

## NEW PATIENT INFORMATION

### *Instructions from Dr. Yanuck...*

The forms that follow provide you an opportunity to describe the details of your child's case. Please look over the forms now, as they may take you longer than you would expect to fill them out. Patients usually set aside two to three hours to complete them. The more effectively you can convey information using these forms, the more efficiently I can come to the level of understanding necessary to properly manage your child's case.

**One of the most important elements in the history is the narrative that you write.** This exercise can feel a bit intimidating at first, but you will find that it's a great way to clarify the information that gives me clues about what's going on. It creates a starting point of clarity that sets the stage for a successful clinical process.

**The narrative should be submitted as a Word document** that you create and send to us by email to [staff@yanuckcenter.com](mailto:staff@yanuckcenter.com). This should be done **in advance of your appointment** (even if it is the same day) so that I have it in front of me on my computer during our initial discussion. The narrative should tell the story of your child's illness, from when it started, up to the present. It should include the following elements:

1. Relevant dates... "I first noticed a problem in June of \_\_\_\_\_" "The problem got much worse in September of \_\_\_\_\_, when \_\_\_\_\_"
2. Key things that make it better or worse... "I noticed my child felt better with medication xyz... when they took supplement xyz... I noticed my child got worse when they got xyz infection... when we moved to a new house... when they changed their food..."
3. Key tests with dates... "...an MRI in June 2022 that was negative..." "...a blood test on March 10, 2023 that showed an xyz infection..."

In short, please make your narrative clear, sequential, detailed, and to the point.  
I look forward to starting our work together.

- *Dr. Sam Yanuck*



## Child Health Questionnaire

*(to be filled out by the parent(s) - if your child is old enough to fill this out, please use the adult questionnaire)*

Full Name \_\_\_\_\_ Parent 1 \_\_\_\_\_

Address \_\_\_\_\_ Parent 2 \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Emergency Contact \_\_\_\_\_

Date of birth \_\_\_ / \_\_\_ / \_\_\_ Sex \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_

Parent's phones: (cell 1) \_\_\_\_\_ (cell 2) \_\_\_\_\_ (email 1 / 2) \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_ Relationship to you \_\_\_\_\_

I, \_\_\_\_\_, have read and understand Dr. Yanuck's office policies listed at the end of these forms.

I understand that I am personally responsible for payment at the time when services are rendered.

Signature \_\_\_\_\_ Date \_\_\_\_\_

---

---

### Primary Concern

What is your child's primary health problem? \_\_\_\_\_

\_\_\_\_\_

Date of original problem: \_\_\_\_\_ Date of most recent recurrence: \_\_\_\_\_

Was there an event that created the problem? \_\_\_\_\_

Have your child had this or similar conditions in the past? \_\_\_\_\_ Is the problem getting worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_ Worse? \_\_\_\_\_

Is this problem interfering with school? \_\_\_\_\_ Sleep? \_\_\_\_\_ Activity? \_\_\_\_\_ Other? \_\_\_\_\_

What can your child not do now that he/she would like to do? \_\_\_\_\_

What are your goals for your child's treatment? \_\_\_\_\_

## Health History

List all other **CURRENT** problems in their order of importance \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

List other practitioners seen, treatments, self care activities, and results \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Has your child ever seen a chiropractor? No Yes (Name: \_\_\_\_\_ Result: \_\_\_\_\_)

Does your child have any spinal abnormalities that you are aware of? \_\_\_\_\_

List **ALL** significant PAST illnesses \_\_\_\_\_

\_\_\_\_\_

Please list **ALL** chronic infections (Epstein barr, herpes, chlamydia, hepatitis, HIV, bladder infections, respiratory infections, etc.)

\_\_\_\_\_

List **ALL** surgeries your child has had, with dates and results \_\_\_\_\_

\_\_\_\_\_

Has your child ever been hospitalized other than for surgery? \_\_\_\_\_

Has your child ever been in an accident or seriously injured? List dates and describe \_\_\_\_\_

\_\_\_\_\_

**Has your child ever had:** whiplash? Yes \_\_\_ No \_\_\_ // a hard fall on the tailbone? Yes \_\_\_ No \_\_\_ // a seizure? Yes \_\_\_ No \_\_\_

Describe your child's worst injury ever, and any long lasting effects it has had on his/her health \_\_\_\_\_

\_\_\_\_\_

Describe any travel related illnesses \_\_\_\_\_

Is there a time in your child's life when he or she began feeling significantly less healthy? Yes \_\_\_ No \_\_\_ If yes, please describe... \_\_\_\_\_

How many root canals does your child have? \_\_\_\_\_ How many doses of antibiotics (total lifetime)? \_\_\_\_\_

How many times **per month** does your child take aspirin? \_\_\_ Ibuprofen? \_\_\_ Tylenol? \_\_\_ Antacids? \_\_\_ Laxatives? \_\_\_

For what purpose are these taken? \_\_\_\_\_

**The Yanuck Center**  
*for Life and Health*  
www.YanuckCenter.com  
329 Providence Road  
Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN, FIAMA  
A Professional Association  
Tel: 919/401-9500  
Fax: 919/401-9900

## Family History

Have any of your child's blood relatives (parents, brothers, sisters, aunts, uncles, grandparents), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with your child.

