Keller Family Chiropractic, LLC

Glen E. Keller, DC

NUTRITION RESPONSE TESTING INFORMATION FORM

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State_____ ZIP_____

Shipping Address _____

Home Phone (____) ____-_____ Work Phone (____) ____-_____

e-mail address: _____

Occupation_____Employer_____

Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____

Overall health (circle one): Excellent / Good / Fair / Poor / Other:_____

Chief complaint (reason you are here): (use separate sheet if more room needed)_____

_____

Previous treatments for this complaint_____

_____

Other complaints or problems: (use separate sheet if needed)_____

_____

Current medications/drugs being taken: (use separate sheet if needed)_____

_____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):_____

Nutritional supplements you are taking: _____

Do you smoke, vape, drink coffee or alcohol? (if yes indicate how much/day or week)

Cigarettes_____ Vape _____Coffee _____Alcohol_____

REFERRED BY: _____

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Office Use Only:

Keller Family Chiropractic, LLC
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Name: _____ Date_____

HISTORY:

List any major illnesses (with approx. dates):_____

_____

List any surgery or operations with approx. date:_____

Past Accidents or injuries:_____

_____

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Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any ____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____		M/F	_____
_____		M/F	_____
_____		M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other

Any household pets or other animals you or family members are in close contact with:_____

_____

What can we do to make you happier?_____

_____

_____

SIGNED:_____ DATE _____