New Patient Intake

This is a confidential questionnaire that will help us to determine the optimal treatment plan specific to your needs. Please complete all pages of this form as accurately and completely as possible. Some information may not appear to be related to your problem, however, experience has proven that providing comprehensive information is essential to getting you better as quickly as possible. Whatever additional information you provide will be helpful in evaluating your condition.

Name _____ **Today's Date** _____

Address _____ **Sex** ☐ **M** ☐ **F** **Birth date** _____ **Age** _____

City _____ **State** _____ **Zip** _____ **Occupation** _____

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

SS # ____ / ____ / ____ **No. of children & ages** _____

Marital Status (check one) ☐ **Married** ☐ **Single** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐ **Significant Other**

E-Mail _____ **Employer** _____

Are you presently under a doctor's care? ☐ **Yes** ☐ **No** **Who & what for?** _____

Insurance company _____ **ID #** _____

What is the purpose of this appointment? _____

What was the initial cause? _____

When did it begin _____ **Have you had the same or similar symptoms in the past?** ☐ Yes ☐ No

What makes it worse _____

What makes it better _____

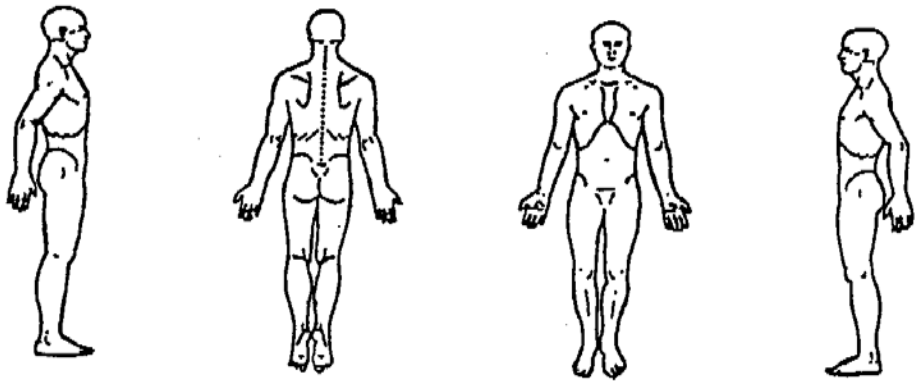
Which daily activities are affected by this problem?

☐ Work	☐ Sitting	☐ Stretching	☐ Recreation	☐ _____
☐ Sleep	☐ Standing	☐ Social Life	☐ Relationships	_____
☐ Walking	☐ Bending	☐ Sex	☐ Emotional	_____

What have you done about it? _____

What are your health goals? _____

Please indicate the areas of problem(s) on the appropriate figures below:



Pain Key:

^^^ Ache === Numbness
xxx Burning /// Stabbing
ooo Pins & needles

How often do you experience your symptoms?

- ☐ Constantly (76-100% of the time)
- ☐ Frequently (51-75% of the time)
- ☐ Occasionally (26-50% of the time)
- ☐ Intermittently (0-25% of the time)

Please put a mark on the scale to show how bad your usual discomfort has been recently.

No discomfort	0	1	2	3	4	5	6	7	8	9	10	Worst possible discomfort

PAST HISTORY

Below is a list of diseases that may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Anemia
- ☐ Measles
- ☐ HIV positive
- ☐ Mumps
- ☐ Small pox
- ☐ Chicken pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart disease
- ☐ Thyroid
- ☐ Allergies
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental disorders
- ☐ Lumbago
- ☐ Eczema
- ☐ Psoriasis

DO YOU USE:

- ☐ Coffee
- ☐ Tea
- ☐ Alcohol
- ☐ Cigarettes
- ☐ Former smoker?
- ☐ Pot
- ☐ White sugar

CHECK ANY OF THE FOLLOWING YOU HAVE HAD IN THE PAST 6 MONTHS:

MUSCULO-SKELETAL

- ☐ Low back pain
- ☐ Pain between shoulders
- ☐ Neck pain
- ☐ Arm pain
- ☐ Joint pain ☐ Stiffness
- ☐ Walking problems
- ☐ Difficulty chewing or ☐ Clicking jaw
- ☐ General stiffness

NERVOUS SYSTEM

- ☐ Nervous
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion or ☐ Depression
- ☐ Fainting
- ☐ Convulsions
- ☐ Tingling or ☐ Cold extremities
- ☐ Stress

GASTROINTESTINAL

- ☐ Poor or ☐ Excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Gall bladder problems
- ☐ Weight trouble
- ☐ Abdominal cramps (not menstrual)
- ☐ Gas or ☐ Bloating after meals
- ☐ Heartburn
- ☐ Black or ☐ Bloody stools
- ☐ Colitis