Condition	Yes	No	Age	Relationship
Alcoholism / Drug Addiction	—	—	—	—
Allergies / Asthma	—	—	—	—
Arthritis	—	—	—	—
Blood disorders	—	—	—	—
Cancer (type _____)	—	—	—	—
Diabetes	—	—	—	—
Digestive Disorders (type _____)	—	—	—	—
Heart attack before age 55	—	—	—	—
Heart attack after age 55	—	—	—	—
High blood pressure	—	—	—	—
Kidney or Liver disease	—	—	—	—
Lung disease / tuberculosis	—	—	—	—
Mental health problems/ depression	—	—	—	—
Seizure Disorder	—	—	—	—
Stroke	—	—	—	—
Thyroid disease	—	—	—	—
Uterine / Ovarian problems	—	—	—	—

List other problems that run in your family \_\_\_\_\_

## Habits

Describe your child's exercise habits (activity / times per week) \_\_\_\_\_

Describe your child's current sleeping pattern (bedtime, waking time, napping, difficulty with sleep) \_\_\_\_\_

Does your child have enough energy for normal activities? Yes \_\_\_ No \_\_\_ How long does your child watch TV each day? \_\_\_

What does your child do for fun / pleasure / relaxation? \_\_\_\_\_

## Preventive Measures and Screening

When did your child last receive the following (leave blank if it does not apply). Circle the test if you've had an abnormal result

General physical exam \_\_\_\_\_ CBC/chemistry \_\_\_\_\_

Dental exam \_\_\_\_\_ Eye exam \_\_\_\_\_ Hearing test \_\_\_\_\_

Other tests/scans (describe) \_\_\_\_\_

Has your child ever had an X-RAY, MRI or CT (CAT) scan? Yes \_\_\_ NO \_\_\_ If so, what for? \_\_\_\_\_

Has your child received the following vaccines:

Tetanus/Diphtheria (Td) \_\_\_ COVID-19 \_\_\_ Flu \_\_\_ Polio \_\_\_ Measles/Mumps/Rubella \_\_\_ Hepatitis B \_\_\_ Other \_\_\_\_\_

**The Yanuck Center**  
*for Life and Health*  
 www.YanuckCenter.com  
 329 Providence Road  
 Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN, FIAMA  
 A Professional Association  
 Tel: 919/401-9500  
 Fax: 919/401-9900

## Allergies and Sensitivities

Please list any allergies you are aware of (**foods / medications / other**): \_\_\_\_\_

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) \_\_\_\_\_

Is your child particularly sensitive to the effects of medications? Yes \_\_\_ No \_\_\_

Has your child ever reacted to a medication in an unexpected way? Yes \_\_\_ No \_\_\_ If yes, please describe \_\_\_\_\_

Has your child had problems with damp or moldy places? Yes \_\_\_ No \_\_\_ Problems with new building materials? Yes \_\_\_ No \_\_\_

## Nutrition

What does your child usually eat and drink on a typical weekday?

Breakfast \_\_\_\_\_

Morning snack \_\_\_\_\_

Lunch \_\_\_\_\_

Afternoon snack \_\_\_\_\_

Dinner \_\_\_\_\_

Evening snacks \_\_\_\_\_

Desserts \_\_\_\_\_

How many glasses of water per day? \_\_\_\_\_ **Circle** those that apply: tap water, distilled, bottled, well-water, other

How many servings per day of the following: Fruits & Vegetables \_\_\_ Coffee \_\_\_ Tea \_\_\_ Soda \_\_\_ Diet Soda \_\_\_

If your child takes nutritional supplements, is there a specific improvement in the way he/she functions? \_\_\_\_\_

How many meals each week are:

At home \_\_\_\_\_ Alone \_\_\_\_\_ In restaurant \_\_\_\_\_ At fast food place \_\_\_\_\_ TV Dinners or "convenience" food \_\_\_\_\_

While watching TV \_\_\_\_\_ From deli \_\_\_\_\_ At "health food" restaurant or takeout \_\_\_\_\_

Does your child eat if he/she is not hungry but feels depressed, anxious or bored? Frequently / Occasionally / Rarely / Never (circle)

Does your child ever: **a)** binge eat? Yes \_\_\_ No \_\_\_ **b)** sneak or hide foods? Yes \_\_\_ No \_\_\_ **c)** make him/herself vomit? Yes \_\_\_ No \_\_\_

**d)** eat slowly and chew his/her food well? Yes \_\_\_ No \_\_\_ **e)** use extra salt on food at the table? Yes \_\_\_ No \_\_\_

List the oils or fats you use in cooking/preparing food: \_\_\_\_\_

Does your child enjoy eating cheese? Yes \_\_\_ No \_\_\_ Drinking milk? Yes \_\_\_ No \_\_\_ If so, how much per day? \_\_\_\_\_

Does your child like sweets, pastries, cakes, donuts, etc.? Yes \_\_\_ No \_\_\_ How many servings per week? \_\_\_\_\_

Does your child eat sugarcoated cereal or add sugar to cereal? Yes \_\_\_ No \_\_\_ How many servings per week? \_\_\_\_\_

**The Yanuck Center**  
*for Life and Health*  
www.YanuckCenter.com  
329 Providence Road  
Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN, FIAMA  
A Professional Association  
Tel: 919/401-9500  
Fax: 919/401-9900

Does your child use artificial sweeteners (in diet soda or other foods)? Yes\_\_\_ No\_\_\_ How many servings per week? \_\_\_\_\_

When your child eats bread, is it white or whole wheat?\_\_\_\_\_ After eating, does he/she feel: Better / Worse / No different (circle)

Does your child usually eat breakfast? Yes\_\_ No\_\_ Does your child feel better if he/she skips breakfast? Yes\_\_\_ No\_\_\_

Does your child snack between meals? Yes\_\_ No\_\_ Does your child frequently skip meals? Yes \_\_\_\_\_ No \_\_\_\_\_

What is your child's preferred snack food? \_\_\_\_\_

Is there one food that your child likes the most, eats a lot of, and craves when he/she doesn't have it? \_\_\_\_\_

Does your child have any reaction to eating food with MSG in it? Yes\_\_ No\_\_ If so, please describe: \_\_\_\_\_

Does your child have trouble with gaining weight too easily?.....Yes\_\_\_\_\_ No \_\_\_\_\_

