

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, head space 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](mailto:info@JudahStClinic.com) so that Dr. Wirtz can review them and prepare for your first appointment.

2

Your first appointment will be 20-30 minutes. During this appointment you will discuss the reasons you are seeking care and go through the questionnaire you filled out. Dr. Wirtz will conduct an examination from which he will be able to determine a course of action. At the end of the appointment, Dr. Wirtz will apply therapies based on your exam findings. 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 possible exercises or reading that . 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 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. The goal is for us to work together to meet your goals.

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) \_\_\_\_\_  
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: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer Name: \_\_\_\_\_  
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: \_\_\_\_\_  
Have you received any Blood Analysis/Blood testing within the past 18 months?  Yes  No  
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 detailen family history you can share: \_\_\_\_\_



**BRAIN AND CERVICAL:**

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

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

**HEART / LUNGS / DIGESTIVE**

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

- |  |  |
|--|--|
| ! Heart Palpitations                   | ! Asthma / Wheezing  |
| ! Heart Murmurs                        | ! Shortness Of Breath  |
| ! Tachycardia                          | ! ANY history of Auto-Immune Ds                                      |
| ! Heart Attacks/Angina                 | ! Fatigue between meals  |
| ! Recurrent Lung Infections/Bronchitis | ! Rashes / Skin / Nail changes                                       |
| ! Mid / Upper Back Pain                | ! Nausea / Vomiting  |
| ! Pain Into Your Ribs/Chest            | ! Diabetes / Insulin resistance                                      |
| ! Indigestion/Heartburn                | ! Hypoglycemic symptoms  |
| ! Reflux / Ulcers                      | ! 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       | ! Weakness/injuries in your hips/knees/ankles | ! Low back pain |
| ! Numbness/tingling in your legs/feet | ! Recurrent bladder infections                |                 |
| ! Coldness in your legs/feet          | ! Frequent/difficulty urinating               |                 |
| ! Muscle cramps in your legs/feet     | ! Menstrual irregularities/cramping (females) |                 |
| ! Constipation / Diarrhea             | ! Sexual dysfunction                          |                 |

Please list any health conditions not mentioned: \_\_\_\_\_

Please list any medications currently taking and their purpose: \_\_\_\_\_

Please list all past surgeries: \_\_\_\_\_

Please list all previous accidents and falls: \_\_\_\_\_

How supportive is your Spouse/Family/Significant other to you seeking care? (be very specific) \_\_\_\_\_

Is there anything that you eat or drink that makes you feel better or worse? \_\_\_\_\_

What have you been diagnosed with from prior doctors? \_\_\_\_\_

**What is YOUR idea of a 'perfect' doctor?** \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I attest to the previous being true 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** \_\_\_\_\_