
Park St.
Healing
Arts

ABOUT YOU

Date:

Mr. Mrs. Ms. Dr. Pastor Name _____ I go by _____

Mailing Address _____ City _____ St ____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ (for contact purposes only, will not be sold)

Occupation _____ SSN _____ Birth Date _____

Employer _____ Address _____

Spouse's Name _____ Spouse SSN _____ Spouse Employer _____

Spouse Phone _____ Spouse Occupation _____ Spouse Birth Date _____

Emergency Contact Name _____ Phone _____

How, or from whom, did you hear about our office? _____

REASON FOR THIS VISIT

IF THIS IS AN ACCIDENT RELATED INJURY, please see the receptionist for an Accident Form. Thank you!

Describe the purpose of your visit _____

When did this episode begin? _____ Has it occurred before? When? _____

Is the condition: (circle one) Constant – 100% of the time Frequent – 75% Intermittent – 50% Occasional – 25%

How severe is it (on a scale of 1- 10) _____ Does it radiate to other parts of your body? _____

What makes it better? _____ What makes it worse? _____

Other Doctors seen for this condition: No Yes Who? _____

Type of treatment _____ Results _____

What do you believe is wrong with you? _____

Does this condition interfere with: (circle all that apply) Work Family Sleep Daily routine Recreation Other activities

HEALTH HISTORY

What accidents, falls, injuries have you had? NOTE: This includes childhood traumas. Please include approximate dates:

_____

_____

Have you broken any bones? Which ones? How? When? _____

List all surgeries that you have had and approximate date _____

Drugs currently taken and reason for use _____

Previous Doctor's and date of last visit _____

Were there any complications during your birth? _____

Type of birth (circle all that apply) Natural Drug induced Cesarean Forceps Suction

Height _____ Weight _____

DAILY LIFE

Do you smoke? No Yes _____ packs/day Do you drink alcohol? No Yes Frequency? _____

Do you eat nutritional supplements? No Yes Which ones? _____

How much water do you drink? _____ Oz./day

Do you drink soda? No Yes Frequency? _____ Do you drink coffee? No Yes _____ Cups per day

Have you ever been on a restricted diet? No Yes If yes, explain _____

Do you have pets? No Yes If yes, what kind? _____

How often do you exercise? _____ Days/week What types of exercise? _____

How long do you do each of these during the day?

Standing _____ hrs/day Sitting _____ hrs/day Computer _____ hrs/day Driving _____ hrs/day

What activities have you had to restrict due to health problems? _____

_____

HEALTH CONDITIONS

Please check each of the diseases or conditions that you now have or have had in the past.

- ☐ Current Infection
- ☐ Sinus problems
- ☐ Dizziness
- ☐ Loss of sleep
- ☐ Frequent neck pain
- ☐ Pain between the shoulders
- ☐ Numbness or pain in arms / hands / legs
- ☐ Lower back pain
- ☐ Foot problems
- ☐ Digestive problems
- ☐ Heart attack / stroke
- ☐ Skin Conditions / Rashes
- ☐ Hepatitis
- ☐ Heart surgery / pacemaker
- ☐ Cancer
- ☐ Anemia
- ☐ Arthritis
- ☐ Diabetes
- ☐ Shingles
- ☐ Kidney problems
- ☐ Liver problems
- ☐ High / low blood pressure
- ☐ Breathing difficulty
- ☐ Asthma
- ☐ Thyroid problems
- ☐ Osteoporosis / Osteopenia
- ☐ Blood clots / Varicose veins
- ☐ Food Allergies
- ☐ Others not listed _____

_____

_____

For Women:

Are you pregnant? No Yes

Are you nursing? No Yes

- ☐ Painful periods
- ☐ Irregular cycle

UNDERSTANDING INSURANCE

I understand that health and accident insurance policies are an arrangement between an insurance carrier and myself. Although the doctors office will attempt to determine my health insurance benefits, it is ultimately my responsibility to understand these benefits. Furthermore, I understand that the doctors office will prepare any necessary forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the doctors office will be credited to my account upon receipt. However, I clearly understand that all service rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate care, any fees for professional services rendered me will be immediately due and payable. I authorize assignment of my insurance benefits (if applicable) directly to the provider for services rendered.

Signature: _____ Date: _____

Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child

Name of Primary Insured: _____ Insured's Date of Birth: _____

Nutritional Informed Consent

A vitamin is not a drug, neither is a mineral, trace element, amino acid, herb or homeopathic remedy.

Although a vitamin, mineral, trace element, amino acid or herb may have an effect on any disease process or symptom, this does not mean this it can be misrepresented as, or classified as, a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary recommendations are not intended as primary treatment and/or therapy for any disease or particular bodily symptom.

The nutritional reflex testing performed by Dr. Kohr is not a method for "diagnosing" or "treating" disease processes or symptoms.

Nutritional counseling, supplement recommendations, nutritional advice and the adjunctive schedule is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition, thereby supporting the natural physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the chemical components of the Vertebral Subluxation Complex (VSC).

I, _____ have read and understand the above.
Print Name

Signature: _____ Date: _____

SYSTEMS SURVEY FORM

(Restricted to Professional Use)

PATIENT_____ DOCTOR _____ DATE _____

AGE_____ PHONE (_____)_____ VEGETARIAN ____ Yes ____ No

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use **(1)** for **MILD** symptoms (occurs once or twice a month), **(2)** for **MODERATE** symptoms (occurs several times a month), and **(3)** for **SEVERE** symptoms (you are aware of it 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 seems 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 ½ - 1 hour after eating; may be up to 3 – 4 hrs.
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 rending" 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
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_____