JUDAH ST CLINIC

HELLO!

Welcome to the Judah St. Clinic. We are honored to work with you on your path towards optimal health. It is important to begin this process with as much information as possible. Your overall health today is where it is due to a number of variables: diet, lifestyle, exercise, past accidents, traumas, and genetics. You will work together with Dr. Wirtz while you are under his care to rebuild your body in order to reach your health goals. Our goal at Judah St. Clinic is to identify what is interfering with your body's ability to heal itself and clear that interference.

1

Please take time to answer these questions as accurately as possible. Your answers are very important and will provide an understanding of your current symptoms, personal history, and health goals. When you finish, please email them back to our office at info@JudahStClinic.com so that Dr. Wirtz can review them and prepare for your first appointment.

2

Your first appointment will be an hour and a half. During this appointment you will discuss the reasons you are seeking care and go through the questionnaire you filled out. Dr. Wirtz will conduct a thorough examination from which he will be able to determine a diagnosis. At the end of the appointment, Dr. Wirtz will apply therapies based on your exam findings. Additional information may be needed, such as laboratory panels (blood, urine or saliva) or x-rays. You will be able to ask any questions you may have.

3

Once you clearly understand your case and diagnosis, customized treatment will be recommended which will include intervals of office visits, dietary recommendations and supplementations. Your treatment plan will be tailored to your diagnosis and health goals. Treatment specifics will change as your body begins to heal itself.

4

For most cases, patients will need to perform a series of exercises at home in between office appointments. It is very important that you take these exercises seriously and apply them to your daily routine. This will help get you to your health goals faster and more effectively. You may also need nutritional supplements and may need to make some dietary changes. Your body is a complex system and the food and nutrition you put into it are of utmost importance. We know dietary changes can be very challenging and we are committed to helping you along the way.

5

When you are comfortable with the findings and recommendations, treatment can begin and will continue as long as you keep making progress and/or until your health goals are attained. Diligence and communication will help both parties to do the work needed to achieve these goals.

HEALTH APPLICATION SURVEY

Date: ________________

Name: ____ (Age) _______ Gender: M F

Home Address: ____ Home Phone: ( ) ______________________

City, State, Zip: ____ Work Phone: ( ) ______________________

Email Address: ____ Cell Phone: ( ) ______________________

Birth Date: ______ / ______ / _______ Marital Status: S M D W I Have a 'significant other' (circle one)

Height: ________________ Weight: _________________ Weight gain / loss in past 18 months: ______________________

Names of Children: ____ Ages: ____________________

Occupation: ____ Employer Name: ______________________________

Spouse's Name: __________________________ Work Phone: ( ) __________________ Cell Phone: ( ) ________________________

Spouse's Employer: ____ Occupation: ____

How were you referred to this office? ____

PURPOSE OF THIS VISIT

Reason for this visit – Main Complaint:____

When did this condition begin? __________/_____/________ Did it begin: Gradual Sudden Progressive over time

What activities aggravate your symptoms? ____

Is there anything, which has relieved your symptoms? ☐ Yes ☐ No Describe:____

Is this condition getting worse? ☐ Yes ☐ No Explain: ____

How often do you experience these symptoms throughout the day?: 100% 75% 50% 25% 10% Only with Activity

Does complaint(s) interfere with: __Work __Sleep __Hobbies __Daily Routine Explain: ___________________________________

Have you experienced this condition before? ☐ Yes ☐ No If so, please explain: ____

Who have you seen for this? ____ What did they do? ____________________________

How did you respond? ____

EXPERIENCE WITH DOCTORS

Have you seen a Medical Doctor for this condition? ☐ Yes ☐ No Who? ____________________________ When? __________________

Type of Specialty: ___________________________________ What was recommended?____

How did you respond?____

____

Did your previous doctor take X-Rays, MRI, or CT scan? ☐ Yes ☐ No Did you receive other diagnostic tests? ☐ Yes ☐ No

Type and results: ____ Please BRING a copy of the results

Have you received any Blood Analysis/Blood testing within the past 18 months? ☐ Yes ☐ No Please BRING a copy of the results .

Have you seen a Chiropractor before? ☐ Yes ☐ No Who? ____________________________________ When? ______________________

Reason for visits: ____________________________ How did you respond? ________________________________

FAMILY HEALTH HISTORY

List any health history issues in your family: Arthritis, Rheumatoid Arthritis, Juvenile RA, Lupus, Diabetes I or II, Hashimotos, Sarcodosis, Psoriasis, Celiac, Crohns, Gout, Cancer, Heart Disease Who? ____

Are your parents still living, healthy, and if not healthy, please explain details with their ages. Also share any other detailon family history you can share: ____

____

Family History

____

____

____

NARRATIVE OF CURRENT PROBLEM

SHARE YOUR STORY IN YOUR OWN WORDS. A DETAILED NARRATIVE OF THE SEQUENCE OF EVENTS, TREATMENTS ATTEMPTED, AND RESULTS, EVERYTHING LEADING TO TODAY IS NEEDED:

