

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Rate each of the following symptoms to the best of your ability based upon your typical health profile over the last year. If you cannot answer a question, simply leave it blank.

| Point Scale | | |
|---|---|---|
| 0 = Never had the symptom | 2 = Occasionally have it, severe effect | 4 = Frequently have it, severe effect |
| 1 = Occasionally have it, mild effect | 3 = Frequently have it, mild effect | |

### Column #1

| | |
|---|---|
| | Anxiety |
| | Mood swings |
| | Enraged behavior or anger for no reason |
| | Excessive shyness, timidity, social phobia (not typical to your personality) |
| | Irritability (not typical to your personality) |
| | Low body temperature (below 97.5º) |
| | Insomnia (can't get to sleep or return to sleep |
| | Dizziness |
| | Sound in ears (ringing or hearing your heart beat) |
| | Psychological symptoms, even thoughts of suicide |
| | Sensitivity to sound |

| | |
|---|---|
| | Indecisiveness |
| | Feeling of being overwhelmed or fearful |
| | Metallic taste in your mouth |
| | Bad breath |
| | Bleeding gums |
| | Sensitive teeth |
| | Canker sores or other sores in the mouth |
| | Floaters, shadows or swimmers when you read or look into the sky |
| | Dyslexia or loss of place while reading, even as a child |
| | Swelling eyelids |
| | Peeling on top layer of skin (hands, feet) |
| | Dry skin |
| | Heart pain (angina) and you are under 45 years old |
| | Depression |
| | Gout (arthritic pain, especially in big toes) |
| | Pain in shoulders or upper back |
| | Twitching eyelids |
| | Anemia (low iron/hemoglobin on blood test) |
| | Wrist/ankle drop or weak extensor muscles |
| | Hair falls out (not normal male pattern baldness) |

### Column #2

| | |
|---|---|
| | Sensitivity to light |
| | Fatigue after exercising (feeling worse) |
| | Bad night vision or seeing halos around lights |
| | Shortness of breath, with very little effort |
| | Excessive thirst and/or frequent urination |
| | Red eyes or tearing |
| | Blurred vision at times |
| | Morning stiffness |
| | Sensitivity to smells, including chemicals such as petrochemicals, perfumes, air fresheners |
| | Chronic fatigue or weakness |
| | Non-restful sleep |

| | |
|---|---|
| | Receive static shock more often and w/more dramatic effect than normal (doorknobs, car, light switch, people, etc.) |
| | Trouble processing new information |
| | Word reversal or trouble finding words |
| | Sensitivity to touch |
| | Short-term memory loss |
| | Chronic sinus congestion |
| | Dry non-productive cough |
| | Muscle twitching |
| | Excessive sweating, especially at night |
| | Joint pain-not necessarily true arthritis-can move from joint to joint |
| | Difficulty losing weight regardless of diet or exercise |
| | Persistent fungal or viral infection, including athletes foot, warts, jock itch, candidiasis |
| | Frequent illness, prolonged illness or sick days |
| | Numbness or weakness in arms and legs |
| | Headaches |
| | Trouble adding or dividing numbers in your head |
| | Fluctuating constipation and diarrhea |
| | Stomach pain for no apparent reason |
| | Appetite swings |
| | Frequent muscle aches, cramps, unusual sharp sudden pains |
| | Rashes or rosacea |
| | Cold extremities (hands and feet) |

| | |
|---|---|
| | **Total Columns 1 & 2** |

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Name: ______________________________ Date: ________________

Please list what you have eaten the last three days. If you cannot remember specifics, please list what three typical days of eating are.

| DAY ONE | DAY TWO | DAY THREE |
| --- | --- | --- |
| Breakfast: | Breakfast: | Breakfast: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| Snack: | Snack: | Snack: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| Lunch: | Lunch: | Lunch: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| Snack: | Snack: | Snack: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| Dinner: | Dinner: | Dinner: |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |
| ______________________ | ______________________ | ______________________ |

Please list how many days per week you are eating out (1-7) beside each meal time, give examples of your most frequented spots.

Breakfast: ______ Days per week.

