McMichael Chiropractic Clinic **NUTRITIONAL CONSULTATION**

NAME _____ Date _____

Please list your top 5 complaints or health goals in the order of their importance:

1 _____

2 _____

3 _____

4 _____

5 _____

Please list any **medications** you are taking & what you take them for:

Please list any **vitamins, herbs, or supplements** you are taking (be specific):

Were any of these prescribed or recommended by another physician? Yes No

Please list any current allergies:

Please list foods you crave:	Please list any foods you avoid:

Please list any surgeries or medical procedures you have had and the approximate date performed:

Did any of these procedures include the implanting an electrical device (pacemaker, etc.)? Yes No

If you are beginning the purification program, please provide your e-mail address in order to receive daily support e-mails: