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I would like to take this opportunity to thank you for making an appointment with us.

It is our goal to provide you with high quality professional care. In doing this, we will evaluate your individual needs to get you on the path of improving and maintaining your health. If at any time you have questions or comments, please call immediately.

Enclosed is paperwork and questionnaires that you need to fill out before coming to the office for your first appointment. This paperwork will greatly help us in evaluating your health. This must be completed and brought with you on your first appointment. If it is not completed or is forgotten, your appointment will be cancelled and rescheduled for a later time.

Please bring any blood work reports that have been performed on you in the last two years to your first appointment. This can be obtained by calling your primary care physician.

Our office cancellation policy requires you to give us a 24 hour notice. Failure to do so will result in you being charged for the missed appointment.

Thank You.

Yours in Health,

Thomas G. Smith, D.C.

CHIROPRACTIC ASSOCIATES OF MICHIGAN

31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
http://www.chirowarren.com/

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PIN1

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PATIENT INFORMATION~NUTRITION

Patient Name _____ Date ____ / ____ / ____ Signature _____

Address _____ Apt # _____ City_____ State_____ Zip _____

Home Phone (____) _____ Work Phone (____) _____ Cell Phone: (____)

Which number do you prefer to be reached at? ❑ Home ❑ Work ❑ Cell Email address _____

Who/what referred you to our office? _____

Occupation _____ Date of Birth ____ / ____ / ____

Age _____ Blood Type _____ Gender ❑ M ❑ F Height ___' ____" Weight _____

Overall Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Other: _____

Chief concern (reason you are here): _____

_____

Previous treatments for this complaint: _____

Other complaints or problems: _____

_____

_____

List nutritional supplements you are taking:

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Women only: Are you pregnant? ❑ Yes ❑ No ❑ Uncertain Do you use birth control? ❑ Yes ❑ No

Check the following items which apply to you, and ***indicate the amount used***:

❑ Coffee _____	❑ Artificial Sweetener_____	❑ Ice cream _____
❑ Tea _____	❑ Antacids _____	❑ Alcohol _____
❑ Soft Drinks_____	❑ Laxatives _____	❑ Cigarettes_____
❑ Diet Soft Drinks_____	❑ Candy _____	❑ Other Tobacco Proucts_____

Continue to page 2

PIN2

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PATIENT INFORMATION~NUTRITION (page 2)

List any major illness with approx. dates:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

List any surgery or operations with approx. dates:

1. _____ 4. _____
2. _____ 5. _____
3. _____

Past accidents or injuries: _____

_____

Marital Status: ❑ S ❑ M ❑ D ❑ W Name of spouse: _____

Describe health of spouse: _____ Number of children, if any: _____

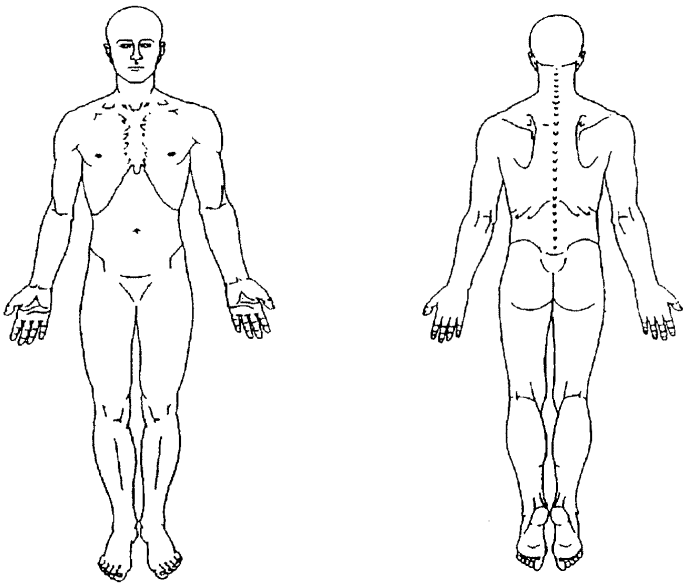
Any family history of serious illnesses: ❑ Cancer ❑ Diabetes ❑ Heart ❑ Other

What is your level of commitment to improve your health? _____ %

What can we do to make you happier? _____

_____

Important! Please mark any locations where you have scars including episiotomy, piercings, tattoos, etc.