Does your child have trouble with losing weight too easily? .....Yes\_\_\_\_\_ No \_\_\_\_\_

If your child's weight has changed, please describe the circumstances involved \_\_\_\_\_

Does your child have more than one meal a day that lacks a vegetable other than corn, potatoes, peas or beans? Yes \_\_\_\_\_ No \_\_\_\_\_

Are there days when your child does not eat any raw vegetables? ..... Yes \_\_\_\_\_ No \_\_\_\_\_

List the three healthiest foods your child eats in the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

List the three un-healthiest foods your child eats in the average week: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Are there specific foods that irritate your child in any way? Yes \_\_\_ No \_\_\_ If yes, name the foods and describe the problem:

\_\_\_\_\_

Please describe any ways in which you feel your child's diet is excessive: \_\_\_\_\_

\_\_\_\_\_

Please describe any ways in which you feel your child's diet is deficient: \_\_\_\_\_

\_\_\_\_\_

List all vitamins, herbs and other supplements your child is now taking \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Metabolic Assessment

Please **CIRCLE** the appropriate number on all questions. **0 = least/never. 3 = most/always.**

<b>Category I - C</b>		<b>Category VII - GB</b>	
Feeling that bowels don't empty completely.....	0 1 2 3	Greasy or high-fat foods cause distress .....	0 1 2 3
Lower abdomen pain relief passing stool or gas.....	0 1 2 3	Lower bowel gas and/or bloating hours after eating .....	0 1 2 3
Alternating constipation and diarrhea .....	0 1 2 3	Bitter metallic taste in mouth, especially in the morning .....	0 1 2 3
Diarrhea.....	0 1 2 3	Unexplained itchy skin .....	0 1 2 3
Constipation .....	0 1 2 3	Yellowish cast to eyes .....	0 1 2 3
Hard, dry, or small stool.....	0 1 2 3	Stool color alternates from clay colored to normal.....	0 1 2 3
Coated tongue or "fuzzy" debris on tongue.....	0 1 2 3	Reddened skin, especially palms .....	0 1 2 3
Pass large amount of foul smelling gas.....	0 1 2 3	Dry or flaky skin and / or hair .....	0 1 2 3
More than 3 bowel movements daily .....	0 1 2 3	History of gallbladder attacks or stones .....	0 1 2 3
Use laxatives frequently (more than twice a month) .....	0 1 2 3	Have you had your gallbladder removed .....	Yes No
<b>Category II - P</b>		<b>Category VIII - LV</b>	
Increasing frequency of food reactions .....	0 1 2 3	Acne and unhealthy skin .....	0 1 2 3
Unpredictable food reactions .....	0 1 2 3	Excessive hair loss .....	0 1 2 3
Aches, pains, and swelling throughout the body .....	0 1 2 3	Overall sense of bloating .....	0 1 2 3
Unpredictable abdominal swelling .....	0 1 2 3	Bodily swelling for no reason .....	0 1 2 3
Frequent bloating and distention after eating .....	0 1 2 3	Hormone imbalances .....	0 1 2 3
Abdominal intolerance to sugars and starches .....	0 1 2 3	Weight gain .....	0 1 2 3
<b>Category III - Chem</b>		<b>Category IX - HG</b>	
Intolerance to smells .....	0 1 2 3	Crave sweets during the day .....	0 1 2 3
Intolerance to jewelry .....	0 1 2 3	Irritable if meals are missed .....	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc. ....	0 1 2 3	Depend on caffeine to get started or keep going .....	0 1 2 3
Multiple smell and chemical sensitivities .....	0 1 2 3	Get light headed if meals are missed .....	0 1 2 3
Constant skin outbreaks .....	0 1 2 3	Eating relieves fatigue .....	0 1 2 3
<b>Category IV - HCL -</b>		<b>Category X - IR</b>	
Excessive belching, burping, or bloating.....	0 1 2 3	Fatigue after meals .....	0 1 2 3
Gas immediately following a meal.....	0 1 2 3	Crave sweets during the day .....	0 1 2 3
Offensive breath.....	0 1 2 3	Eating sweets does not relieve craving for sugar .....	0 1 2 3
Difficult bowel movements.....	0 1 2 3	Must have sweets after meals .....	0 1 2 3
Sense of fullness during and after meals.....	0 1 2 3	Waist girth is equal or larger than hip girth .....	0 1 2 3
Difficulty digesting fruits and vegetables; Undigested food visible in stool.....	0 1 2 3	Frequent urination .....	0 1 2 3
<b>Category V - HCL +</b>		<b>Category XI - A-</b>	
Stomach pain, burning, or ache 1-4 hours after eating .....	0 1 2 3	Cannot stay asleep at night .....	0 1 2 3
Use antacids.....	0 1 2 3	Crave salt .....	0 1 2 3
Feel hungry an hour or two after eating.....	0 1 2 3	Slow starter in the morning .....	0 1 2 3
Heartburn when lying down or bending forward.....	0 1 2 3	Afternoon fatigue .....	0 1 2 3
Temporary relief from antacids, food, milk, carbonated beverages.....	0 1 2 3	Dizziness when standing up quickly .....	0 1 2 3
Digestive problems subside with rest and relaxation...	0 1 2 3	Afternoon headaches .....	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine.....	0 1 2 3	Headaches with exertion or stress .....	0 1 2 3
<b>Category VI - SI</b>		<b>Category XII - A+</b>	
Roughage and fiber cause constipation.....	0 1 2 3	Cannot fall asleep .....	0 1 2 3
Indigestion and fullness lasts 2-4 hours after eating...	0 1 2 3	Perspire Easily .....	0 1 2 3
Pain, tenderness, soreness on left side under rib cage..	0 1 2 3	Under high amount of stress .....	0 1 2 3
Excessive passage of gas.....	0 1 2 3	Weight gain when under stress .....	0 1 2 3
Nausea and/or vomiting.....	0 1 2 3	Wake up tired even after 6 or more hours of sleep .....	0 1 2 3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed.....	0 1 2 3	Perspire excessively or with little activity .....	0 1 2 3
Frequent urination .....	0 1 2 3		
Increased thirst and / or appetite.....	0 1 2 3		
Difficulty losing weight .....	0 1 2 3		

