## Confidential Patient Health Record

Date:_____/_____/_____

Alternative Health Oasis, 10223 Sawmill Pkwy Powell, OH 43065

**Personal History---(Fill out every line below):**

Circle One: Single Married Birth Date: _____/_____/_____ Age: ____
First Name: _____ M.I. __ Last: _____ Gender: Male Female
Address: _____
City: _____ State: ____ Zip: _____
Home Phone: ( ____ ) _____ - _____ Cell: ( ____) _____ - _____
Work Phone: ( _____) _____ - _____ Job/Occupation: _____

Email Address (optional): _____
**May we send you email notices, articles & our newsletter periodically? Yes No
How were you referred to our office? _____
Primary Family/Treating Physician: _____
Have you ever had chiropractic care before? Yes No
Chiropractic Doctor/s: _____ Last Appt. _____
Date of X-rays taken and diagnosis: _____
**List your chief complaints in order of severity or concern:**

1. _____ For how long? ____
2. _____ For how long? ____
3. _____ For how long? ____
4. _____ For how long? ____

**Any medical diagnosis of your condition?** _____
**Surgeries/Hernias/Scars/Accidents, etc.** _____
Is there any pain at night that wakens you? Yes No Is there any bleeding? Yes No
Is there any tingling or numbness? Yes No Any pain with coughing, sneezing, bowel or bladder elimination? Yes No Your stress level (Low is 0-10 is high)? _____
Is there anything that makes your condition worse?_____
_____
Do you have any implants or fears that may affect adjustments? Yes No
**Vaccinations and flu shots taken:** _____
**Have you been on birth control pills and for how long?**_____
**What supplements or prescriptions are you taking?**_____
_____
Do you smoke cigarettes? Yes No Are you around cats #__ or dogs#__? Yes No
Do you have any interest in (Circle): Nutritional Anti-aging Weight Loss Detoxifying Programs or Colon Hydrotherapy
How many meals per day _____ and bowel movements do you have daily? _____
Do you know your blood sugar count? Yes No It is: _____ Parasite Test Score ____
How is your energy? ____ Low all the time ____Low in the afternoon ___ Good
What sports or activities do you participate in? _____
I can do # _____ sit-ups, #____ pull-ups, #____ push-ups, and run 100 yards in ____ sec.

If this is a workman's compensation or auto accident, it will be necessary to fill out another form. Fees are payable at time of service. We accept Visa/MC, check or cash.

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

## CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

### INTAKE

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ White Sugar

Have you been tested HIV positive? ☐ Yes ☐ No

## CHECK ANY OF THE FOLLOWING YOU HAVE HAD THE PAST 6 MONTHS:

### MUSCULO-SKELETAL CODE

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness

### NERVOUS SYSTEM CODE

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion/Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Cold/Tingling Extremities
- ☐ Stress

### GENERAL CODE

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches

### GASTRO-INTESTINAL CODE

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps
- ☐ Gas/Bloating After Meals
- ☐ Heartburn
- ☐ Black/Bloody Stool
- ☐ Colitis

### GENITO-URINARY CODE

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine

### C-V-R CODE

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

### EENT CODE

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Stuffed Nose

### MALE/FEMALE CODE

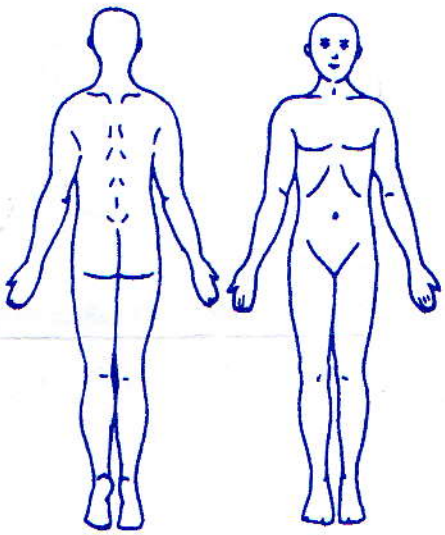
- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems
- ☐ _____
- ☐ _____
- ☐ _____

### FEMALES ONLY:

When was your last period?_____

Are you pregnant?

☐ Yes ☐ No ☐ Not Sure



Please outline on the diagram the area of your discomfort

### FAMILY HISTORY

The following members have a same or similar problem as I do:

- ☐ Mother
- ☐ Father
- ☐ Brother
- ☐ Sister
- ☐ Spouse
- ☐ Child

## DO NOT WRITE BELOW THIS LINE

ANALYSIS:

DIAGNOSIS:

Patient Accepted: ☐ Yes ☐ No ☐ Referred

Doctor's Signature _____

# Parasites

**Alternative Health Oasis**
10223 Sawmill Parkway
Powell, OH 43065

## What is a Parasite?

A parasite is an organism that lives by feeding upon another organism. Parasites living in the human body feed on our cells. our energy, our blood, the food we eat and even the supplements we take. There are several types of parasites: protozoa are single celled organisms that are only visible under a microscope, while worms come in all sizes from threadworms, that measure less than one centimeter, to tapeworms that grow up to 12 meters in length.

