



The doctor of the future will give no medicine, but will interest her or his patients in the care of the human frame, in a proper diet, and in the cause and prevention of disease.

Thomas Edison

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Natural Health Solutions is located in Apple Valley, MN. Dr. Brandon Mannie is a doctor of chiropractic with over 400 hours of post graduate training in clinical nutrition and functional medicine. The clinic focuses on both chiropractic care and integrative holistic care employing natural methods of treatment. We find the answers to your medial mysteries when other forms of treatment fail. Utilizing cutting edge laboratory testing for food allergies, heavy metal toxicity, hormones etc. along with a thorough physical examination, we seek for the underlying cause of your health problems. Most doctors only spend a few minutes with patients and write a prescription medication which often only masks the symptoms of disease.

Dr. Mannie is a functional medicine physician who spends quality time with each patient. No one is rushed or herded through the office like cattle because giving quality health care takes time. At Natural Health Solutions, you will be able to address all of your health concerns naturally. Dr. Mannie specializes in finding answers to complex health issues. Many patients come to Natural Health Solutions after being passed from doctor to doctor receiving little to no help. Please help us better take care of your needs by filling out the attached comprehensive health questionnaire.

Welcome to Natural Health Solutions! This is your new patient information packet. Please take the time to read, fill out, and sign the appropriate sections. Please plan to arrive **15 minutes** prior to your scheduled appointment time as this allows us to better take care of your needs. If you wish to cancel or reschedule your appointment please contact our office **24 hours or more in advance**. There is a **\$75 administrative fee for missed appointments or for appointments not cancelled 24 hours in advance**. It is our goal to provide each of our patients the best care possible. If you feel you have been treated otherwise please let us know.

Patients Signature: _____ **Date:** _____

Name: _____

Date of Birth: _____ Age: _____ Height: _____ Weight _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact: Name _____ Telephone: _____

Occupation: _____

Which one of our patients recommended you to our office? _____

List the main problem(s) you are having or the purpose for your consultation:

- | | | | |
|--|--|--|---------------------------------------|
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Headaches | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Thyroid disorder | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hand/wrist pain | <input type="checkbox"/> Hip pain | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Acid reflux |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Foot/ankle pain | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Other |

Please elaborate on your condition below:

How long ago did your symptoms begin? _____

What types of treatments have you received for your condition? _____

Have any of these treatments been helpful and if so which ones? _____

What makes your symptoms worse (i.e. certain movements, weather changes,etc)? _____

Please describe your pain symptoms:

Achy Sharp Dull Burning Tight Numb Stiff
Throbbing Shooting Stinging Stabbing Other

How often do your symptoms occur?

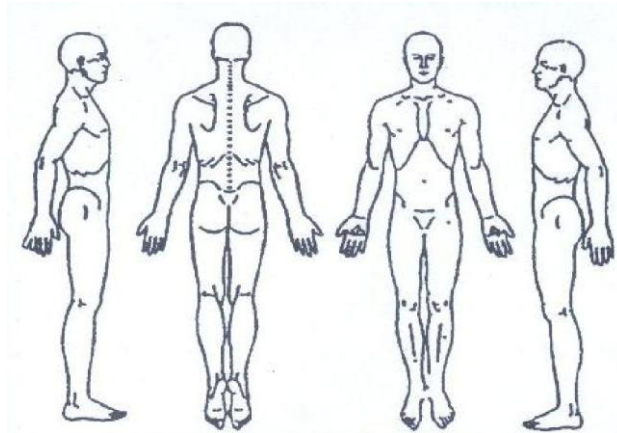
Constant (all the time) Frequent Intermittent

Is it worse in the: A.M. P.M. After activity With movement

Other

Please describe:

Please use the diagram below to demonstrate the location of your pain:



Rate the severity of your pain: No pain 0-1-2-3-4-5-6-7-8-9-10 Severe Pain

Rate your overall health: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

Rate your energy levels: Poor 0-1-2-3-4-5-6-7-8-9-10 Excellent

If you could make only one improvement in your health, what would it be?



Symptom Questionnaire: The following questions have been developed to help evaluate your health needs. This process is only as accurate as the information that you provide. If you feel that the topics below do not allow you to verbally express your problem(s), please elaborate during our personal consultation. I would like to remind you that all of this information is strictly confidential unless you state otherwise. If Yes or No does not apply to you then elaborate in the margin.