## Metabolic Assessment

Please **CIRCLE** the appropriate number on all questions. **0 = least/never. 3 = most/always.**

<b>Category XIII - pH</b>		<b>Category XVII - P+</b>	
Edema and swelling in ankles and wrists .....	0 1 2 3	Increased sex drive .....	0 1 2 3
Muscle cramping .....	0 1 2 3	Reduced tolerance sugars .....	0 1 2 3
Poor muscle endurance .....	0 1 2 3	“Splitting” type headaches .....	0 1 2 3
Frequent urination .....	0 1 2 3	<b>Category XVIII (Males Only)</b>	
Crave salt .....	0 1 2 3	Urination difficulty or dribbling .....	0 1 2 3
Abnormal sweating from minimal activity .....	0 1 2 3	Frequent urination .....	0 1 2 3
Alteration in bowel integrity .....	0 1 2 3	Pain inside of legs or heels .....	0 1 2 3
Inability to hold breath for long periods .....	0 1 2 3	Feeling of incomplete bowel evacuation .....	0 1 2 3
Shallow, rapid breathing .....	0 1 2 3	Leg nervousness at night .....	0 1 2 3
<b>Category XIV – T-</b>		<b>Category XIX (Males Only)</b>	
Tired, sluggish .....	0 1 2 3	Decreased libido .....	0 1 2 3
Feel cold – hands, feet, all over .....	0 1 2 3	Decrease in spontaneous morning erections. ....	0 1 2 3
Require lots of sleep to function properly .....	0 1 2 3	Decrease in fullness of erections .....	0 1 2 3
Increase in weight gain even with low-calorie diet ....	0 1 2 3	Difficulty in maintaining morning erections .....	0 1 2 3
Gain weight easily .....	0 1 2 3	Spells of mental fatigue .....	0 1 2 3
Difficult, infrequent bowel movements.....	0 1 2 3	Inability to concentrate .....	0 1 2 3
Depression, lack of motivation.....	0 1 2 3	Episodes of depression .....	0 1 2 3
Morning headaches that wear off during the day .....	0 1 2 3	Muscle soreness .....	0 1 2 3
Outer third of the eyebrow thins .....	0 1 2 3	Decrease in physical stamina .....	0 1 2 3
Thinning of hair on scalp, face, or genitals or		Unexplained weight gain.....	0 1 2 3
Excessive falling hair .....	0 1 2 3	Increase in fat distribution around chest and hips .....	0 1 2 3
Dryness of skin and / or scalp .....	0 1 2 3	Sweating attacks .....	0 1 2 3
Mental Sluggishness .....	0 1 2 3	More emotional than in the past .....	0 1 2 3
<b>Category XV – T+</b>		<b>Category XX (Menstruating Females Only)</b>	
Heart palpitations .....	0 1 2 3	Are you perimenopausal	
Inward trembling .....	0 1 2 3	(going through the transition into menopause) .....	Yes No
Increased pulse even at rest .....	0 1 2 3	Alternating menstrual cycle lengths .....	Yes No
Nervous and emotional .....	0 1 2 3	Extended menstrual cycle, greater than 32 days .....	Yes No
Insomnia .....	0 1 2 3	Shortened menses, less than every 24 days .....	Yes No
Night sweats .....	0 1 2 3	Pain and cramping during periods .....	0 1 2 3
Difficulty gaining weight .....	0 1 2 3	Scanty menstrual flow .....	0 1 2 3
<b>Category XVI – P-</b>		Heavy menstrual flow .....	0 1 2 3
Diminished sex drive .....	0 1 2 3	Breast pain and swelling during menses .....	0 1 2 3
Menstrual disorders or lack of menstruation .....	0 1 2 3	Pelvic pain during menses .....	0 1 2 3
Increased ability to eat sugars without symptoms .....	0 1 2 3	Irritable and depressed during menses .....	0 1 2 3
		Acne breakouts .....	0 1 2 3
		Facial hair growth .....	0 1 2 3
		Hair loss / thinning .....	0 1 2 3

**Please answer all that apply (Only for females for whom these questions are appropriate):**

Number of pregnancies \_\_\_\_\_ Number of deliveries \_\_\_\_\_ Difficulties with child birth \_\_\_\_\_

Birth control method you are using currently \_\_\_\_\_ Have you ever used an IUD? \_\_\_\_\_

**The Yanuck Center**  
*for Life and Health*  
 www.YanuckCenter.com  
 329 Providence Road  
 Chapel Hill, NC 27514

Samuel F. Yanuck, DC, FACFN, FIAMA  
 A Professional Association  
 Tel: 919/401-9500  
 Fax: 919/401-9900



