New Patient Intake Form

Today's Date: _____ **Confidential Case History**

Please fill out this questionnaire. It will help us to determine how our care can help you. If we do not sincerely believe that your condition will respond satisfactorily, we will refer you to the appropriate health care provider. If you need help with this form, please ask us for assistance.

Personal Information

Name: _____ SSN: _____
How do you wish to be addressed in our office? _____
Address: _____ City: _____
State:_____ Zip code:_____ Date of Birth: _____ ❒Married ❒Single
Home Phone: _____ Occupation:_____
Work Phone: _____ Employer: _____
Cell Phone: _____ Employer Address: _____
E-mail: _____ _____
Spouse's Name:_____ Hobbies: _____
Children's Names & Ages: _____, _____,
_____, _____, _____.
How did you hear about us? ❒Drove by and saw your sign ❒Phone book ❒Internet
❒Referral Who? _____ ❒Ad ❒Other:_____

Health Information

Have you ever received wellness care or chiropractic care before? ❒Yes ❒No
If so, what was the reason? _____
Have you had previous healthcare for your present problem? ❒Yes ❒No
If yes, where? _____ When? _____

Reason for Consulting Our Office

❒ I have a specific problem and require help only with this problem.
❒ After I have received relief, I am interested in strategies ensuring this problem does not return.
❒ I am interested in strategies to improve my overall health.
❒ I feel great and am interested in strategies to keep me well, or feeling even better.

What is/are your major complaint(s)? _____
How long have you had this condition? _____
Have you had this or similar conditions in the past? ❒Yes ❒No If yes, when? _____
What activities aggravate your condition? _____
What makes it better? _____
Is this condition getting progressively worse? ❒Yes ❒No ❒Constant ❒Comes and goes
Is this condition interfering with your ❒Work ❒Sleep ❒Daily Routine ❒Other_____
How long has it been since you felt really well? _____
List surgical operations and/or major surgeries: _____
_____

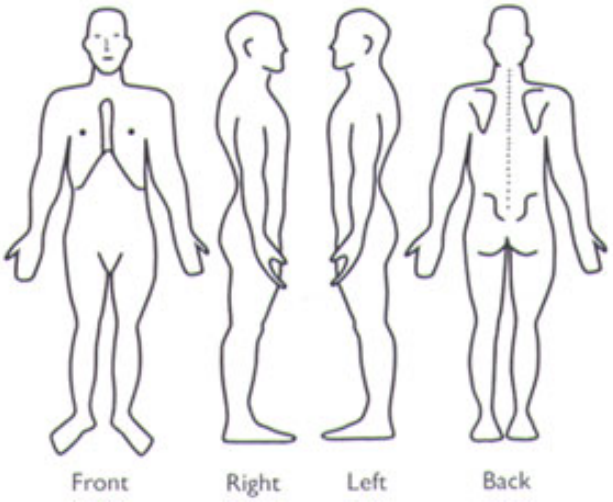
List any prescription drugs, over the counter drugs, vitamins, and natural supplements that you are presently taking: _____

_____

Are you wearing ❒Heel Lifts ❒Sole Lifts ❒Inner Soles ❒Arch Support ❒Orthotics
Have you ever been in an auto accident? ❒No ❒Recently ❒Past Year ❒Past 5 years or more
Describe the accident: _____
Have you had another personal injury/accident: ❒No ❒ Recently ❒Past Year ❒Past 5 years or more Describe: _____
Date of most recent physical exam: _____

Please Mark the Areas of Pain and/or Discomfort on the Figures Below

Please mark an **X** on the picture where you have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 to 10. (1 = least, 10 = greatest) _____

Type of Pain:

❒Sharp	❒Dull	❒Throbbing
❒Numbness	❒Aching	❒Shooting
❒Burning	❒Tingling	❒Cramps
❒Stiffness	❒Swelling	❒Other

How often do you have this pain? _____
_____

Are you affected by any of the following?