GENERAL

- ☐ Fatigue
- ☐ Allergies
- ☐ Loss of sleep
- ☐ Fever
- ☐ Headache ☐ Migraines

GENITO-URINARY

- ☐ Bladder trouble
- ☐ Painful or ☐ Excessive urination
- ☐ Discolored urine
- ☐ Prostate or ☐ Sexual dysfunction

CARDIO-VASCULAR

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ High blood pressure
- ☐ Irregular heartbeat
- ☐ Heart problems
- ☐ Lung problems or ☐ Congestion
- ☐ Varicose veins
- ☐ Ankle swelling
- ☐ Stroke

EYES EARS NOSE THROAT

- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Ear aches
- ☐ Hearing difficulty
- ☐ Stuffed nose

FEMALE ONLY

- ☐ Menstrual irregularity
- ☐ Menstrual cramps
- ☐ Vaginal pain or ☐ Infection
- ☐ Breast pain or ☐ lumps

Are you pregnant? ☐ Yes ☐ No

Date of last period: _____

MEDICATION or VITAMINS YOU TAKE?

- ☐ Birth control pills
- ☐ Aspirin/Tylenol
- ☐ Ibuprofen
- ☐ Pain killers
- ☐ Muscle relaxant
- ☐ Blood pressure
- ☐ Diabetic
- ☐ Thyroid
- ☐ Heart
- ☐ Hormones
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

MAJOR SURGERY OR OPERATIONS:

- ☐ Tonsils
- ☐ Appendix
- ☐ Gall bladder
- ☐ Hernia
- ☐ Heart
- ☐ Other
- ☐ **Pacemaker**
- ☐ Back
- ☐ Neck
- ☐ Hysterectomy
- ☐ Prostate

FAMILY HISTORY

	Alive	Dec'd	Present health/cause of death
Mother	☐	☐	
Father	☐	☐	
Brother	☐	☐	
Sister	☐	☐	
Child	☐	☐	

Were you ever emotionally, physically or sexually abused? ☐ Yes ☐ No

Name_____

Web of Wellness

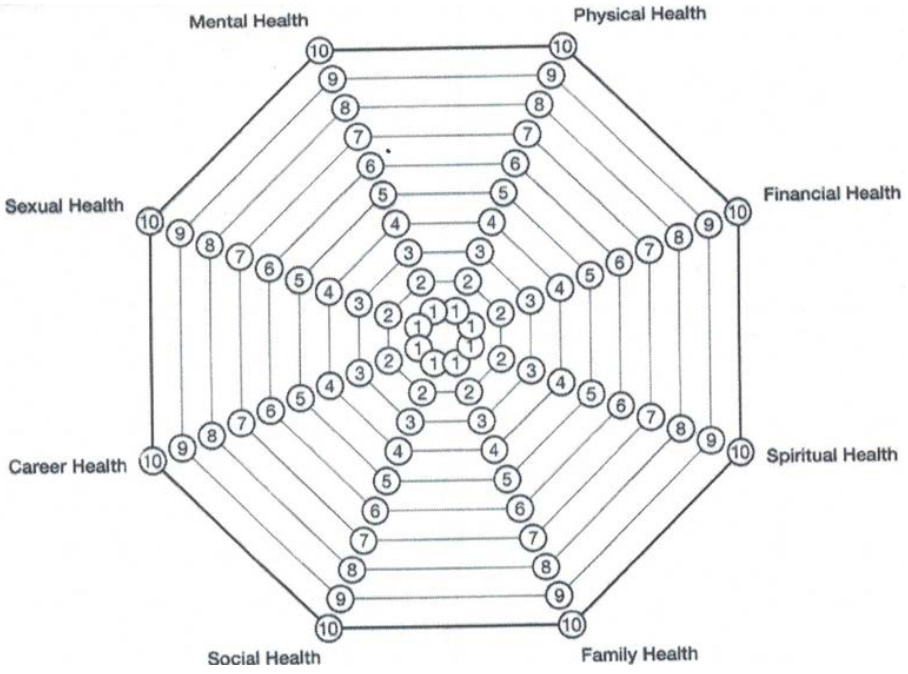
Health and wellness are a balance of many factors that affect our lives in many ways. These factors weave a web of health and well-being.

Using the diagram choose your level of satisfaction in each of the areas by shading in the appropriate circle.

"1" the center of the web being BEST and "10" extremely dissatisfied and "5" being neutral

1=GOOD

10=BAD



Commitment

On a scale from 1-10, how committed are you to correcting your problem(s)?