SS1

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SYMPTOM SURVEY

Patient Name _____ Date ____/ ____/ ____ Signature _____

NAME: _____ DATE: _____

Phone: _____ E-mail: _____

Fax: _____ DOB: ____/____/____

Sex : ☐ Male ☐ Female Tissue Calcium:_____

Height : _____ Weight : _____

Blood Pressure: Pulse:____

Sitting:_____ Laying:_____ Standing:_____

INSTRTIONS: Completely black out one of the three circles: 1-mild, 2-moderate, 3-severe

● ○ ○ **MILD** symptoms (once or twice last 6 months)
○ ● ○ **MODERATE** symptoms (once or twice last month)
○ ○ ● **SEVERE** symptoms (Chronic, once or twice last week)
○ ○ ○ Leave circles **BLANK** if they do not apply to you!

	1	2	3	
				---------- GROUP 1 ----------
1	○	○	○	Acid foods upset
2	○	○	○	Feel chilled often
3	○	○	○	"Lump" in throat
4	○	○	○	Dry mouth-eyes-nose
5	○	○	○	Pulse speeds after meals
6	○	○	○	Keyed up; unable to feel calm
7	○	○	○	Cuts heal slowly
8	○	○	○	Gag easily
9	○	○	○	Unable to relax; startles easily
10	○	○	○	Extremities cold and/or clammy
11	○	○	○	Strong light irritates
12	○	○	○	Urine amount reduced
13	○	○	○	Heart pounds after retiring
14	○	○	○	"Nervous" stomach
15	○	○	○	Appetite reduced
16	○	○	○	Cold sweats often
17	○	○	○	Body temperature rises easily
18	○	○	○	Skin sensitive to touch
19	○	○	○	Staring, blinks little
20	○	○	○	Frequently has a sour stomach
				---------- GROUP 2 ----------
21	○	○	○	Joint stiffness after rising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen or puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; "lightheaded" often
29	○	○	○	Food digests rapidly
30	○	○	○	Vomit frequently
31	○	○	○	Frequently hoarse
32	○	○	○	Irregular breathing
33	○	○	○	Pulse slow or feels "irregular"
34	○	○	○	Slow gag reflex
35	○	○	○	Difficulty swallowing
36	○	○	○	Alternating constipation and diarrhea
37	○	○	○	"Slow starter"
38	○	○	○	Not easily chilled
39	○	○	○	Perspire easily
40	○	○	○	Poor circulation or sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis
				---------- GROUP 3 ----------
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetitie

	1	2	3	
				---------- GROUP 3 continued ----------
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Feeling fatigued, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Upset feeling from excessive eating of sweets
52	○	○	○	Awaken after few hours sleep hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks
				---------- GROUP 4 ----------
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	Discomfort at high altitude
60	○	○	○	Opens windows in closed room
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon yawner
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles worse at night
65	○	○	○	Muscle cramps, worse during exercise; "charley-horse"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily,"black/blue"spots on arms or legs
69	○	○	○	Tendency to anemia
70	○	○	○	Frequently have "nose bleeds"
71	○	○	○	"Ringing in ears" or noises in head
72	○	○	○	Tension under the breast-bone, or feeling of "tightness" in the chest, gets worse on exertion
				---------- GROUP 5 ----------
73	○	○	○	Dizziness
74	○	○	○	Dry skin
75	○	○	○	Burning feet
76	○	○	○	Blurred vision
77	○	○	○	Itching skin and feet
78	○	○	○	Excessive falling hair
79	○	○	○	Frequent skin rashes
80	○	○	○	Bitter or metallic taste in mouth in the mornings
81	○	○	○	Bowel movements painful or difficult
82	○	○	○	Feelings of worry, dread, or insecurity
83	○	○	○	Feeling queasy; headache over eyes
84	○	○	○	Greasy foods upsets
85	○	○	○	Stools light-colored
86	○	○	○	Skin peels on foot soles
87	○	○	○	Pain between shoulder blades
88	○	○	○	Using laxatives
89	○	○	○	Stools alternate from soft to watery
90	○	○	○	History of gallbladder attacks or gallstones
91	○	○	○	Sneezing attacks
92	○	○	○	Dreaming, nightmares/bad dreams
93	○	○	○	Bad breath (halitosis)
94	○	○	○	Milk products cause distress
95	○	○	○	Sensitive to hot weather
96	○	○	○	Burning or itching anus
97	○	○	○	Crave sweets
				---------- GROUP 6 ----------
98	○	○	○	Loss of taste for meat
99	○	○	○	Lower bowel gas several hours after eating
100	○	○	○	Burning stomach sensations, eating relieves
101	○	○	○	Coated tongue
102	○	○	○	Pass large amounts of foul smelling gas
103	○	○	○	Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
104	○	○	○	Mucus colitis or "irritable bowel"
105	○	○	○	Gas shortly after eating
106	○	○	○	Stomach "bloating" after eating