To the right is the Parasite Self-Test. Answer each question and then place the appropriate score in the box to the right. Add your score for each question to find your total score. If you score 3 or higher, then a parasite cleanse may be helpful to you.

## Take The Parasites Self Test

1.) Do you experience unexplained muscle aches and pains?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

2.) Do you experience normal bowel movements with bouts of intermittent diarrhea or constipation?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

3.) Do you have unexplained weight loss and/or fever?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

4.) Do you have a distended belly?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

5.) Do you grind your teeth while you sleep?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

6.) Do you have dark circles under your eyes and/or acne?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

7.) Do you have insomnia or disturbed sleep?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

8.) Have you traveled outside of the United States?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

9.) Do you regularly eat unpeeled raw fruit and/or vegetables?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

10.) Do you have pets that sleep in bed with you or do you eat after contact with your pets?
YES___ NO___ (YES = 1 NO = 0) ____→ ____

**A score of 3 or higher indicates you may be suffering from Parasites. Find out more about this serious condition in this issue.**

TOTAL SCORE _____

**SYMPTOM SURVEY FORM**
(Restricted to Professional Use)

PATIENT _____ AGE ____ DOCTOR Fritz DATE _____

**INSTRUCTIONS:** Circle the number that applies to you. If a symptom does not apply, leave it blank.
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly)

## GROUP ONE

**1** – 1 2 3 Acid foods upset
**2** – 1 2 3 Get chilled, often
**3** – 1 2 3 "Lump" in throat
**4** – 1 2 3 Dry mouth-eyes-nose
**5** – 1 2 3 Pulse speeds after meal
**6** – 1 2 3 Keyed up - fail to calm
**7** – 1 2 3 Cuts heal slowly
**8** – 1 2 3 Gag Easily
**9** – 1 2 3 Unable to relax, startles easily
**10** – 1 2 3 Extremities cold, clammy
**11** – 1 2 3 Strong light irritates
**12** – 1 2 3 Urine amount reduced
**13** – 1 2 3 Heart pounds after retiring
**14** – 1 2 3 "Nervous" stomach
**15** – 1 2 3 Appetite reduced
**16** – 1 2 3 Cold sweats often
**17** – 1 2 3 Fever easily raised
**18** – 1 2 3 Neuralgia-like pains
**19** – 1 2 3 Staring, blinks little
**20** – 1 2 3 Sour stomach frequent

## GROUP TWO

**21** – 1 2 3 Joint stiffness after arising
**22** – 1 2 3 Muscle-leg-toe cramps at night
**23** – 1 2 3 "Butterfly" stomach, cramps
**24** – 1 2 3 Eyes or nose watery
**25** – 1 2 3 Eyes blink often
**26** – 1 2 3 Eyelids swollen, puffy
**27** – 1 2 3 Indigestion soon after meals
**28** – 1 2 3 Always seem hungry; feels "lightheaded" often
**29** – 1 2 3 Digestion rapid
**30** – 1 2 3 Vomiting frequent
**31** – 1 2 3 Hoarseness frequent
**32** – 1 2 3 Breathing irregular
**33** – 1 2 3 Pulse slow; feels "irregular"
**34** – 1 2 3 Gagging reflex slow
**35** – 1 2 3 Difficulty swallowing
**36** – 1 2 3 Constipation, diarrhea alternating
**37** – 1 2 3 "Slow starter"
**38** – 1 2 3 Get "chilled" infrequently
**39** – 1 2 3 Perspire easily
**40** – 1 2 3 Circulation poor, sensitive to cold
**41** – 1 2 3 Subject to colds, asthma, bronchitis

## GROUP THREE

**42** – 1 2 3 Eat when nervous
**43** – 1 2 3 Excessive appetite
**44** – 1 2 3 Hungry between meals
**45** – 1 2 3 Irritable before meals
**46** – 1 2 3 Get "shaky" if hungry
**47** – 1 2 3 Fatigue, eating relieves
**48** – 1 2 3 "Lightheaded" if meals delayed
**49** – 1 2 3 Heart palpitates if meals missed or delayed
**50** – 1 2 3 Afternoon headaches
**51** – 1 2 3 Overeating sweets upsets
**52** – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
**53** – 1 2 3 Crave candy or coffee in afternoons
**54** – 1 2 3 Moods of depression - "blues" or melancholy
**55** – 1 2 3 Abnormal craving for sweets or snacks