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Please indicate level of pain

Pain Scale

No Pain — Definitely Hurts — Writhing Agony

0 1 2 3 4 5 6 7 8 9 10

Please circle location of problem(s)

Right Left Right Left Left Right Right Left R L L R Left Right Right Left Left Right Left Right

HEALTH LIFESTYLE

Do you exercise? Yes No How often? 1X 2X 3X 4X 5X per week other: ____________________

What activities? Running Jogging Weight Training Cycling Yoga Pilates Swimming ____________________

Do you smoke? Yes No How much? ____________________

Do you drink alcohol? Yes No How much / week? ____________________

Do you drink coffee? Yes No How many cups / day? ____________________

Do you take any supplements (i.e. vitamins, minerals, herbs –PLEASE BRING ALL THESE, IN THEIR BOTTLES, WITH YOU TO YOUR APPOINTMENT) ____________________

BRAIN AND CERVICAL:

Do you currently experience: (please write 'past' if you did experience this but are not currently)

- ! Confusion / Brain Fog
- ! Memory Loss /Forgetfulness
- ! Depression / Sadness
- ! Emotional swings
- ! Anger / Frustration
- ! Unclear Thinking
- ! Mixing up data
- ! Difficult speech / can't find words
- ! Procrastination / Disorganized
- ! OCD or early OCD symptoms
- ! Attention deficit / Focus issues
- ! Early Dementia issues
- ! Difficult / Dislike social situations
- ! Anxious / Panic Attacks
- ! Phobias / Addictions
- ! Neck Pain, soreness, achy
- ! Pain into your shoulders/arms/hands
- ! Numbness/tingling in arms/hands
- ! Hearing disturbances
- ! Weakness in grip
- ! Headaches
- ! Dizziness
- ! Visual disturbances
- ! Coldness in hands
- ! Thyroid conditions
- ! Sinusitis
- ! Allergies/Hay fever
- ! Recurrent colds/Flue
- ! Low Energy/Fatigue
- ! TMJ/Pain/Clicking

HEART / LUNGS / DIGESTIVE

Do you currently experience: (please write 'past' if you did experience this but are not currently)

- ! Heart Palpitations
- ! Heart Murmurs
- ! Tachycardia
- ! Heart Attacks/Angina
- ! Recurrent Lung Infections/Bronchitis
- ! Asthma / Wheezing
- ! Shortness Of Breath
- ! ANY history of Auto-Immune Ds
- ! Fatigue between meals
- ! Rashes / Skin / Nail changes

- ! Mid / Upper Back Pain
- ! Pain Into Your Ribs/Chest
- ! Indigestion/Heartburn
- ! Reflux / Ulcers
- ! Nausea / Vomiting
- ! Diabetes / Insulin resistance
- ! Hypoglycemic symptoms
- ! Tired/Irritable after eating or when you haven't eaten for a while

SPINAL CORD:

Do you currently experience: (please write 'past' if you did experience this but are not currently)

- ! Pain into your hips/legs/feet
- ! Numbness/tingling in your legs/feet
- ! Coldness in your legs/feet
- ! Muscle cramps in your legs/feet
- ! Constipation / Diarrhea
- ! Weakness/injuries in your hips/knees/ankles
- ! Recurrent bladder infections
- ! Frequent/difficulty urinating
- ! Menstrual irregularities/cramping (females)
- ! Sexual dysfunction
- ! Low back pain

Please list any health conditions not mentioned: ______________________________

Please list any medications currently taking and their purpose: ______________________________
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____

Please list all past surgeries: ______________________________
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____

Please list all previous accidents and falls: ______________________________
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How supportive is your Spouse/Family/Significant other to you seeking care? (be very specific) ______________________________
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Is there anything that you eat or drink that makes you feel better or worse? ______________________________
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What have you been diagnosed with from prior doctors? ______________________________
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____

What is YOUR idea of a 'perfect' doctor? ____
____
____

Are you willing to make strict dietary changes and possibly take supplements necessary for your recovery? Yes No

How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities?
____

____

What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.)
____

____

What are you most concerned with regarding your problem? ______________________

____

Where do you picture yourself being in the next 5 years if this problem is not taken care of?
____

____

What would be different/better without this problem? Please be specific.
____

____

What do you desire most to get from working with Dr. Wirtz? ______________________

____

What one thing would you like to be able to do that your current health is preventing you from doing? ______________________

____

Please list anything else we should know that would help us assess your case:

____
____
____
____
____

I attest to the previous beingtrue and complete to the best of my ability. I understand that care with Dr. Wirtz may or may not be appropriate for my case and desire to consult with him regarding my condition to determine for myself.

______________________________ ______________________________

Signature **Date**