# Symptom Survey

Please check the appropriate boxes : → → → **C = Current P = Past**

<p><b>C P Headache</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Base of Skull</p> <p><input type="checkbox"/> <input type="checkbox"/> Entire Head</p> <p><input type="checkbox"/> <input type="checkbox"/> Forehead</p> <p><input type="checkbox"/> <input type="checkbox"/> Top of Head</p> <p><input type="checkbox"/> <input type="checkbox"/> Temples</p> <p><input type="checkbox"/> <input type="checkbox"/> Throbbing</p> <p><input type="checkbox"/> <input type="checkbox"/> Migraine</p> <p><input type="checkbox"/> <input type="checkbox"/> Visual Disturbance</p> <p><input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Double Vision</p> <p><input type="checkbox"/> <input type="checkbox"/> Lightheaded</p> <p><input type="checkbox"/> <input type="checkbox"/> Ringing in Ears</p> <p><b>C P Neck</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Grinding Noise</p> <p><input type="checkbox"/> <input type="checkbox"/> Head Feels Heavy</p> <p><input type="checkbox"/> <input type="checkbox"/> Sharp Pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Dull Ache</p> <p><input type="checkbox"/> <input type="checkbox"/> Stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> <input type="checkbox"/> Lumps in Neck</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen Glands</p> <p><b>C P Arms / Hands</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Arms “fall asleep”</p> <p><input type="checkbox"/> <input type="checkbox"/> Arm pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Wrist pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Hand pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscles twitch L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Loss of grip L R</p> <p><b>C P Mid-Back</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Ache</p> <p><input type="checkbox"/> <input type="checkbox"/> Sharp pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Breathing hurts</p> <p><input type="checkbox"/> <input type="checkbox"/> stiff</p> <p><b>C P Shoulders</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder Bursitis L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Can’t raise arm L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Rotator cuff L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Ache L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Sharp pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Ache into neck L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Stiff L R</p>	<p><b>C P Low Back / Hips / Legs</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Cold feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Legs fall asleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Legs restless at night</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg muscles twitch</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> hip pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> ankle pain L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Unstable ankle L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Unstable knee L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Unstable hip L R</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg cramps with walking</p> <p><input type="checkbox"/> <input type="checkbox"/> Legs cramp at night</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip bursitis</p> <p><b>C P Muscles and Joints</b></p> <p><input type="checkbox"/> <input type="checkbox"/> TMJ (Jaw problems)</p> <p><input type="checkbox"/> <input type="checkbox"/> Osteoarthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Degenerative joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatoid arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Gout</p> <p><input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Tendinitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Muscle aches</p> <p><input type="checkbox"/> <input type="checkbox"/> Eyelids or other facial muscles twitch</p> <p><b>C P Low Back Pain with:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Bending</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough / sneeze</p> <p><input type="checkbox"/> <input type="checkbox"/> Lifting</p> <p><input type="checkbox"/> <input type="checkbox"/> Sitting</p> <p><input type="checkbox"/> <input type="checkbox"/> Standing</p> <p><input type="checkbox"/> <input type="checkbox"/> Twisting</p> <p><input type="checkbox"/> <input type="checkbox"/> Driving</p> <p><input type="checkbox"/> <input type="checkbox"/> Sleeping</p> <p><b>Please list areas where you have any numbness or swelling</b></p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>C P Psychological</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> <input type="checkbox"/> Bipolar disorder</p> <p><input type="checkbox"/> <input type="checkbox"/> Depression</p> <p><input type="checkbox"/> <input type="checkbox"/> Insomnia/difficult sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> Irritability</p> <p><input type="checkbox"/> <input type="checkbox"/> Brain Fog</p> <p><input type="checkbox"/> <input type="checkbox"/> Mental Disorganization</p> <p><input type="checkbox"/> <input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor memory</p> <p><input type="checkbox"/> <input type="checkbox"/> Suicidal ideas</p> <p><input type="checkbox"/> <input type="checkbox"/> Violent thoughts</p> <p><b>C P Cardiac</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Arrhythmia</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest tightness</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> High cholesterol</p> <p><input type="checkbox"/> <input type="checkbox"/> Palpitations</p> <p><input type="checkbox"/> <input type="checkbox"/> Racing heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> <input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Swelling in feet</p> <p><input type="checkbox"/> <input type="checkbox"/> Trouble breathing</p> <p><b>C P Respiratory</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Cough</p> <p><input type="checkbox"/> <input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> <input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> <input type="checkbox"/> Sputum</p> <p><input type="checkbox"/> <input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p><b>C P Peripheral Vascular</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Blood clots</p> <p><input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> Leg cramps</p> <p><input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> Varicose veins</p>
---	---	---



## T Cell Polarization Assessment

Please **CIRCLE** the number that reflects whether the statement applies to you:

0 = Does not apply | 1 = Rarely applies | 2 = Sometimes applies | 3 = Applies | 4 = Strongly applies

Th1 Polarization Support Factors						Th2 Modulation Factors					
Chronic inflammation	0	1	2	3	4	Childhood asthma	No=0		Yes=3		
High stress level	0	1	2	3	4	Childhood intestinal problems	No=0		Yes=3		
Autoimmune disease flares	0	1	2	3	4	Childhood ear infections	No=0		Yes=3		
Tendency to intestinal problems	0	1	2	3	4	Tendency to asthma or other lung issues	0	1	2	3	4
Current intestinal problem	0	1	2	3	4	Active or medicated asthma	0	1	2	3	4
Catch colds that are going around	0	1	2	3	4	Active or medicated other lung problem	0	1	2	3	4
Stay sick longer once you get sick	0	1	2	3	4	Tendency to sinusitis	0	1	2	3	4
Get cold sores	0	1	2	3	4	Headache in forehead, cheek, face	0	1	2	3	4
Tendency to bladder infections	0	1	2	3	4	Current sinus problem	0	1	2	3	4
Current bladder infection	0	1	2	3	4	Produce copious nasal mucous	0	1	2	3	4
Tendency to sinus infections	0	1	2	3	4	Mucous in stool	0	1	2	3	4
Current sinus infection	0	1	2	3	4	Allergy to environment (pollen, mold, etc.)	0	1	2	3	4
Tendency to respiratory infections	0	1	2	3	4	Food sensitivities/reactions	0	1	2	3	4
Current respiratory infection	0	1	2	3	4	Tendency to IBS, SIBO, Dysbiosis, etc.	0	1	2	3	4
Chronically elevated viral burden	0	1	2	3	4	IBS, SIBO, Dysbiosis, other GI currently	0	1	2	3	4
Age: add 2 points for every 5 years over 50						Chronic Stress	0	1	2	3	4
<b>Total of the numbers you circled plus any for age</b>						Work with toxic chemicals	0	1	2	3	4
						Age: add 2 points for every 5 years over 50					
						<b>Total of the numbers you circled plus any for age</b>					

Number of days with symptoms of autoimmune flare in the past month \_\_\_\_ in the past week \_\_\_\_

Number of days with symptoms of inflammation in the past month \_\_\_\_ in the past week \_\_\_\_

Can be body inflammation (aches & pains, body fatigue, GI symptoms, etc.) or brain inflammation (mental fatigue, brain fog, etc.)



