



What Vitamins and supplements do you need and why?

In an ideal world, we would eat the most nutritious foods providing us with the adequate amount of vitamins and minerals our body needs. Unfortunately, it is not as easy to consume all of the vitamins and minerals that we need to nourish our bodies on a daily, or a weekly basis for that matter. Supplements are vital because they do one thing; they fill in the void of the nutrients we are missing from our diet. Supplements are not to be taken in replacement for the foods that provide us with vitamins, but to SUPPLEMENT those. We understand that supplements are a commonly sought out topic by individuals today.

The questions below and on the back of this sheet will serve as a guide as we design a supplement protocol for you. Once you fill this out, we will combine it with your health history to make wellness-based recommendations for you.

Name: _____ **Ph:** _____

Email: _____

List all medications you consume including all OTC and prescriptions below.

Medication Name	Condition prescribed for/Reason taking it	Doctor or Person that recommended/prescribed it
Example: Norvasc	High blood pressure	Dr Jim Smith, Internist at St John's Hospital 212-555-1212
Example: Pepcid OTC	Indigestion/Reflux	Self prescribed (Saw ad on TV)

- *Medications will deplete certain nutrients from our system. (See Wellness Center of NY's Nutrient Depletion Chart)*
- *While no medication is a magic bullet or pill, the same can be said for natural supplements. There is however evidence that proves that lifestyle increasing scientific and natural approaches to health should always be a regular part of care.*

1	What is your age?	
2	What is your gender?	M / F
3	Are you currently under regular wellness-based/corrective chiropractic care	Y / N
4	Have you been diagnosed with high cholesterol or elevated triglycerides?	Y / N
5	Do you have type II diabetes?	Y / N
6	Do you find yourself frequently getting sick especially during the winter?	Y / N
7	Do you have difficulty focusing your attention for an extended period of time?	Y / N
8	Do you have osteoporosis or any early bone loss?	Y / N
9	Do you have "arthritis", joint pain or joint swelling?	Y / N
10	Do you suffer from menopausal or post-menopausal symptoms (night sweats, dryness etc)?	Y / N
11	Is your skin blemished or does it frequently break out?	Y / N
12	Have you or any members of your immediate family (parents/siblings) had cancer?	Y / N
13	Are you concerned about cardiovascular disease or is there a history of cardiovascular disease in your immediate family?	Y / N
14	Do you have a history of neurological condition (Parkinson's, M.S, Alzheimer's)?	Y / N
15	Do you have a history of macular degeneration?	Y / N
16	Does stress impact your overall feeling of well-being?	Y / N
17	Do you consume more than 2 or more alcoholic beverages per day?	Y / N
18	Do you smoke?	Y / N
19	Do you consume 3 or more servings of fruits and vegetables daily?	Y / N
20	Do you have trouble recovering from exercise?	Y / N
21	Are you a vegetarian (specify)?	Y / N
22	Are you over weight?	Y / N
23	Do you exercise moderately for at least 30 minutes 3 or more times per week?	Y / N
24	Are you currently pregnant or planning on becoming pregnant in the next 6 months?	Y / N
25	Do you have difficulty sleeping or obtaining a full night's rest?	Y / N