Health Solutions Wellness Center
Chiropractic & Therapeutic Massage

Health Participant Information		
Health Participant:		**Date:**
Address:		
City:	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone**
Email Address:		**Date of Birth:**
Health Professionals You Have Seen:		
How did you hear about Dr. Kevin & Trish Vinzani?		

Give Me An Idea Of What You Eat On A Typical Day			
Breakfast	**Lunch**	**Dinner**	**Snacks**

What foods have you currently eliminated from your diet?
What foods have you tried to eliminate from your diet in the past?
List all liquids you drink:

Tell Me About The Medications & Supplements You Are CURRENTLY Taking	
Current Medications	**Current Supplements**

When was the last time you took antibiotics?

Indicate the most recent DATE you had any of these tests:					
Adrenal Salivary:		Food Allergy:		Blood Test:	
Heavy Metal:		Stool Analysis:		Hormone Test:	
Neutotransmitter:		Upper G.I.:		Colonoscopy:	
Other (Specify Test & Date):					

Do you have any of the following digestive symptoms?					
Bloating or Gas	□YES	□NO	Heartburn/Indigestion/GERD	□YES	□NO
Constipation	□YES	□NO	Stomach area pain	□YES	□NO
Diarrhea	□YES	□NO	Ulcers	□YES	□NO

Indicate whether you have had or currently have any of the following conditions:					
Alcoholism	□YES	□NO	Gout	□YES	□NO
Allergies	□YES	□NO	High Blood Pressure	□YES	□NO
Anemia	□YES	□NO	High Cholestrol	□YES	□NO
Bulimia	□YES	□NO	Heart Disease	□YES	□NO
Anxiety Attacks	□YES	□NO	Headaches	□YES	□NO
Auto Immune Disease	□YES	□NO	Kidney Disease	□YES	□NO
Cancer	□YES	□NO	Liver Disease	□YES	□NO
Celiac Disease	□YES	□NO	Osteoporosis	□YES	□NO
Chronic Fatigue	□YES	□NO	PMS	□YES	□NO
Depression	□YES	□NO	Psychiatric Care	□YES	□NO
Diabetes	□YES	□NO	Sleep Problems	□YES	□NO
Fibromyalgia	□YES	□NO	Thyroid Problems	□YES	□NO
Other:					
Please list your symptoms:					
When & how did your symptoms start?					
List any surgeries:					
What treatments have you tried to date?					
Any other information you need to share?					