Where:

___________________________________________________________________________

___________________________________________________________________________

______________________________________________________

Lunch: _______ Days per week.

Where:

___________________________________________________________________________

___________________________________________________________________________

______________________________________________________

Dinner: _______ Days per week.

Where:

___________________________________________________________________________

___________________________________________________________________________

______________________________________________________

What time do you wake up in the morning?

_________________________________________________________

What time do you leave your house for work/school/errands?

_________________________________________________________

What is your favorite food?

_________________________________________________________

What is your favorite restaurant?

_________________________________________________________

Do you wake up hungry?

_________________________________________________________

We are about life and health transformation in this office. If we find that you are a good fit for our protocols, we want to be of help you to the best of our ability. Please answer the following questions thoughtfully and honestly.

## LIFE GOALS

What are your top life goals that you want to achieve in the next 5-10 years?

"Think big, dream big, believe big, and the results will be big!"

- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖
- ❖

## YOUR WHY

Why is it so important for you to be health right now?

- o I want to improve my performance at work
- o I want to improve the quality of my relationships
- o I would love to enjoy life more
- o I would love to have the energy to do the things that bring me joy
- o I want to be my best years from now
- o I want to feel better about myself
- o I want to prevent disease
- o I want to be here to see grandkids
- o I want to start a family
- o I want to enjoy my retirement
- o I want to stop being so impatient with my family
- o Other (please describe):
  ___________________________________________
  ___________________________________________
  ___________________________________________
  ___________________________________________
  ___________________________________________
  ___________________________________________
  ___________________________________________

## PAST HEALTH PROGRAMS

(include medical protocols, weight loss, chiropractic, gym, boot camps, etc)

When you have done other health programs before what obstacles did you find that were hard to overcome? What held you back from succeeding at these programs/protocols?

- o Not enough time
- o Too expensive
- o Lacked motivation
- o Couldn't stop cravings
- o Lacked focus
- o Didn't have a support system
- o It got boring
- o My insurance didn't cover it
- o Fear of discomfort
- o Lacked discipline
- o Other: ______________________________________

## COACHING PREFERENCES

When being coached, how do you like to be best supported?

- Give me a step-by-step process
- Show me the big picture, then break it down step-by-step
- Give me examples – I get motivated by other people's success
- Show me, don't tell me
- Give me lots of details
- Too much detail is overwhelming – just give me the basics
- I need a lot of support
- I need a lot of structure
- Other:______________________________________________________________________________
  ______________________________________________________________________________
  ______________________________________________________________________________

## FUTURE HEALTH GOALS

On a scale of 1 to 10 (1=low, 10=high), how healthy do you feel right now? ______________________________

My greatest health challenge right now is: __________________________________________________

How would life be different if you didn't have this health challenge? __________________________________

On a scale of 1 to 10 (1=low, 10=high), how committed are you to doing EVERYTHING possible to overcome this health challenge? ______________________

What obstacles do you see, right now, holding you back from getting healthy?
______________________________________________________________________________
______________________________________________________________________________

## Please check the statement that best applies to you.

| Support System | Nutrition/Diet | Supplements |
|---|---|---|
| o I have a great support system at home and around me<br>o I don't have/need a great support system at home around me<br>o I don't have a great support system so I need you to be mine | o I'm willing to make any and all food changes necessary<br>o I am willing to make some changes to my food and diet<br>o I don't want to make any food or diet changes | o I'll take any and all supplements needed<br>o I'll take a few supplements, but I don't want to add much<br>o I don't want to take supplements |
| **Budget** | **Detox** | **Time** |
| o I am on a really tight budget<br>o I have flexibility with my budget<br>o My budget is not a concern, this is a top priority for me | o I'm willing to do whatever detox is necessary<br>o I would like to detox, but do not want to do a DEEP detox<br>o I am not interested in doing a detox | o I have a busy schedule and not much extra time<br>o I have a busy schedule, but have some extra time for this<br>o Time is not a concern for me, I just want to be well |

# 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, or Herb 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.

I have read and understand the above information:

Signature ______________________________________ ________________ Date