1. Were you breastfed as a baby? If yes how long? _____	Yes	No
2. Were you delivered via cesarean section?	Yes	No
3. Have you been through any stressful situations recently?	Yes	No
4. Do you consider yourself to be a person who is easily stressed out?	Yes	No
5. Do you need glasses to read?	Yes	No
6. Do you need glasses to see things at a distance?	Yes	No
7. Do you ever have pain or pressure in your eyes?	Yes	No
8. Are your eyes often red or inflamed?	Yes	No
9. Do your eyes or face often appear puffy?	Yes	No
10. Do your eyelids constantly twitch?	Yes	No
11. Are your eyes often dry and itchy?	Yes	No
12. Do you often have dark circles under your eyes?	Yes	No
13. Do you have to wear sunglasses when outside?	Yes	No
14. Do you find it difficult to drive at night?	Yes	No
15. Do you have trouble seeing clearly in dark lighting?	Yes	No
16. Are your mouth, eyes, or throat chronically dry?	Yes	No
17. Do you frequently have a sour or metallic taste in your mouth?	Yes	No
18. Do you have to wear lip balm regularly to keep your lips from chapping?	Yes	No
19. Do your lips crack and bleed on a regular basis?	Yes	No
20. Do fever blisters or canker sores often bother you?	Yes	No
21. Are you troubled by bleeding gums?	Yes	No
22. Have you lost any of your adult teeth?	Yes	No
23. Do you have a history of dental caries (cavities)?	Yes	No
24. Have you often had severe toothaches?	Yes	No
25. Do you have any dental implants?	Yes	No
26. Do you have any metal fillings?	Yes	No
27. Is your tongue usually badly coated?	Yes	No
28. Do you have chronic halitosis (bad breath)?	Yes	No
29. Have you ever had fluids leaking from your ear?	Yes	No
30. Do you wear a hearing aid?	Yes	No
31. Do you have constant ringing or noises in your ear?	Yes	No
32. Do you get dizzy on a regular basis?	Yes	No
33. Do you have to clear your throat constantly?	Yes	No
34. Have you had your tonsils removed?	Yes	No
35. Are you often troubled with spells of sneezing or allergies?	Yes	No
36. Is your nose continually stuffed up?	Yes	No
37. Are you sensitive to fumes, smoke, perfumes, or other chemical odors?	Yes	No
38. Do you often find it difficult to breathe out of your nose?	Yes	No
39. Do you suffer from a constantly running nose?	Yes	No

40. Have you at times had bad nosebleeds?	Yes	No
41. Do you ever have spontaneous nosebleeds?	Yes	No
42. Have you noticed any changes in your ability to taste or smell recently?	Yes	No
43. Do you suffer from asthma or any other chronic lung disease?	Yes	No
44. Are you troubled by constant coughing?	Yes	No
45. Do you get sick more than twice per year?	Yes	No
46. Have you taken antibiotics recently?	Yes	No
47. Have you ever had to take antibiotics more than once for a chronic ailment?	Yes	No
48. Do you suffer from frequent or severe headaches?	Yes	No
49. Do you often have sinus congestion?	Yes	No
50. Is your appetite always poor?	Yes	No
51. Do you usually eat sweets or other foods between meals?	Yes	No
52. Do you always gulp your food hurriedly?	Yes	No
53. Do you often suffer from an upset stomach?	Yes	No
54. Do you usually feel bloated after eating?	Yes	No
55. Do you usually belch a lot after eating?	Yes	No
56. Are you often sick to your stomach?	Yes	No
57. Do you ever suffer from indigestion?	Yes	No
58. Do you often take medication for heartburn?	Yes	No
59. Have you ever been diagnosed with stomach ulcers?	Yes	No
60. Do you suffer from frequent loose bowel movements?	Yes	No
61. Do you experience gut pain shortly after bowel movements?	Yes	No
62. Do you have at least one bowel movement per day?	Yes	No
63. Do you ever experience a burning or itching sensation in the anus?	Yes	No
64. Have you ever had severe bloody diarrhea?	Yes	No
65. Is the color of your stool often tan?	Yes	No
66. Is the color of your stool ever dark black?	Yes	No
67. Were you ever troubled with intestinal worms or parasites?	Yes	No
68. Do you constantly suffer from constipation?	Yes	No
69. Have you ever had piles (rectal hemorrhoids)?	Yes	No
70. Have you traveled out of the country recently?	Yes	No
71. Have you ever had jaundice (yellow eyes and skin)?	Yes	No
72. Have you ever had serious liver or gall bladder trouble?	Yes	No
73. Do you find it difficult to get to sleep at night?	Yes	No
74. Do you have difficulty remembering dreams from the night before?	Yes	No
75. Are you bothered by nightmares?	Yes	No
76. Do you find it impossible to take a regular rest period each day?	Yes	No
77. Are you exhausted upon waking in the morning?	Yes	No
78. Do you need coffee to wake up and have energy in the morning?	Yes	No
79. Are you often exhausted or fatigued?	Yes	No
80. Do you sleep less than 8 hours a day?	Yes	No
81. Does every little effort wear you out?	Yes	No
82. Does nervous exhaustion run in your family?	Yes	No
83. Are you frequently confined to bed by illness?	Yes	No
84. Are you always in poor health?	Yes	No
85. Are you considered a sickly person?	Yes	No
86. Did you ever have scarlet fever?	Yes	No
87. As a child, did you have rheumatic fever?	Yes	No