Not committed Looking for relief	0	1	2	3	4	5	6	7	8	9	10	Very Committed Willing to do what it takes

Describe other conditions that you would like us to help you with, if any.

_____

_____

_____

Medications & Supplements

Please list ALL medications, vitamins, minerals, or herbs currently take. Include all Rx or OTC items, inhalers and patches.

ITEM	DOSAGE	REASON FOR TAKING	HOW LONG?

Name_____

Cancellation Policy

Our office generally runs on a "no wait" schedule when patients come in on time. If we are running late, we try to call patients to give them notice and expect the same consideration.

If for any reason you will not be able to attend your scheduled appointment, you will be expected to call within 24 hours to cancel and reschedule. If cancellations are not reported within 24 hours, depending on circumstances, a $40 fee may be charged.

The missed appointment fee is $40. (Your insurance does not cover missed appointments). Fee must be paid in full prior to or at the time of your next scheduled appointment.

I have read and understand the Cancellation Policy and agree to be as courteous as possible in making and canceling appointments.

INITIAL HERE_____

Informed Consent for Treatment

I voluntarily consent to participate in treatment performed at the Center.

I understand that treatment may include, but not limited to, chiropractic, acupuncture, hypnotherapy, laser therapy, electrical stimulation, ultrasound, traction, massage, biopuncture, cupping, moxibustion, gua sha, tuina, nutritional counseling, herbal, homeopathic and food supplements.

I understand that while treatment is generally safe, it may have some rare side effects and risks that may include feeling sore, weak, nauseated, fainting, or dizziness.

I understand that bruising, hematomas, bleeding and/ temporary soreness may occur from acupuncture or cupping that may last a few days. No guarantees or assurances have been made regarding the results of these treatments or procedures.

I have not withheld any information about my medical history and except as stated, I am in good health.

By voluntarily signing below I verify that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of treatment, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I hereby authorize the Doctor to treat my condition as he deems appropriate using natural, non-invasive methods such as spinal adjustments, massage, nutrition or acupuncture.

To be completed by the patient or patient's representative, (e.g. if the patient is a minor or is physically or mentally incapacitated)

INITIAL HERE_____

Gardens Wholistic Health Center

Your medical information will be required to be disclosed by law in certain circumstances such as for billing and in case of emergency. If you wish to keep your medical information from being disclosed to insurance carriers, you may pay for your services in full when rendered.

Right to Request Confidential Contacts: You have the right to request that this office contact you about medical issues in a specific manner outside of normal practice, such as by mail. You must specify how and where you wish to be contacted and we'll try to accommodate any reasonable requests.

Right to Copy of this Notice: You have the right to a paper or electronic copy of this notice, which is available in our office and on the website – www.healthy-answers.com.

Changes to this Notice: This office reserves the right to change this notice and to make the revised notice effective for health information this office created or received about your prior to the revision, as well as to information it receives in the future. Revised notices will be available at the office and the above website.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with this office's Privacy Official or with the Secretary of the Department of Health and Human Services, Office of Civil Rights.
I hereby authorize the following individual(s) to receive information regarding my care (if desired):

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

You may notify me, or the parties listed above with appointment reminders, normal test results and other information regarding my health information as follows:

☐ Message on answering machine ☐ Message on cell phone ☐ Message on work voice mail

☐ Other:_____

I understand that this authorization will remain in effect until it is revoked by me in writing.

Print Name _____

Signature _____

Guardian's Signature if patient is a minor _____

Name_____

Consent for Purposes of Treatment, Payment and Healthcare Operations

I consent to use and disclosure of my Protected Health Information (PHI) for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the practice's diagnosis or treatment of me may be conditioned upon by my consent as evidenced by my signature on this document.

For purposes of this consent, PHI means any information, including my demographic information, created or received by the Practice, that relates to my past, present or future physical or mental health condition; the provision of health care to me; or past, present, or future payment for the provision of health care services to me; and that either indemnifies me from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my PHI for the purposes of treatment, payment of healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the practice.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to signing this document. The notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my PHI.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance to this consent.

INITIAL HERE_____

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

I understand and agree that health and accident policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Center will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care at this office any outstanding charges for professional services rendered will be immediately due and payable.

INITIAL HERE_____

FUNCTIONAL OUTCOME ASSESSMENT – For Neck & Back Problems

In order to properly assess your condition, we must understand how much your neck and/or back problems have affected your ability to manage everyday activities.
For each item below, please circle the number that most closely describes your condition right now.