## GROUP FOUR

**56** – 1 2 3 Hands and feet go to sleep easily, numbness
**57** – 1 2 3 Sigh frequently, "air hunger"
**58** – 1 2 3 Aware of "breathing heavily"
**59** – 1 2 3 High altitude discomfort
**60** – 1 2 3 Opens windows in closed room
**61** – 1 2 3 Susceptible to colds and fevers
**62** – 1 2 3 Afternoon "yawner"
**63** – 1 2 3 Get "drowsy" often
**64** – 1 2 3 Swollen ankles worse at night
**65** – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
**66** – 1 2 3 Shortness of breath on exertion
**67** – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
**68** – 1 2 3 Bruise easily, "black and blue" spots
**69** – 1 2 3 Tendency to anemia
**70** – 1 2 3 "Nose bleeds" frequent
**71** – 1 2 3 Noises in head, or "ringing in ears"
**72** – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

## GROUP FIVE

**73** – 1 2 3 Dizziness
**74** – 1 2 3 Dry skin
**75** – 1 2 3 Burning feet
**76** – 1 2 3 Blurred vision
**77** – 1 2 3 Itching skin and feet
**78** – 1 2 3 Excessive falling hair
**79** – 1 2 3 Frequent skin rashes
**80** – 1 2 3 Bitter, metallic taste in mouth in mornings
**81** – 1 2 3 Bowel movements painful or difficult
**82** – 1 2 3 Worrier, feels insecure
**83** – 1 2 3 Feeling queasy; headache over eyes
**84** – 1 2 3 Greasy foods upset
**85** – 1 2 3 Stools light-colored
**86** – 1 2 3 Skin peels on foot soles
**87** – 1 2 3 Pain between shoulder blades
**88** – 1 2 3 Use laxatives
**89** – 1 2 3 Stools alternate from soft to watery
**90** – 1 2 3 History of gallbladder attacks or gallstones
**91** – 1 2 3 Sneezing attacks
**92** – 1 2 3 Dreaming, nightmare type bad dreams
**93** – 1 2 3 Bad breath (halitosis)
**94** – 1 2 3 Milk products cause distress
**95** – 1 2 3 Sensitive to hot weather
**96** – 1 2 3 Burning or itching anus
**97** – 1 2 3 Crave sweets

## GROUP SIX

**98** – 1 2 3 Loss of taste for meat
**99** – 1 2 3 Lower bowel gas several hours after eating
**100** – 1 2 3 Burning stomach sensations, eating relieves
**101** – 1 2 3 Coated tongue
**102** – 1 2 3 Pass large amounts of foul-smelling gas
**103** – 1 2 3 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours
**104** – 1 2 3 Mucous colitis or "irritable bowel"
**105** – 1 2 3 Gas shortly after eating
**106** – 1 2 3 Stomach "bloating" after eating

## GROUP SEVEN

(A)
**107** – 1 2 3 Insomnia
**108** – 1 2 3 Nervousness
**109** – 1 2 3 Can't gain weight
**110** – 1 2 3 Intolerance to heat
**111** – 1 2 3 Highly emotional
**112** – 1 2 3 Flush easily
**113** – 1 2 3 Night sweats
**114** – 1 2 3 Thin, moist skin
**115** – 1 2 3 Inward trembling
**116** – 1 2 3 Heart palpitates
**117** – 1 2 3 Increased appetite without weight gain
**118** – 1 2 3 Pulse fast at rest
**119** – 1 2 3 Eyelids and face twitch
**120** – 1 2 3 Irritable and restless
**121** – 1 2 3 Can't work under pressure

(B)
**122** – 1 2 3 Increase in weight
**123** – 1 2 3 Decrease in appetite
**124** – 1 2 3 Fatigue easily
**125** – 1 2 3 Ringing in ears
**126** – 1 2 3 Sleepy during day
**127** – 1 2 3 Sensitive to cold
**128** – 1 2 3 Dry or scaly skin
**129** – 1 2 3 Constipation
**130** – 1 2 3 Mental sluggishness
**131** – 1 2 3 Hair coarse, falls out
**132** – 1 2 3 Headaches upon arising wear off during day
**133** – 1 2 3 Slow pulse, below 65
**134** – 1 2 3 Frequency of urination
**135** – 1 2 3 Impaired hearing
**136** – 1 2 3 Reduced initiative

(C)
**137** – 1 2 3 Failing memory
**138** – 1 2 3 Low blood pressure
**139** – 1 2 3 Increased sex drive
**140** – 1 2 3 Headaches, "splitting or rendering" type
**141** – 1 2 3 Decreased sugar tolerance

