Dr. Jinaan Jawad
D.C., D.A.C.N.B.

Become a patient

Welcome to Total Health and Wellness Center of Dupage

Enclosed in this packet you will find all the necessary paperwork and forms that need to be filled out and returned to our office. It is mandatory that you complete them fully and bring them with you to your scheduled consultation and examination.

Completing these forms before your appointment will allow our office to be efficient with your appointment time and ultimately give the doctor a greater understanding of your health status. Please reserve about 40-45 minutes of your time to complete the paperwork.

We do request that previous health records such as blood work, MRI, CT scan, EMG, etc. be supplied so that the doctor can review this part of your health history.

We ask that you arrive 15 minutes prior to your scheduled appointment time so that our office staff can complete preparation of your file and welcome you to our office.

Be sure to complete:

- All enclosed paperwork
- Have these required forms returned to us in their entirety on your scheduled visit
- Have all prior health records (i.e. blood work or any other valuable information concerning your condition) faxed to our office before your appointment time

I look forward to being your partner in regaining your health.

Sincerely,

Jinaan Jawad DC, DACNB
Chiropractic Neurologist

www.totalhealthdupage.com

CHRONIC NEUROLOGICAL & METABOLIC CASE HISTORY

What is the main problem/symptom that you are having? (Be as specific as possible)

____

____

When did this begin? _____________ **How did this begin?** _______________________

Have you had this or similar conditions in the past? ❑ Yes ❑ No
If yes, when? ____

What aggravates your condition? ____

What makes it better? ____

Describe what you are feeling? ____

Do you experience Numbness or Tingling? ❑ Yes ❑ No
If yes, where? ____

SYMPTOM INTENSITY: Please circle the number describing the intensity of symptoms.

None —> 0 1 2 3 4 5 6 7 8 9 10 <— Unbearable

When you are awake, how often are you feeling these symptoms? (0 – 100%) ______**%**

Is this progressively getting worse? ❑ Yes ❑ No

Is your condition: ❑ Constant ❑ Comes & goes

Is this condition interfering with your: ❑ Work ❑ Sleep ❑ Daily routine
❑ Other ____

Has there been any medical diagnosis of your complaint: ❑ Yes ❑ No
If yes, please list doctor's name and diagnosis: ______________________________________

How have you tried to take care of this problem in the past? <u>**Circle all that apply**</u>
Medications Emergency room Surgery Routine Medical Exercise Supplements
Regular Chiropractic Other (specify) ____

How did the previous method(s) work out for you? <u>**Circle all that apply**</u>
Bad results Some results Great results Nothing changed
Didn't get worse Didn't work very long

What are you afraid this might be?____

Medication List: Please list the name of each current prescribed and over the counter medications, it's prescribed use and any side effects/reactions/positive responses (example of use: BCP – birth control pills used to prevent pregnancy, manage menopause or acne, etc.; example of side-effect: Tylenol caused liver enzymes to increase)

	Medication	Name of Condition or purpose for taking med	Any side-effects
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
9)			
10)			

Other Medical or Physical conditions: **Please check all that apply**

- ❑ ADD/ADHD
- ❑ Adrenal gland disorder
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Autoimmune disease: ____________________
- ❑ Bladder issue
- ❑ Bleeding disorder
- ❑ Blurred vision
- ❑ Buzzing/Ringing in ear
- ❑ Cancer – type? ____________________
- ❑ Carpal Tunnel Synd.
- ❑ Celiac disease (gluten sensitive)
- ❑ Chest pains
- ❑ Chronic fatigue
- ❑ Cold hands or feet
- ❑ Colitis/Diverticulitis
- ❑ Compression fractures
- ❑ Concussion
- ❑ COPD
- ❑ Dementia/Memory Loss
- ❑ Depression
- ❑ Diabetes (Type 1 /2)
- ❑ Digestive/bowel issues
- ❑ Dizziness or vertigo
- ❑ Dyslexia
- ❑ Ear infections
- ❑ Fibromyalgia
- ❑ Food sensitivity
- ❑ Fusions (spinal, joint)
- ❑ Gall Bladder issue
- ❑ Gout
- ❑ Hashimoto's thyroiditis
- ❑ Heart disease
- ❑ Hepatitis A, B, C, etc.
- ❑ Herpes
- ❑ High blood pressure
- ❑ Hip replacement
- ❑ HIV/AIDS
- ❑ Immune deficiency
- ❑ Insomnia
- ❑ Kidney disease
- ❑ Knee surgery
- ❑ Leaky Gut Syndrome
- ❑ Light/Sound sensitivity
- ❑ Liver disease
- ❑ Marfan's syndrome
- ❑ Motion sickness
- ❑ Multiple Sclerosis
- ❑ Osteoporosis/penia
- ❑ Parkinson's disease
- ❑ Rotator cuff problem
- ❑ Shoulder surgery
- ❑ Spinal surgery
- ❑ STI/STD
- ❑ Stroke/TIA
- ❑ Thyroid problems
- ❑ Traumatic Brain Injury
- ❑ Tuberculosis
- ❑ Other ____________________
- ❑ Other ____________________

Where do you picture yourself being in the next 1-3 years if this problem isn't taken care of?

____

____

____

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

____

____

____

What do you desire most to get from working with us?

____

____

____

What is it worth to you?

____

____

____

What is your idea of the ideal doctor?

____

____

____

Please complete the following pages.

We thank you for your patience and cooperation in completely filling out this form.

*****Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE IMPACT on your health. Don't worry about trying to impress us by telling the doctor what you think he wants to hear. *****

DAY 1

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

DAY 2

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

DAY 3

Breakfast	Lunch	Dinner
Time:	**Time:**	**Time:**
Mid-morning snack	**Mid-afternoon snack**	**Post-dinner snack**
Time:	**Time:**	**Time:**

Metabolic Assessment Form™

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** ______________________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3

Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII				
Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Lowered gastrointestinal motility, constipation	0	1	2	3
Raised gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?		Yes	No	

Category VIII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?		Yes	No	

Category IX				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category XI				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal?	_______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat out per week? ________

How many times do you eat raw nuts or seeds per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many times do you eat fish per week? ________

How many times do you work out per week? ________

List the three worst foods you eat during the average week: ____________________ ____________________ ____________________

List the three healthiest foods you eat during the average week: ____________________ ____________________ ____________________

PART IV

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____

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