88. Did you ever have malaria?	Yes	No
89. Were you ever treated for severe anemia?	Yes	No
90. Were you ever treated for venereal disease?	Yes	No
91. Do you have diabetes?	Yes	No
92. Did a doctor ever say you had a goiter in your neck?	Yes	No
93. Did a doctor ever treat you for a tumor or cancer?	Yes	No
94. Do you suffer from any chronic disease?	Yes	No
95. Did you ever have a serious operation?	Yes	No
96. Did you ever have a serious injury?	Yes	No
97. Are your joints often painfully swollen?	Yes	No
98. Do you have constant muscle aches and pains?	Yes	No
99. Do your muscles and joints constantly feel stiff?	Yes	No
100. Have you ever been told that you had arthritis?	Yes	No
101. Do pains in the back make it hard for you to keep up with your work?	Yes	No
102. Do muscle cramps or spasms frequently bother you?	Yes	No
103. Do you have numbness or tingling in any part of your body?	Yes	No
104. Do your feet ever feel like they burn?	Yes	No
105. Have you ever had a seizure or convulsion?	Yes	No
106. Has a doctor ever said your blood pressure was too high?	Yes	No
107. Has a doctor ever said your blood pressure was too low?	Yes	No
108. Do you have pains in the heart or chest?	Yes	No
109. Are you often bothered by thumping of the heart?	Yes	No
110. Does your heart often race like mad?	Yes	No
111. Do you often have difficulty with breathing?	Yes	No
112. Do you run out of breath easily?	Yes	No
113. Do you sometimes get out of breath just sitting still?	Yes	No
114. Are your ankles often badly swollen?	Yes	No
115. Do cold hands or feet trouble you, even in hot weather?	Yes	No
116. Do you suffer from frequent cramps in your legs?	Yes	No
117. Has a doctor ever said you had heart trouble?	Yes	No
118. Does heart trouble run in your family?	Yes	No
119. Has your cholesterol ever been high?	Yes	No
120. Do you get up every night to urinate?	Yes	No
121. During the day, do you usually have to urinate frequently?	Yes	No
122. Do you often have severe burning when you urinate?	Yes	No
123. Do you sometimes lose control of your bladder?	Yes	No
124. Has a doctor ever said you had kidney or bladder disease?	Yes	No
125. Is your memory poor?	Yes	No
126. Do you have difficulty remembering daily tasks or recent events?	Yes	No
127. Do your thoughts seem foggy or cloudy?	Yes	No
128. Do you find it difficult to focus or concentrate on daily activities?	Yes	No
129. Have you ever been under the care of a psychiatrist?	Yes	No
130. Does worrying continually get you down?	Yes	No
131. Do you feel alone and sad at a party?	Yes	No
132. Do you usually feel unhappy or depressed?	Yes	No
133. Do you often cry?	Yes	No
134. Have you ever had a nervous breakdown?	Yes	No
135. Do you always do things on sudden impulse?	Yes	No