SS2

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SYMPTOM SURVEY ~ page 2

	1	2	3	
				---------- GROUP 7A ----------
107	○	○	○	Insomnia
108	○	○	○	Nervousness
109	○	○	○	Can't gain weight
110	○	○	○	Intolerance to heat
111	○	○	○	Highly emotional
112	○	○	○	Flush easily
113	○	○	○	Night sweats
114	○	○	○	Skin is thin and moist
115	○	○	○	Inward trembling
116	○	○	○	Heart palpitates
117	○	○	○	Increased appetite without weight gain
118	○	○	○	Pulse races when resting
119	○	○	○	Eyelids and face twitch
120	○	○	○	Irritable and restless
121	○	○	○	Can't work under pressure
				---------- GROUP 7B ----------
122	○	○	○	Noticeable weight gain
123	○	○	○	Decrease in appetite
124	○	○	○	Easily fatigued
125	○	○	○	Ringing in ears
126	○	○	○	Sleepy during day
127	○	○	○	Sensitive to cold
128	○	○	○	Dry or scaly skin
129	○	○	○	Constipation
130	○	○	○	Mental sluggishness
131	○	○	○	Hair coarse, falls out
132	○	○	○	Headaches upon arising wear off during day
133	○	○	○	Pulse slow, below 65
134	○	○	○	Frequent urination
135	○	○	○	Impaired hearing
136	○	○	○	Reduced initiative
				---------- GROUP 7C ----------
137	○	○	○	Failing memory
138	○	○	○	Low blood pressure
139	○	○	○	Increased sex drive
140	○	○	○	Headaches, "splitting or rending" type
141	○	○	○	Decreased sugar tolerance
				---------- GROUP 7D ----------
142	○	○	○	Abnormal thirst
143	○	○	○	Bloating of the abdomen
144	○	○	○	Weight gain around hips or waist
145	○	○	○	Sex drive reduced or lacking
146	○	○	○	Tendency toward ulcers and/or colitis
147	○	○	○	Increased sugar tolerance
148	○	○	○	(FEMALE) Menstrual disorders
149	○	○	○	(YOUNG GIRLS) Lack of menstrual function
				---------- GROUP 7E ----------
150	○	○	○	Dizziness
151	○	○	○	Headaches
152	○	○	○	Hot flashes
153	○	○	○	Increased blood pressure
154	○	○	○	(FEMALE) Hair growth on face or body
155	○	○	○	Sugar in urine (not diabetes)
156	○	○	○	(FEMALE) Masculine tendencies
				---------- GROUP 7F ----------
157	○	○	○	Weakness and/or dizziness
158	○	○	○	Chronic fatigue
159	○	○	○	Low blood pressure
160	○	○	○	Nails weak and/or ridged
161	○	○	○	Tendency towards hives
162	○	○	○	Arthritic tendencies
163	○	○	○	Perspiration increase
164	○	○	○	Bowel disorders
165	○	○	○	Poor circulation
166	○	○	○	Swollen ankles
167	○	○	○	Crave salt
168	○	○	○	Brown spots or bronzing of skin
169	○	○	○	Allergies - tendency to asthma
170	○	○	○	Weakness after colds or influenza
171	○	○	○	Muscular and nervous exhaustion
172	○	○	○	Respiratory disorders

