TURACK CHIROPRACTIC
AND PERFORMANCE HEALTH

10850 PERRY HIGHWAY
WEXFORD, PA 15090
724.940.3499

Functional Medicine Intake Form

Name:

Date: Insurance:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

E-mail Address:

Age: Date of Birth: Gender: ☐ Male ☐ Female

Status:

☐ Married ☐ Widowed
☐ Separated ☐ Single
☐ Divorced ☐ Partnership

Live with:

☐ Spouse ☐ Children
☐ Partner ☐ Friends
☐ Parents ☐ Alone

Education:

Occupation: Hours per week: ☐ Retired

Employer	Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone

How did you hear about our Wellness and Nutrition Program?

What is your major complaint and when did these symptoms begin?

What are your current medications?

What are your current vitamins and/or supplements?

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

Is there anything in your medical history that you consider to be relevant to your current condition?

What is your employment history? Please provide brief summary.

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

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

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

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloated feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total: _____

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches or ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears or hearing loss	0	1	2	3	4

Total: _____

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, or nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Uncaring or disinterest	0	1	2	3	4

Total: _____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total: _____

5. EYES

a. Watery or itchy eyes	0	1	2	3	4
b. Swollen, reddened, or sticky eyelids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred or tunnel vision	0	1	2	3	4

Total: _____

6. HEAD

a. Headaches	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total: _____

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma or bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total: _____

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total: _____

9. MOUTH / THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging or frequent need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums, lips	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total: _____

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total: _____

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, or dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total: _____

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total: _____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness or limited movement	0	1	2	3	4
e. Pain or aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tiredness	0	1	2	3	4

Total: _____

14. WEIGHT

a. Binge eating or drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total: _____

15. OTHER

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total: _____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16.	Circle the corresponding number for questions 16a - 16f below.									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily	

a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0	1	2	3	4
b. How often are pesticides used in your home?	0	1	2	3	4
c. How often do you have your home treated for insects?	0	1	2	3	4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0	1	2	3	4
e. How often are you exposed to nail polish, perfume, hair spray, or other cosmetics?	0	1	2	3	4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4

Total: _____

17.	Circle the corresponding number for questions 17a - 17b below.							
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change	

a. Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
b. Have you noticed any negative change in your health since you started your new job?	0	1	2	3

Total: _____

18.	Answer yes or no and circle the corresponding number for questions 18a - 18d below.	
	No 2	Yes 0
a. Do you have a water purification system in your home?		
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

GRAND TOTAL (Section I + Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.