136. Are you easily upset or irritated?	Yes	No
137. Do little annoyance get on your nerves and get you angry?	Yes	No
138. Do people often annoy and irritate you?	Yes	No
139. Do you often shake or tremble?	Yes	No
140. Are you constantly keyed up or jittery?	Yes	No
141. Do sudden noises make you jump or shake?	Yes	No
142. Do you tremble or feel weak whenever someone shouts at you?	Yes	No
143. Do frightening thoughts keep coming back in your mind?	Yes	No
144. Do you often become frightened for no apparent reason?	Yes	No
145. Do you often break out in a cold sweat?	Yes	No
146. Does life look entirely hopeless?	Yes	No
147. Do you often wish you were dead and away from it all?	Yes	No
148. Do you bruise easily?	Yes	No
149. Does it take longer than 10 days for a cut or bruise to heal?	Yes	No
150. Is acne constantly a problem?	Yes	No
151. Is your skin constantly broken out with bumps?	Yes	No
152. Do you have to wear lotion to keep your skin from drying out?	Yes	No
153. Do you break out in rashes on a regular basis?	Yes	No
154. Is your hair dry and brittle?	Yes	No
155. Did your hair turn gray prematurely?	Yes	No
156. Are your finger nails weak or ridged?	Yes	No
157. Do you have food cravings?	Yes	No
158. Do you crave ice?	Yes	No
159. Are you hungry shortly after a meal?	Yes	No
160. Do you eat out at restaurants frequently?	Yes	No
161. Do you consume fast food often?	Yes	No
162. Do you drink soda on a daily basis?	Yes	No
163. Do you have a history of sexual promiscuity with multiple partners?	Yes	No
164. Have you ever been diagnosed with a sexually transmitted disease?	Yes	No
165. Have you ever been a substance abuser?	Yes	No
166. Have you ever abused alcohol?	Yes	No
167. Do you drink alcohol on a daily basis?	Yes	No
168. Do you drink coffee on a daily basis?	Yes	No
169. Do certain foods make you feel ill? (corn, wheat, dairy)	Yes	No
170. Do you smoke or use any tobacco products?	Yes	No
171. Are you constantly exposed to second hand smoke?	Yes	No
172. Do you consider yourself to be over weight?	Yes	No
173. Do you consume less than 5 servings of fruits and vegetables per day?	Yes	No
174. Do you exercise 5 times per week or more?	Yes	No
175. Does fatigue keep you from exercising?	Yes	No
176. Is your water intake less than 64 ounces (8 cups) per day?	Yes	No
177. Do you get less than 2 hours/week direct sunlight without using sunscreen?	Yes	No
178. Do you consume a lot of foods which contain artificial sweeteners?	Yes	No

If you experience other symptoms not asked about, please elaborate below:



Past Medical History: please indicate below any health problems you have experienced in the past.

Major Illnesses (Please list dates when conditions were diagnosed):

Accidents or Major Trauma (Please list dates. For scars please give locations):

Surgeries/Hospitalizations (Please list dates):

- | | | |
|---|--|---|
| <input type="checkbox"/> Colostomy | <input type="checkbox"/> Esophageal | <input type="checkbox"/> Cholecystectomy |
| <input type="checkbox"/> Gastric | <input type="checkbox"/> Ileostomy | <input type="checkbox"/> Nephrectomy |
| <input type="checkbox"/> Hemorrhoidectomy | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Bowel (intestinal) | <input type="checkbox"/> Vasectomy | <input type="checkbox"/> Hysterectomy (partial or complete) |
| <input type="checkbox"/> Other | | |

Dental Procedures (Root canals, total number of cavities, etc):

Allergies and/or Sensitivities (Drugs, chemicals, foods, environmental):

Occupational Exposures (i.e. mercury, asbestos, etc):

Lifestyle - Check those that apply to you:

- | | |
|---|---|
| <input type="checkbox"/> Alcohol (daily weekly monthly) | <input type="checkbox"/> Exercise (none daily weekly monthly) |
| <input type="checkbox"/> Housebound | <input type="checkbox"/> Smoker (_____ packs/day) |
| <input type="checkbox"/> Soft drink consumption (____/day) | <input type="checkbox"/> Coffee consumption (____ cups/day) |
| <input type="checkbox"/> Sedentary Job | <input type="checkbox"/> Fast food consumption (daily weekly monthly) |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Married (yes no divorced) |

Women Only: Last Pap-_____ Date of Last menstrual period-_____

Marital History: Years married-_____ # of children-_____ Ages-_____

of Pregnancies-_____ Deliveries-_____ Complications-_____

Use of Contraceptives? _____ What type? _____

Currently menstruating? _____ Abnormal Pap (HPV, CIN, etc.)? _____

If yes check any of the following symptoms you experience around your periods:

- Heavy bleeding Painful cramping Intense mood swings Bloating
- Food Cravings (sweets, chocolate, etc.) Headaches Irregularly timed cycles
- Extreme fatigue Anxiety Depression Breast tenderness

If peri/post-menopausal check any symptoms that you are currently experiencing:

- Hot/cold flashes Vaginal dryness Hair loss Dry skin

Men Only: Date of last prostate exam-_____ Abnormal Prostate findings?-_____

Marital History: Years married-_____ # of children-_____ Rate your job stress (0-10)-_____

Nutritional (diseases, diet, food habit, etc):

