TED CIBIK'S

INNER STRENGTH INCORPORATED

825 Lovers Leap Rd
Leechburg, PA 15656
(724) 845-1041

Client Pre-Appointment Information

Todays Date_____

Please Print Clearly

Name:	_____	**Email:**	_____
Address:	_____	**Cell Phone:**	_____
City	_____	**Home Phone:**	_____
State	_____ **Zip** _____	**Birth date:**	_____/_____/_____

Reason for today's consultation:

Have you ever previously had or utilized:
◊ Spinal care ◊ Homeopathic remedies ◊ Herbal remedies ◊ Nutritional work up ◊ Meridian/acupuncture treatment

Health Care Professionals:

Physicians consulted in the past 12 months:	Reason

Lifestyle questions:

Smoking status ◊ Never have ◊ Quit over 10 yrs ago ◊ Quit < 10 years ago
◊ Smoke pipe or cigar occasionally ◊ Use smokeless
◊ Smoke up to 10 cigarettes / day ◊ Smoke more than 10 cigarettes / day

Job: _____hours per week Occupation:_____
More than 24% time spent: ◊ sitting ◊ lifting ◊ standing ◊ walking ◊ driving

Sleep: On average, how many hours of sleep do you have daily?_____ From _____ to _____

Exercise: ◊ More than ½ hour heavy activity daily ◊ ½ hour heavy activity daily
◊ More than ½ hour activity daily ◊ ½ hour activity daily
◊ ½ hour activity 2-3 times/week ◊ No regular exercise
Types of exercise:_____

Stress: *How do you feel about the stress in your life (professionally and personally)*
◊ Seldom stressed ◊ Coping very well
◊ Sometimes stressed ◊ Coping fairly well
◊ Often stressed ◊ Occasionally have trouble coping
◊ Heavily stressed ◊ Often have trouble coping
◊ Excessively stressed ◊ Unable to cope

Diet /Nutritional Information:

Prescription Drugs / Herbals / Supplements currently taking:_____

_____

_____

Food Preparation _____% High fat (fried foods, use butter, shortening, creamy dressings)
_____% Low fat (trim of fats from meats, bake or broil meats, use vegetable oils)

Grain Products: _____% refined grains(white bread, items w/ processed flour, white rice, cereals)
_____% Whole grain breads, brown rice, whole grain baked goods

Convenience foods: Such as hamburgers, hot dogs, tacos, fried chicken, French fries, etc.
◊ Seldom/never ◊ 1-3 times / month ◊ 1-3 times/week ◊ Daily

Salt: how often do you add salt to your foods
◊Seldom/never ◊ Occasionally ◊ Regularly ◊ Prefer salty foods

Daily meals How often do you eat atleast 2 meals per day at a regular time
◊Seldom/never ◊ Occasionally ◊ Almost Daily ◊ Regularly

Snacks How often do you eat between meal snacks (candy bars, granola, soft drinks) (exceptions are fruit, fruit juice, whole grain muffins)
◊Seldom/never ◊ Occasionally ◊ Almost Daily ◊ Regularly

Alcoholic beverages How often (one 1 oz. of alcohol, one glass of wine or 12 oz. beer)
◊Seldom/never ◊ less than 2 days / week ◊ 2-6 days/ week ◊ Daily

Caffeine How often (contained in coffee, non-herbal tea, chocolate, cola drinks)
◊Seldom/never ◊ Occasionally (not daily) ◊ < 2 cups/day ◊ > 2 /day

Medical Limitations/restrictions:_____

_____

Are there any religious, spiritual, or personal beliefs that we should be aware of that could affect our choice of treatment with you ?_____

Health Questionnaire:

Read each question. If it does not apply to you, leave it blank. If it does apply, rate it on a degree of severity (1= extremely mild, 10=very severe or unbearable) in the brackets before the question, and write any explanations needed after the question.

General

( ) Degree your are overweight _____

( ) Degree you are underweight_____

( ) Heart problems _____

( ) Experience rapid heartbeats _____

( ) Aware of skipping beats_____

( ) Blood pressure problems_____

( ) Circulatory problems_____

( ) Episodes of dizziness?_____

( ) Cold hands or feet?_____

( ) Varicose veins?_____

( ) Seems to have excessive thrist?_____

( ) Usually tired most of the time?_____

( ) Usually jumpy or nervous?_____

( ) Suffer from epilepsy or seizures?_____

( ) Suffer from motion sickness?_____

( ) Eye condition?_____

( ) Sensitive to bug bites?_____

( ) Loss of memory?_____

( ) Confusion? _____

( ) Get lightheaded when you stand quickly?_____

( ) Bright lights bothersome to eyes_____

( ) Trouble falling asleep? _____

( ) Wake at night at regular times? _____

( ) Sweat for no reason at night? _____

( ) Wake up tired after a good nights sleep? _____

( ) Frequently feel hot? _____

( ) Frequently feel cold? _____

( ) Eating relieves fatigue? _____

( ) Feel shaky when hungry? _____

( ) Poor concentration? _____

( ) Crave sweets/ stimulants /salt? _____

( ) Sexual problems_____

Men

( ) Prostate, dribbling after urination, difficulty starting stream? _____

( ) Impotency or decrease sexual desire? _____

Women

( ) Are you pregnant? _____

( ) Morning sickness? _____

( ) Take birth control pills? _____

( ) Suffer from PMS? _____

( ) Retain fluid during period? _____

( ) Dysmenorrhea (menstrual cramps/pain)? _____

( ) Suffer from frequent yeast infections? _____

( ) Intercourse painful? _____

( ) Diminished sex drive? _____

( ) Problems with fertility? _____

( ) Problems with miscarriage? _____

( ) Feminine discharge? _____

( ) Breast cysts, lumps or mastitis? _____

( ) Breast implants? Type and for how long? _____

( ) Menopause? _____

( ) Have you had/have breast or uterine cancer _____

Have had a hysterectomy? –if yes, how many years ago? _____

Skin:

( ) Acne?_____

( ) General unhealthy skin?_____

( ) Oily, dry or itchy skin?_____

( ) Eczema – psoriasis or cracking skin?_____

( ) Cysts, warts, moles, liver sports, fungus growths?_____

( ) Rashes, vesibles?_____

( ) Herpes or shingles?_____

( ) Boils?_____

( ) Sores that are slow to heal?_____

( ) Bruise easily?_____

Immune System:

( ) Food allergies? _____

( ) Sensitivity to chemicals? _____

( ) Hay fever? _____

( ) Asthma? _____

( ) Emphysema? _____

( ) Frequent colds or flus? _____

( ) Frequent sore throats? _____

( ) Glands swollen often? _____

( ) Frequent laryngitis? _____

( ) Frequent cough? _____

( ) Chronic chest condition? _____

( ) Post nasal drip_____

( ) Frequent sinus problems? _____

( ) Frequent 'stuffy'? _____

( ) Spit up phlegm? _____

( ) Frequent earaches or discharges? _____

( ) Hair or nail problems? _____

( ) Weakness or exhaustion? _____

( ) Do you have skin or genital warts? _____

Digestion:

( ) Stomach ulcers_____

( ) Liver or gall bladder problems? _____

( ) Are you diabetic? _____

( ) Eat when you are nervous? _____

( ) Have black tarry or bloody stools? _____

( ) Constipation? _____

( ) Use laxatives_____

( ) Diarrhea or colitis? _____

( ) Indigestions, gas or bloat? _____

( ) Heartburn? _____

( ) Hemorrhoids, fissures, polyps? _____

( ) Ever had an intestinal worm, itchy nose or rectum? _____

( ) Gout? _____

( ) Frequent nausea? _____

( ) Excessive appetite? _____

( ) Desire to vomit after eating? _____

( ) Obsessive dietary habits? _____

Neuro/musculo/skeletal:

( ) Suffer rheumatoid arthritis? _____

( ) Any part of your body experience numbness/tingling? _____

( ) Neck complaints? _____

( ) Shoulder complaints? _____

( ) Mid-back complaints? _____

( ) Low back complaints? _____

( ) Hip complaints? _____

( ) Have a spinal curvature? _____

( ) Suffer from muscles spasms? _____

( ) Muscles frequently sore? _____

( ) Muscle weakness? _____

( ) Joints stiff in the morning? _____

( ) Suffer from painful feet? _____

( ) Suffer from heel spurs? _____

( ) Troubles by corns? _____

( ) Sciatica_____

( ) Headaches? Type: sinus/tension/migraine – where do they start? _____

( ) Sports injuries? _____

( ) Jaws problems (TMJ)? _____

( ) Tremors, twitches or neurological diseases? _____

Urinary:

( ) Frequent urination?_____

( ) Bed wetter? _____

( ) Have lost control of bladder or dribble when sneeze or laugh? _____

( ) Painful urination? _____

( ) Difficulty in starting stream? _____

( ) Frequent kidney or bladder infections? _____

( ) Suffer from kidney stones? _____

( ) Blood in your urine? _____

Behavioral:

( ) Nervousness? _____

( ) Agoraphobia – fear of closed spaces? _____

( ) Manic depressive or severe personality shifts? _____

( ) Any severe mental or emotional traumas? _____

( ) Grief or guilt? _____

( ) Insomnia? _____

( ) Do you feel under emotional stress? _____

( ) More than the occasional feeling of depression? _____

Family Medical History:

Blood Pressure:_____

Cancers:_____

Allergies/Asthma;_____

Diabetes:_____

Coronary Disease:_____

Other Information you would like me to know:_____

_____

Services Requested:

Y / N Desire a through physical consult?_____

Y / N Desire a through nutritional consult?_____

Y / N Desire emotional blockage consult?_____

Personal Health Events:

Please list all health events in a chronological order, going back as far as you can remember, including prior to birth (health events related to mother or father at time of conception or pregnancy). Please consider the following events:

Physical: drugs, alcohol, smoking sever illness sever emotional shocks, invasive testing
Birth: difficult labor, use of anesthetics on mother, late breathing or other possible oxygen deprivation
Vaccinations: dates(if possible) of first vaccination and each type received
Accidents: car accidents, falls, blows to the head, broken bones, animal bites
Surgical interventions: tonsils, appendix, adenoids, dental, abdominal, etc.
Drug use: anti biotics, anti-depressants, recreational, etc
Hormones: birth control, replacement therapy, IVF, etc
Severe Infections: Lyme disease, mononucleosis, Epstein-Barr, measles, mumps, chicken pox, TB, pneumonia, etc
Electrical shocks(including medical treatment)
Mental emotional: traumas that triggered any of the following emotions: loss, abandonment, grief, betrayal, fear, anxiety, stress, anger, humiliation, guilt, envy, jealousy, shame

Month/Year	Event