Please check: **O** = Occasionally **F** = Frequently **C** = Constantly

	O	F	C		O	F	C		O	F	C
Asthma	❒	❒	❒	Headaches	❒	❒	❒	Heart burn	❒	❒	❒
Backache	❒	❒	❒	Sinus trouble	❒	❒	❒	Migraines	❒	❒	❒
Neck pain	❒	❒	❒	Digestive upset	❒	❒	❒	High blood pressure	❒	❒	❒
Allergy	❒	❒	❒	Constipation	❒	❒	❒	**Females only:**	❒	❒	❒
Earache	❒	❒	❒	Dizziness	❒	❒	❒	Painful menstruation	❒	❒	❒
Sore throat	❒	❒	❒	Shoulder pain	❒	❒	❒	PMS	❒	❒	❒
Foot pain	❒	❒	❒	Leg pain	❒	❒	❒	Are you pregnant? ❒Yes ❒No			

I, the undersigned, having been explained the risks of treatment, do hereby request and consent to the performance of wellness care and related procedures upon the above-named patient (my dependent or myself). I wish to rely on the doctor or practitioner to exercise judgement for my best interest during the course of treatment. I will inform the doctor or practitioner who is treating me of any sensitive areas or adverse conditions I may have had prior to, during, or after treatment. I intend this consent to cover the entire course of treatment.

We thank you for your patience and cooperation in completely filling out this form.

Patient's Signature: _____ Date: _____

Chemical Balance Form

The purpose of this NUTRITIONAL QUESTIONNAIRE is to help determine your alkaline reserve status (your pH), because healing happens within the body in a certain chemical range. Anything outside of that range can slow down or stop the healing process.

The Stiff Test – The Fist Test – The Sniff Test

1. Are you stiff and sore when you get up in the morning? ❒Yes ❒No
2. Do you feel good in the morning but have pain and tightness as the day goes on? ❒Yes ❒No
3. Are you generally restless and don't sleep well? ❒Yes ❒No
4. First thing in the AM, squeeze really hard to make a fist. Does it hurt/or is hard? ❒Yes ❒No
5. Do you notice the smell of ammonia in your urine? ❒Yes ❒No
6. Is your urine foamy? ❒Yes ❒No
7. Do you have a burning sensation when you urinate? ❒Yes ❒No

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How quickly you get well is determined by the chemical balance in your body. Chemical balance is determined, in large, by what you eat. Please indicate the amounts and frequencies you partake in the following:

YOU MUST BE BRUTALLY HONEST!

Amount of:	**Per Day**	**Per Week**
1. Coffee (caffeinated/decaffeinated)	_____ cups	_____ cups
2. Tea (herbal & regular)	_____ cups	_____ cups
3. Sugar, sweets, desserts, candy, and artificial sweeteners	_____ times	_____ times
4. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
5. Do you add salt to food at meal time?	❒Yes ❒No	❒Occasionally
6. Red meat (beef, pork, bacon, ham, etc.)	_____ times	_____ times
7. Chicken/Fish	_____ times	_____ times
8. Dairy (milk, cheese, ice cream, etc.)	_____ glasses/times	_____ glasses/times
9. Water	_____ glasses	_____ glasses
10. Fresh fruits	_____ pieces	_____ pieces
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Alcoholic beverages	_____ servings	_____ servings
13. Soft drinks (caffeinated/decaffeinated)	_____ servings	_____ servings
14. Smoking	_____ packs	_____ packs

Wellness Care Form

Our mind-body strategies are ultimately about wellness care. Granted, many of us will have symptoms or issues that need to be dealt with immediately, but eventually, as those are resolved, we can begin to create the better life, and better health that we dream of.

In order for our office to assist you in achieving your wellness status, help us define what that would look like for you. List 3 goals you would love to achieve regarding your perfect health and your ideal life. (Use your imagination and assume that anything would be possible for you.)

1. _____

2. _____

3. _____

On a scale of 1 – 10, with 1 being "not much" and 10 being "almost anything," demonstrate what you would be willing to change, let go of, shift, start, or stop in order to accomplish these goals.

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1 2 3 4 5 6 7 8 9 10

● Does it *feel* possible to personally achieve these goals?

❒Yes ❒No

● Would you be willing to investigate any *subconscious* interference that may be getting in your way? (You won't need to reveal any personal information in order to do so.)

❒Yes ❒No

● Have you ever had someone demonstrate (via muscle testing) how your *subconscious* beliefs can sabotage your ability to obtain your goals? The Law of Attraction operates through your *subconscious* mind. What your *subconscious* believes is what will manifest in your life.

❒Yes ❒No

● Did you know there is a procedure you can easily learn that would enable you (working with a partner) to remove the *subconscious* interference that stops you from achieving your goals?

❒Yes ❒No

● Would you like to learn how? It's called BEST RELEASE.

❒Yes ❒No

"When we unite our two efforts, you'll receive some profound health benefits."