(D)
**142** – 1 2 3 Abnormal thirst
**143** – 1 2 3 Bloating of abdomen
**144** – 1 2 3 Weight gain around hips or waist
**145** – 1 2 3 Sex drive reduced or lacking
**146** – 1 2 3 Tendency to ulcers, colitis
**147** – 1 2 3 Increased sugar tolerance
**148** – 1 2 3 Women: menstrual disorders
**149** – 1 2 3 Young girls: lack of menstrual function

(E)
**150** – 1 2 3 Dizziness
**151** – 1 2 3 Headaches
**152** – 1 2 3 Hot flashes
**153** – 1 2 3 Increased blood pressure
**154** – 1 2 3 Hair growth on face or body (female)
**155** – 1 2 3 Sugar in urine (not diabetes)
**156** – 1 2 3 Masculine tendencies (female)

(F)
**157** – 1 2 3 Weakness, dizziness
**158** – 1 2 3 Chronic fatigue
**159** – 1 2 3 Low blood pressure
**160** – 1 2 3 Nails, weak, ridged
**161** – 1 2 3 Tendency to hives
**162** – 1 2 3 Arthritic tendencies
**163** – 1 2 3 Perspiration increase
**164** – 1 2 3 Bowel disorders
**165** – 1 2 3 Poor circulation
**166** – 1 2 3 Swollen ankles
**167** – 1 2 3 Crave salt
**168** – 1 2 3 Brown spots or bronzing of skin
**169** – 1 2 3 Allergies - tendency to asthma
**170** – 1 2 3 Weakness after colds, influenza
**171** – 1 2 3 Exhaustion - muscular and nervous
**172** – 1 2 3 Respiratory disorders

### GROUP EIGHT

**173** – 1 2 3 Apprehension
**174** – 1 2 3 Irritability
**175** – 1 2 3 Morbid fears
**176** – 1 2 3 Never seems to get well
**177** – 1 2 3 Forgetfulness
**178** – 1 2 3 Indigestion
**179** – 1 2 3 Poor appetite
**180** – 1 2 3 Craving for sweets
**181** – 1 2 3 Muscular soreness
**182** – 1 2 3 Depression; feelings of dread
**183** – 1 2 3 Noise sensitivity
**184** – 1 2 3 Acoustic hallucinations
**185** – 1 2 3 Tendency to cry without reason
**186** – 1 2 3 Hair is coarse and/or thinning
**187** – 1 2 3 Weakness
**188** – 1 2 3 Fatigue
**189** – 1 2 3 Skin sensitive to touch
**190** – 1 2 3 Tendency toward hives
**191** – 1 2 3 Nervousness
**192** – 1 2 3 Headache
**193** – 1 2 3 Insomnia
**194** – 1 2 3 Anxiety
**195** – 1 2 3 Anorexia
**196** – 1 2 3 Inability to concentrate; confusion
**197** – 1 2 3 Frequent stuffy nose; sinus infections
**198** – 1 2 3 Allergy to some foods
**199** – 1 2 3 Loose joints

### FEMALE ONLY

**200** – 1 2 3 Very easily fatigued
**201** – 1 2 3 Premenstrual tension
**202** – 1 2 3 Painful menses
**203** – 1 2 3 Depressed feelings before menstruation
**204** – 1 2 3 Menstruation excessive and prolonged
**205** – 1 2 3 Painful breasts
**206** – 1 2 3 Menstruate too frequently
**207** – 1 2 3 Vaginal discharge
**208** – 1 2 3 Hysterectomy/ovaries removed
**209** – 1 2 3 Menopausal hot flashes
**210** – 1 2 3 Menses scanty or missed
**211** – 1 2 3 Acne, worse at menses
**212** – 1 2 3 Depression of long standing

### MALE ONLY

**213** – 1 2 3 Prostate trouble
**214** – 1 2 3 Urination difficult or dribbling
**215** – 1 2 3 Night urination frequent
**216** – 1 2 3 Depression
**217** – 1 2 3 Pain on inside of legs or heels
**218** – 1 2 3 Feeling of incomplete bowel evacuation
**219** – 1 2 3 Lack of energy
**220** – 1 2 3 Migrating aches and pains
**221** – 1 2 3 Tire too easily
**222** – 1 2 3 Avoids activity
**223** – 1 2 3 Leg nervousness at night
**224** – 1 2 3 Diminished sex drive

### IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

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

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

### BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

**PRE-MENSES FEMALES AND MENOPAUSAL FEMALES**
Any two days during the month
**FEMALES HAVING MENSTRUAL CYCLES**
The 2nd and 3rd day of flow OR any 5 days in a row.
**MALES**
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____

BP SIT _____ BP STAND _____
PULSE SIT _____ PULSE STAND _____
SALIVA PH _____ BLOOD TYPE _____