- | | | |
|--|--|---|
| <input type="checkbox"/> Anorexia | <input type="checkbox"/> Bulimia | <input type="checkbox"/> Carbohydrate Loading |
| <input type="checkbox"/> Fasting (chronic) | <input type="checkbox"/> Fiber Intake (high) | <input type="checkbox"/> Food Addictive Intake (high) |
| <input type="checkbox"/> Lactose Intolerance | <input type="checkbox"/> Oxalate Intake (high) | <input type="checkbox"/> Phytate Intake (high) |
| <input type="checkbox"/> Malnutrition | <input type="checkbox"/> Protein Intake (high) | <input type="checkbox"/> PUFA Intake (high) |
| <input type="checkbox"/> Salt Intake (high) | <input type="checkbox"/> Saturated Fat Intake (high) | <input type="checkbox"/> Tannic Acid Intake (high) |
| <input type="checkbox"/> Vegetarian Diet | <input type="checkbox"/> Vegan Diet | <input type="checkbox"/> Weight Loss (involuntary) |
| <input type="checkbox"/> Atkins Diet | <input type="checkbox"/> Hollywood Diet | <input type="checkbox"/> South Beach Diet |

Other diet : Please list and describe below.

Nutritional Supplements – Please use the chart below to list all vitamins, minerals, amino acids, or other supplemental products (meal replacement drinks bars, etc.) you are currently taking.

Supplements	Brand	Form	Dose/Frequency	Length of Time
<i>For Example: Vitamin E</i>	<i>Nature's Made</i>	<i>Soft gel cap</i>	<i>400 IU/1 X Day</i>	<i>6 Months</i>



Medications – Please list all medications (prescription and over the counter) you are currently taking

Medication	Physician Contact#	Length of time	Dose	Frequency
<i>For Example: Ibuprofen</i>	<i>OTC</i>	<i>1 week</i>	<i>400 mg</i>	<i>2 X day</i>



24-Hour Diet Recall: Please list all the foods and beverages you have consumed in the past 24 hours.

BREAKFAST:

LUNCH:

DINNER:

SNACKS:



Family Medical History:

Please give age, lists of any illness, or if deceased.

If deceased, list cause of death and age of death.

Children: _____

Mother: _____

Father: _____

Brothers and Sisters:

Mother's Parents:

Father's Parents: _____

Genetic Ethnic Background/Ancestry (i.e. Irish, Scottish, Middle Eastern, etc.):

Examples:

- Arthritis-Type
- Genetic Disease - Type
- Celiac Disease
- Alzheimer's
- Allergies
- Alcoholism
- Asthma
- Bleeding Tendency
- Cancer-Type
- Crohn's Disease
- Diabetes-Age at Onset
- Drug Abuse
- Epilepsy
- Gall Bladder
- Glaucoma
- Heart Disease-Type
- High Blood Pressure
- Hearing Loss
- Hypoglycemia
- Kidney Disease
- Liver Disease-Type
- Osteoporosis
- Lupus
- Mental Illness- Type
- Multiple Sclerosis
- Rheumatoid Arthritis
- Thyroid Disease
- Tuberculosis
- Skin Disease-Type
- Other Conditions



**** Very Important Information ****

Please Read Carefully and Sign After Reading.

Payment Requirements: Payment for all services is expected at the time of appointment. Visa, MasterCard, Discover, American Express, check, cash are accepted. The clinic is now offering a service called Credit Care to help with your financial needs. Please ask for more details at the check out desk.

Appointments: Please kindly give more than 24 hours notice if you must change or cancel your appointment. We charge a \$75 fee for missed appointments or if less than 24 hours notice is given. Please remember that the charge for your first office visit and physical exam does not include lab or supplement prescription costs.

“I understand and agree that my health insurance is an agreement between my insurance company carrier and myself; and that all services furnished to me are charged directly to me. I further understand that Natural Health Solutions has my permission and will attempt to bill my insurance company, but this will not guarantee that payment by the insurance company is made. In the event that the insurance company does not make payment, I am personally responsible for all charges on my account.”

I have read and understand the above statements.

Please Print Name

Signature Date

(Witness signature) (Date)

Many of our patients bring in family members (spouses, parents, etc) to their appointments. This is encouraged, as family support during your treatment is critical to your success. If you would like us to be able to communicate information (lab results, x-rays, etc) about your condition to a family member or designated person in your absence, please list them below.

I _____ give Natural Health Solutions my permission to share my medical information with the following people in my absence (please list names below):

1. _____
2. _____
3. _____