## Pain Questionnaire

*(Skip to the next page if your child is not currently experiencing pain.)*

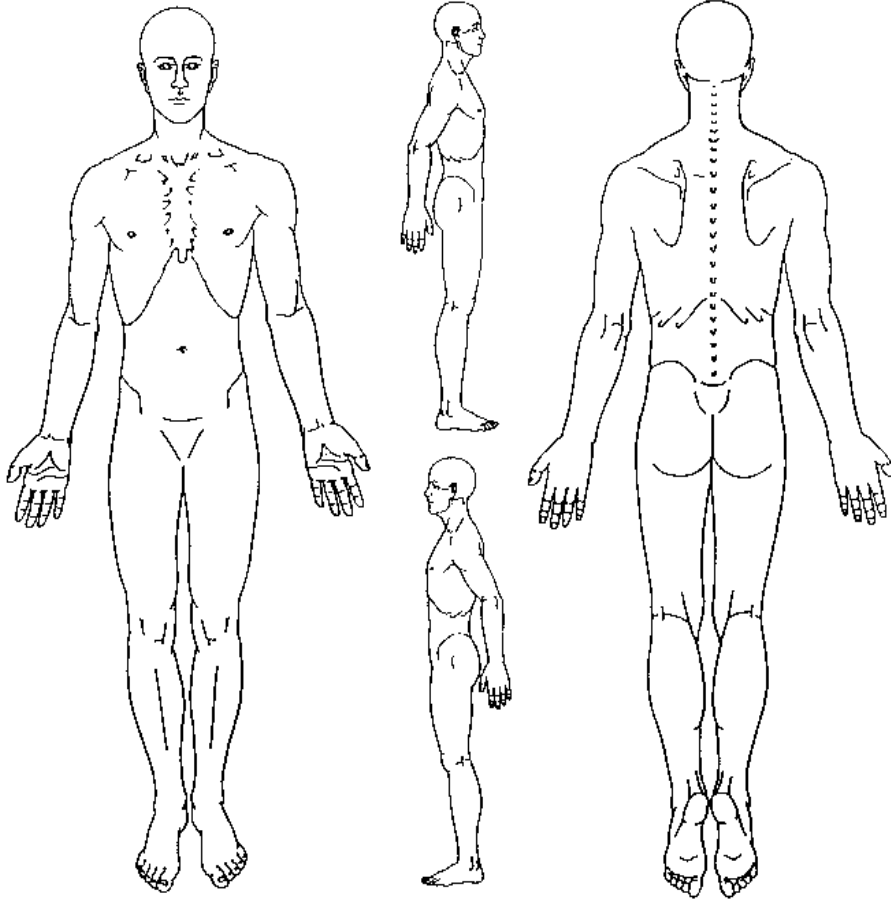
Name \_\_\_\_\_

Please place a single vertical line through the scale below at the point that best describes your child's pain.  
(0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

Mark the areas on your body where you feel the following sensations.  
Use the appropriate symbol. Include all affected areas.

Ache ^ ^ ^ ^ ^ ^	Burning x x x x x x x x	Numbness --- --- --- --- --- ---
Pins & Needles o o o o o o	Stabbing /// ///	Throbbing T T T T T T



