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Patient Survey

Dear Patient,

Please complete this survey and return it to the front desk before you leave today.

1. Are you presently taking any type of nutritional supplements (such as vitamins, minerals, herbs, amino acids, fish oils, etc.)? \_\_\_\_Yes \_\_\_\_ No
2. If you answered yes to question 1, please check the types of supplements you are taking.

\_\_\_\_ Multivitamin \_\_\_\_ Minerals \_\_\_\_ Vitamin C

\_\_\_\_Omega Oils (Fish Oils) \_\_\_\_ Calcium \_\_\_\_ Beta Carotene

\_\_\_\_Vitamin B Complex \_\_\_\_ Antioxidants (Vitamins A & E)

\_\_\_\_ Prostate Formula \_\_\_\_ Women’s Formula

1. Please list any supplements that you are taking that are not listed above.
2. Who recommended that you take these supplements?

\_\_\_\_ Advertisement \_\_\_\_ Family or Friend \_\_\_\_ Store Clerk

\_\_\_\_ Health Professional \_\_\_\_ Other

1. Are your supplements physician grade? \_\_\_\_ Yes \_\_\_\_ No
2. If this office offered group nutrition seminars designed to help improve your dietary habits, would you consider attending? \_\_\_\_ Yes \_\_\_\_ No
3. Are you interested in a comprehensive weight management program?

\_\_\_\_ Yes \_\_\_\_ No