1. Pain Intensity

0 1	2 3	4 5 6	7 8	9 10
No pain	Mild pain	Moderate pain	Severe pain	Worst possible pain

2. Sleeping

0 1	2 3	4 5 6	7 8	9 10
Perfect sleep	Mildly disturbed sleep	Moderately disturbed sleep	Greatly disturbed sleep	Totally disturbed sleep

3. Personal Care (washing, dressing, etc.)

0 1	2 3	4 5 6	7 8	9 10
No pain No restriction	Mild pain No restrictions	Moderate pain Need to go slowly	Moderate pain Need some assistance	Severe pain Need 100% assistance

4. Travel (driving, etc)

0 1	2 3	4 5 6	7 8	9 10
No pain on long trips	Mild pain on long trips	Moderate pain on long trips	Moderate pain on short trips	Severe pain on short trips

5. Work

0 1	2 3	4 5 6	7 8	9 10
Can do usual work plus unlimited extra work	Can do usual work: no extra work	Can do 50% of usual work	Can do 25% of usual work	Cannot work

6. Recreation

0 1	2 3	4 5 6	7 8	9 10
Can do all activities	Can do most activities	Can do some activities	Can do a few activities	Cannot do any activities

7. Frequency of Pain

0 1	2 3	4 5 6	7 8	9 10
No pain	Occasional pain 25% of the day	Intermittent pain 50% of the day	Frequent pain 75% of the day	Constant pain 100% of the day

8. Lifting

0 1	2 3	4 5 6	7 8	9 10
No pain with heavy weight	Increased pain with heavy weight	Increased pain with moderate weight	Increased pain with light weight	Increased pain with any weight

9. Walking

0 1	2 3	4 5 6	7 8	9 10
No pain any distance	Increased pain after 1 mile	Increased pain after 1/2 mile	Increased pain after 1/4 mile	Increased pain with any walking

10. Standing

0 1	2 3	4 5 6	7 8	9 10
No pain after several hours	Increased pain after several hours	Increased pain after 1 hour	Increased pain after 1/2 hour	Increased pain with any standing

Name _____ **Total Score** _____

Name_____ Date_____

The Hormone Balance Test

FOR WOMEN ONLY Check each symptom that applies to you

Group 1

- ☐ Insomnia
- ☐ Early Miscarriage
- ☐ Painful or lumpy breasts
- ☐ Unexplained weight gain
- ☐ Cyclical headaches
- ☐ Anxiety
- ☐ Infertility

Total Checked _____/ 8

Group 2

- ☐ Vaginal dryness
- ☐ Night sweats
- ☐ Painful intercourse
- ☐ Memory problems
- ☐ Bladder infections
- ☐ Lethargic depression
- ☐ Hot flashes

Total Checked _____/ 7

Group 3

- ☐ Puffiness and bloating
- ☐ Cervical dysplasia (abnormal pap test)
- ☐ Rapid weight gain
- ☐ Breast tenderness
- ☐ Mood swings
- ☐ Heavy bleeding
- ☐ Anxious depression
- ☐ Migraine headaches
- ☐ Insomnia
- ☐ Foggy thinking
- ☐ Red flush on face
- ☐ Gallbladder problems
- ☐ Weepiness

Total Checked _____/ 13

Group 4

This group is a combination of the symptoms in groups 1 and 3. If you've checked two or more in each of these two groups, you may belong to this group.

Total Checked _____

Group 5

- ☐ Acne
- ☐ Polycystic ovary syndrome
- ☐ Excessive hair on the face and arms
- ☐ Hypoglycemia
- ☐ Thinning hair on the head
- ☐ Infertility
- ☐ Ovarian cysts
- ☐ Midcycle pain

Total Checked _____ / 8

Group 6

- ☐ Debilitating fatigue
- ☐ Unstable blood sugar
- ☐ Foggy thinking
- ☐ Low blood pressure
- ☐ Thin and/or dry skin
- ☐ Intolerance to exercise
- ☐ Brown spots on face

Total Checked _____ / 7

FOR MEN ONLY:

Group 1

- ☐ Weight loss
- ☐ Loss of muscle
- ☐ Lower sex drive
- ☐ Fatigue
- ☐ Enlarged breasts
- ☐ Lower stamina
- ☐ Softer erections
- ☐ Gallbladder problems

Total Checked _____ / 8

Group 2

- ☐ Hair loss
- ☐ Prostate enlargement
- ☐ Irritability
- ☐ Puffiness / bloating
- ☐ Headaches
- ☐ Breast enlargement
- ☐ Weight gain

Total Checked _____ / 7

Download & Complete the form, then print it or save it and e-mail it to GWHC.info@gmail.com, or fax it to 562.370.6214