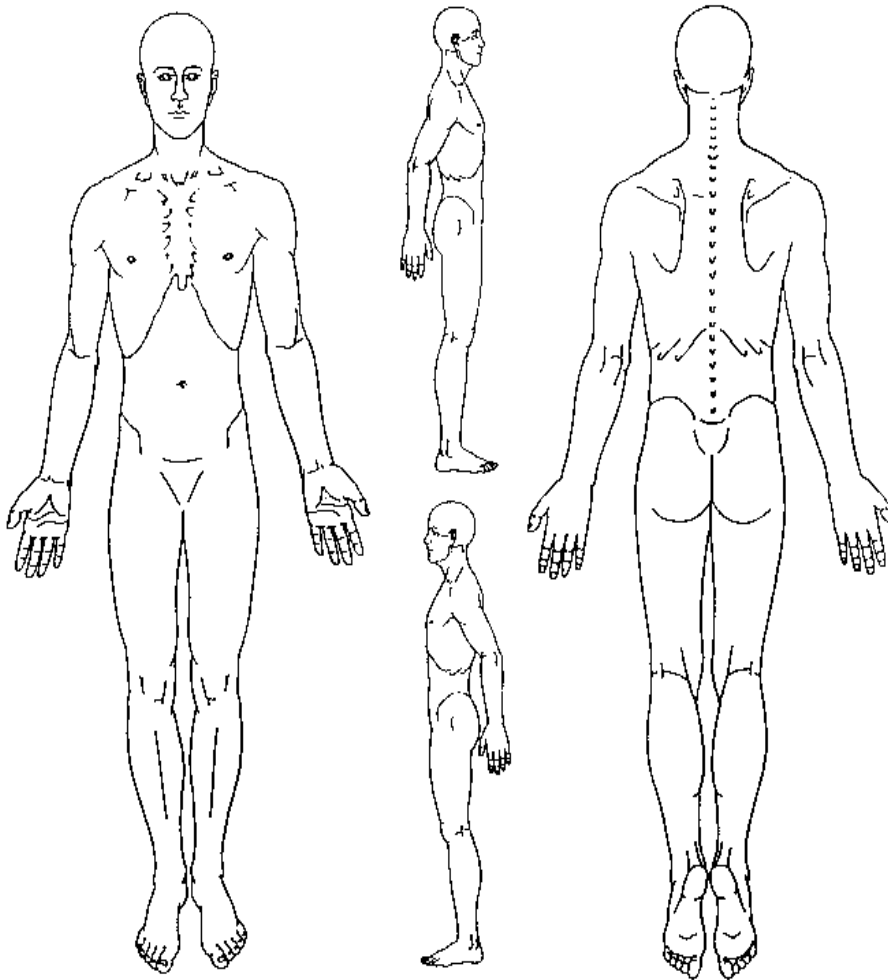


## History of Injury

Name \_\_\_\_\_

Please mark with an "X" all the places where your child has ever been injured (sprains, strains, burns, broken bones, scars from surgeries or accidents, severe bruises, concussions, hard blows to the head, falls, etc.).

Be sure to note any organs that have been operated on or removed. (tonsils, wisdom teeth, appendix, etc.).



### **Authorization For And Consent To Treatment**

This clinic maintains personnel and facilities to assist your doctor in the performance of various manipulative procedures and other diagnostic and therapeutic procedures. These manipulative and ancillary procedures all may involve calculated risks or complications, injury or even death, from both known and unknown causes and no warranty or guarantee has been made as to the result or cure. Except in emergency or exceptional circumstances, procedures are not performed upon patients unless and until the patient has had an opportunity to discuss them with the doctor.

**Each patient, or their parent or guardian, has the right to refuse any proposed procedure, process, or therapy, at any time during each visit.**

Due to the uniqueness of each case and each individual, including his or her willingness and ability to implement the treatment recommendations provided, no guarantees of successful treatment can be offered. In addition, responses to each aspect of treatment can be potentially unique and idiosyncratic. Though the intent of care is improvement, your child's responses can vary. Always inform us of any concerning observations. You further acknowledge that, unless you initiate a specific doctor-patient process with her, Dr. Cheryl Yanuck is not in any way involved in your case.

Your child's doctor may determine that the procedures listed below may be beneficial in the diagnosis or treatment of your child's condition. Upon your signed consent below, such operations or special procedures may be performed for your child by your doctor and/or by other technical staff selected by him or by other clinicians or staff members to whom your child is referred (for example, by a phlebotomist at the lab where you go for a blood draw). This authorization applies both to the listed procedures and to advice given as part of your child's care. In your doctor's absence, this consent applies to the doctor or staff selected to provide coverage for emergencies.

Your signature below constitutes your acknowledgment that: (1) you have read and agreed to the foregoing: (2) You understand that, when appropriate, each procedure will be discussed with you ahead of time, and that if this discussion is not sufficient to provide your understanding, it is your responsibility to request more information (3) You authorize and consent to the performance of procedure(s) or specific tests (4) You consent to the performance of procedures and tests in addition to or different from those specified below whether or not arising from presently unforeseen conditions which your doctor or his associates or assistants may consider necessary or advisable in the course of the procedure(s) specified below: (5) No guarantee of a cure has been promised to you. In addition to other procedures discussed at the time they are performed, procedures may include the following: manipulation, exercise, heat, cold, phlebotomy, nutrition, orthopedic testing, neurologic testing, physical examination, rehabilitation exercises, dietary instructions.

Patient (Print): \_\_\_\_\_ Parent / Guardian (Print): \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_ Date \_\_\_\_\_



### **Informed Consent for Exercise, Training, and Rehabilitative Activities**

In the course of your child's assessment and treatment process, elements of the work may involve exercise or rehabilitative activities. As with virtually any therapeutic modality, there exists a risk of injury. While problems with such activities are unlikely, this page describes your recognition of the risks involved in such activities.

The undersigned hereby voluntarily consents to engage in a program of exercise, training, and/or rehabilitative activities as the clinician deems appropriate to your case. In the course of this process, it is vital that your child provide adequate feedback regarding any changes that they observe. When engaging in an exercise program, it is important to distinguish muscular pain due to fatigue as compared with pain experienced as a result of an injury. If an exercise causes pain, your child should stop that exercise immediately and inform us so that the exercise can be either modified or discontinued. Likewise, when a particular exercise causes pain only in a portion of the range of motion, notify us and do not perform the portion of the exercise that caused pain.

Any questions about the procedures used in any component of your child's care are encouraged. If you have any doubts or questions, please ask for further explanations.

It is understood that you may withdraw consent and discontinue participation in any rehabilitation or exercise component of your child's care at any time.

Finally, the undersigned releases and discharges this facility, their officers, agents, staff, physicians, technicians and any others connected therewith from all claims or damages whatsoever that the undersigned or his/her representatives may have arising from, or incident to your child's exercise program.

Patient (Print): \_\_\_\_\_

Parent / Guardian (Print): \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date \_\_\_\_\_



**Patient Medication List**

Your Child's Name \_\_\_\_\_ Date \_\_\_\_\_

**Please describe each of your child's medications. If a medication is giving your child specific side effects, list them.**

Drug _____	Prescribed by _____	Dose _____	Started _____	Planned End Date _____
Purpose for Taking _____		Is it working? _____		
Side Effects _____		Nutrient Depletion _____		

Drug _____	Prescribed by _____	Dose _____	Started _____	Planned End Date _____
Purpose for Taking _____		Is it working? _____		
Side Effects _____		Nutrient Depletion _____		

Drug _____	Prescribed by _____	Dose _____	Started _____	Planned End Date _____
Purpose for Taking _____		Is it working? _____		
Side Effects _____		Nutrient Depletion _____		

Drug _____	Prescribed by _____	Dose _____	Started _____	Planned End Date _____
Purpose for Taking _____		Is it working? _____		
Side Effects _____		Nutrient Depletion _____		

Drug _____	Prescribed by _____	Dose _____	Started _____	Planned End Date _____
Purpose for Taking _____		Is it working? _____		
Side Effects _____		Nutrient Depletion _____		

Please list medications your child has taken in the past: \_\_\_\_\_

I \_\_\_\_\_ understand that any changes to my child's regimen of medications must be made by, in coordination with, and under the instructions of the physician who prescribes them.