	1	2	3	
				---------- GROUP 8 ----------
173	○	○	○	Apprehension
174	○	○	○	Irritability
175	○	○	○	Morbid fears
176	○	○	○	Never seems to get well
177	○	○	○	Forgetfulness
178	○	○	○	Indigestion
179	○	○	○	Poor appetite
180	○	○	○	Craving for sweets
181	○	○	○	Muscular soreness
182	○	○	○	Depression; feelings of dread
183	○	○	○	Noise sensitivity
184	○	○	○	Acoustic hallucinations
185	○	○	○	Tendency to cry without reason
186	○	○	○	Hair is coarse and/or thinning
187	○	○	○	Weakness
188	○	○	○	Fatigue
189	○	○	○	Skin sensitive to touch
190	○	○	○	Tendency towards hives
191	○	○	○	Nervousness
192	○	○	○	Headache
193	○	○	○	Insomnia
194	○	○	○	Anxiety
195	○	○	○	Anorexia
196	○	○	○	Inability to concentrate; confusion
197	○	○	○	Frequent stuffy nose; sinus infections
198	○	○	○	Allergy to some foods
199	○	○	○	Loose joints
				---------- FEMALE ONLY ----------
200	○	○	○	Very easily fatigued
201	○	○	○	Premenstrual tension
202	○	○	○	Painful menses
203	○	○	○	Depressed feelings before menstruation
204	○	○	○	Excessive and prolonged menstruation
205	○	○	○	Painful breasts
206	○	○	○	Menstruate too frequently
207	○	○	○	Vaginal discharge
208	○	○	○	Hysterectomy / ovaries removed
209	○	○	○	Menopausal hot flashes
210	○	○	○	Menses scanty or missed
211	○	○	○	Acne, worse at menses
212	○	○	○	Long standing depression
				---------- MALE ONLY ----------
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Frequent night-time urination
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Too easily tired
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

List below your five main physical complaints in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

MU

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MEANINGFUL USE CERTIFICATION INFORMATION

Patient Name _____ Date of Birth ____/ ____/ ____ Signature _____
___

PRESCRIBED MEDICATION (Use back of this sheet if you require more space.)

I *do not* take prescribed medication. ❑ Yes ❑ No I *do* take prescribed medication. ❑ No ❑ Yes (If *Yes,* list below):

Medication	#of refills	Qty. of Pills	Strength	Dose Form	Doctor's Instruction
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

DRUG ALLERGIES (Use back of this sheet if you require more space.)

Are You Allergic to ANY Medicines? ❑ No ❑ Yes (If *Yes,* list below):

Drug(i.e. Penicillin)	Symptom(i.e. headache)
1.	
2.	
3.	
4.	

Please check:

Smoking Status: ❑ Smoke everyday ❑ Smoke some days ❑ Former smoker ❑ Never Smoked
Ethnicity/Race: ❑ Caucasian/White ❑ Hispanic/Latino ❑ Black/African American ❑ Other
Preferred Language: ❑ English ❑ Spanish ❑ German ❑ Other

Have you been diagnosed with: Asthma ❑ Yes ❑ No Diabetes ❑ Yes ❑ No

OFFICE USE ONLY
Date ____/____/____

Blood Pressure _____ /_____ Height ___' ___ " Weight_____

NIC

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DR. SMITH NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG' is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of the eight (8) chemical components of the VSC (Vertebral Subluxation Complex).

I have read and understand the above:

Patient Name (Print): _____

Patient Signature _____ Date ____ / ____/ ____

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RFI1

DAILY RECORD OF FOOD INTAKE

Patient Name: _____

Please write down what you eat, don't just circle the food category.

Day 1 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

Day 2 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

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RFI2

DAILY RECORD OF FOOD INTAKE ~pg. 2

Day 3 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

Day 4 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

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RFI3

DAILY RECORD OF FOOD INTAKE ~pg. 3

Day 5 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

Day 6 – Date: ___ / ___ / ___

Breakfast:	**Lunch:**	**Dinner:**
Meat & Dairy	Meat & Dairy	Meat & Dairy
Vegetables & Fruits	Vegetables & Fruits	Vegetables & Fruits
Breads, Cereals and Grains	Breads, Cereals and Grains	Breads, Cereals and Grains
Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils and Fats)	Fats (Butter, Margarine, Oils)
Candy, Sweets & Junk Food	Candy, Sweets & Junk Food	Candy, Sweets & Junk Food
Drinks	Drinks	Drinks
Mid-Morning Snack:	**Mid-Afternoon Snack:**	**Nighttime Snack:**

Notes: _____

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CHIROPRACTIC ASSOCIATES OF MICHIGAN
31850 Schoenherr at Masonic (13-1/2 Mile)
Warren, MI 48088
http://www.chirowarren.com/
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586 / 293 - 4440 • Fax 586 / 293 - 0840