Signed \_\_\_\_\_ Date \_\_\_\_\_

## About Medications

As our work unfolds, your child's body may be better able to heal itself. Because of this, your child's cognitive functions, allergic responses, blood sugar levels, and other important bodily functions might improve. As the body changes, it is possible that the doses of medications your child is taking will need to be modified, to account for these changes. It is your responsibility, in coordination with your child's pediatrician, to monitor or have monitored those of your child's functions that relate to medications he or she is currently taking, to ensure that current doses do not become excessive or deficient in their effect on your child. These and any other changes to your child's regimen of medications must be made by and under the instructions of the physician who prescribed them.

All nutritional supplements should always be discontinued 10 days prior to any surgery and restarted with guidance from both Dr. Yanuck and the surgeon involved.

## Additional Information

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. This will help Dr. Yanuck evaluate your child's condition. Short documents like lab results or MRI reports may be faxed to (919) 401-9900. Longer documents like overall patient records should be copied and sent to the office.

Please list the names of your child's pediatrician and other doctors, so Dr. Yanuck can send a report to them with the details of his findings in your child's case, should it become appropriate for him to do so. List each doctor's full name and as much of the address information as you know.


Please check this box if you wish to give Dr. Yanuck permission to send a report of his impressions to the doctors listed above, and give Dr. Yanuck and the doctors listed above permission to discuss your child's case.

As parent/guardian, I \_\_\_\_\_ hereby authorize the treatment of \_\_\_\_\_ by Dr. Samuel F. Yanuck, chiropractic physician. I understand that I will be responsible for supervising all aspects of care, including follow up, home instructions, and any other needs that might arise.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the patient \_\_\_\_\_





## Dr. Yanuck's Office Policies

### YOUR RESPONSIBILITIES

Every effort will be made to accomplish the maximum result in the most efficient manner. You have three primary responsibilities in support of this goal:

1. **Help your child follow the instructions** that Dr. Yanuck gives you. These may include changes in food, nutrition, sleep management, activity levels, or other instructions.
2. **Keep the schedule** of your child's visits as close as possible to the recommended time of your child's follow up. The timing is based on the specifics of your child's case. Waiting longer than recommended can mean missed opportunities to give feedback and get important course corrections in the process of moving toward normal function.
3. **Dr. Yanuck sees patients remote-only.** If/when Dr. Yanuck determines that it is appropriate to return to in-person visits, you will be informed of the change. At that point, it is your responsibility to bring your child to the Yanuck Center in person.

### APPOINTMENTS

Dr. Yanuck spends significant time in preparation for each of your child's appointments. Missing an appointment is a significant disruption to the flow of that preparation process. Dr. Yanuck allocates substantial time to each patient's appointments. Please note the following policies regarding missed or cancelled appointments:

**For one-hour appointments:** If a one-hour appointment must be rescheduled, no charge will be incurred **provided if you give us notice at least two business days in advance**. You need to call before 5pm Thursday to change a Monday appointment, or before noon Friday to change a Tuesday appointment. If this is not done, the full amount of the visit fee will be charged.

**For 90-minute and two-hour appointments:** If a 90-minute or two-hour appointment must be rescheduled, no charge will be incurred **if you give us notice at least five business days (ONE WEEK) in advance**. If this is not done, the full amount of the visit fee will be charged.

Dr. Yanuck does his best to run on time. However, because he works with each patient until he has accomplished what needs to be done in that session, Dr. Yanuck often runs behind schedule. So, please be available for an on-time start to your child's appointments, but please also plan for delays in the start and end timing of your child's appointments. **Do not schedule other appointments close to the ending time of your child's appointments with Dr. Yanuck.**

## FEES AND BILLING

The fee per hour is \$345. **Payment is due at the end of each session. You are solely responsible for the charges you incur in the office.** If you request them, you will be given forms to submit to your insurance company.

The initial consultation is scheduled for two hours and typically takes 90 minutes to two hours to complete. Subsequent sessions usually last an hour. If sessions go longer or shorter, the fee is adjusted accordingly. Brief sessions are from 5 to 15 minutes. Phone consultations are billed at the hourly rate. There is no charge for brief questions sent by email, provided this function is kept within reason. Complex questions cannot be answered by email.

Dr. Yanuck bills as a chiropractor, so insurance policies that cover chiropractic may be expected to reimburse a modest portion of the fee for his services, though **there is no guarantee they will do so.** Submitting forms to your insurance company is your responsibility, if you wish to do so.

## EMERGENCIES

If your child has an emergency, call 911. If your child has a circumstance that is not an emergency, that involves an urgent need to connect with Dr. Yanuck, call our office and relay the information to the staff. Your call will be returned as soon as possible.

## CONFIDENTIALITY

Our work together is completely confidential, as are your child's records. Your specific written permission is required to release information about your child's treatment to doctors, insurance companies, family members or others.

## ACKNOWLEDGEMENT

I, \_\_\_\_\_, have read these policies and agree to abide by them.  
(parent or guardian print your name)

Signed \_\_\_\_\_ Date \_\_\_\_\_

Relationship to the patient \_\_\_\_\_