

# North Portland Wellness Center – New Patient Info

Welcome to the North Portland Wellness Center. Please print clearly and answer all questions as completely as possible.

Full Name: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Legal Last Name) (Legal First Name) (Middle) (Preferred First Name)

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ Sex/Gender:  Female  Male  Transgendered (circle: FtM/MtF)  Other: \_\_\_\_\_

Address: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
(Street/PO box) (City) (State) (Zip Code)

Phone #: (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
(Home) (Work) (Cell/Other)

PLEASE CHECK ALL THAT APPLY: I authorize NPWC to leave appointment reminders and detailed medical and insurance messages at any phone number EXCEPT my:  
 Home  Work  Cell/Other  
 I need special arrangements (please discuss w/ staff)

Email address: \_\_\_\_\_

Occupation/Employer: \_\_\_\_\_  Full-time  Part-time  Student  Retired  Unemployed

Are you:  Single  Married  Partnered  Divorced  Widowed Partner's Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: (\_\_\_\_\_) \_\_\_\_\_ Relationship: \_\_\_\_\_

**How did you hear about our clinic? Please select one of the following, and let us know whom to thank:**

- Live/Work in Neighborhood
- Insurance Company
- Citysearch
- Doctor/Clinic: \_\_\_\_\_
- Internet Search
- Event: \_\_\_\_\_
- Chinook Book
- Other: \_\_\_\_\_
- Personal Referral: \_\_\_\_\_

May we send you occasional coupons, discounts, event notices, and/or newsletters via email?  
 Y  N

## Primary Insurance

Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary on Policy?  Y  N, answer following for Primary Insured: Legal Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Insured's ID #: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

## Secondary Insurance, if applicable

Insurance Carrier: \_\_\_\_\_ Plan Name: \_\_\_\_\_

ID/Subscriber #: \_\_\_\_\_ Group #: \_\_\_\_\_

Primary on Policy?  Y  N, answer following for Primary Insured: Legal Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_

Insured's ID #: \_\_\_\_\_ Patient's Relationship to Insured: \_\_\_\_\_

## For Motor Vehicle Accidents or Work Injury Only

Insurance Carrier: \_\_\_\_\_ Claim #: \_\_\_\_\_ Claim Submitted:  Y  N

Date of Injury: \_\_\_/\_\_\_/\_\_\_ State where accident occurred: \_\_\_\_\_ Adjuster's Name: \_\_\_\_\_

Address for Claims: \_\_\_\_\_ Carrier or Adjuster's Phone #: \_\_\_\_\_

Attorney's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

By signing below, I verify that the above information is correct and true to the best of my knowledge. I hereby authorize North Portland Wellness Center to submit claims to my insurance carrier(s) or their intermediaries for all services rendered by North Portland Wellness Center and direct them to issue payment directly to North Portland Wellness Center. I understand I am responsible for all charges not covered by my insurance company.

\_\_\_\_\_  
Patient Signature (or Guardian if Patient is a minor)

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY:**

INITIAL: A C M

SECONDARY: A C M

TERTIARY: A C M

## Office Policies

**Please take the time to read, initial, and sign our *Office Policies* to acknowledge your understanding of them. We have found this policy to be most effective for both patients and providers. Outstanding balances can cause embarrassment and communication breakdowns, and potentially decrease adherence to the prescribed treatment program. If you have any questions regarding these agreements, please discuss them with NPWC staff.**

Your insurance policy is a contract between you and your insurance company. North Portland Wellness Center is not a party to that contract. As a service to you and upon your request we can bill your insurance provider. It is your responsibility to provide our office with your insurance details and present your insurance card to our staff so we can bill your insurance carrier completely and accurately. When possible, our staff will call to verify your insurance coverage prior to your appointment. Please be aware that an estimate of benefits is not a guarantee of payment. If an insurance company provides you or our staff with inaccurate information they may not honor the benefits that were quoted.

**Please initial here \_\_\_\_\_**

It is your responsibility to be aware of your coverage and co-pay, as well as any deductible and maximums, per your insurance contract. All co-payments, co-insurance payments, deductibles, supplements/products, supplies, therapeutic equipment, and costs of services not covered by your insurance company are due and payable at the time of each visit.

**Please initial here \_\_\_\_\_**

If you have a deductible and/or co-insurance, the amount you owe at each visit is based on your insurance carrier's usual and customary fee schedule. If this fee schedule is unknown at the time of service, patients with deductibles will pay \$75.00 per visit toward the cost of the service, and patients with a co-insurance will pay \$10.00 per visit toward the cost of the service. Any remaining portion owed by the patient will be billed and collected after the insurance carrier has notified us of payment or non-payment.

**Please initial here \_\_\_\_\_**

If a problem arises with collecting payment on an insurance claim, we will re-bill your insurance company. However, if the cost of collections become over and above what is usual and customary, we will contact you to arrange payment.

**Please initial here \_\_\_\_\_**

Your insurance provider may pay only a portion of the charge for your treatment. After your insurance carrier has notified us of payment or non-payment, any balances due to us will be billed to you. You are responsible to pay for any balance on your account. After ninety (90) days of the date of service, a 1.5% monthly finance charge or minimum \$3.00 monthly fee (whichever is greater) will begin to apply to the account. Considerably delinquent accounts are subject to collection procedures.

**Please initial here \_\_\_\_\_**

PLEASE NOTE: There is a \$50.00 fee for each no-show and/or appointment cancellation with less than 24 hours notice. When you schedule an appointment we reserve that time, carefully planned within the context of the week's schedule, exclusively for you. If you miss that appointment or cancel with less than 24 hours notice, it is too late to schedule another patient for your reserved appointment time. This results in a loss of income to both your practitioner and the clinic. In addition, we also incur administrative expenses related to scheduling, staffing, and housing your missed appointment. Therefore, we charge a fifty dollar fee for each no-show and/or appointment cancellation with less than 24 hours notice, regardless of the reason for the missed appointment. This fee cannot be billed to insurance and is fully the patient's responsibility. If you need to cancel or reschedule an appointment, please be sure to notify us at least 24 hours in advance to avoid being charged.

**Please initial here \_\_\_\_\_**

Arriving late for an appointment can disrupt your practitioner's schedule and the schedules of all subsequent patients. Therefore, out of respect for our patients and our practitioners, all late patients will have less time for their appointment(s) and will be charged in full. Patients arriving considerably late [ten (10) or more minutes for chiropractic appointments, twenty (20) or more minutes late for all other appointments] *may* have their appointment canceled. These instances are considered late cancellations and are subject to the \$50.00 fee described above.

**Please initial here \_\_\_\_\_**

*Office Policies continued on next page*

Once we receive payment from your insurance company, we will apply this to your bill. If we find you have a credit, this will remain on your account for use toward future services and/or purchases. If instead you would like to be issued a refund, please let us know and we will be happy to issue you a check.

**Please initial here \_\_\_\_\_**

Patients must be responsible for following the referral, prescription, or treatment plan prescribed by their physician, practitioner, and/or insurance provider. Insurance companies may not pay for services when the treatment plan is not followed, thus patients are responsible for scheduling and attending appointments accordingly.

**Please initial here \_\_\_\_\_**

Patients are responsible for notifying NPWC staff if their insurance coverage or details change.

**Please initial here \_\_\_\_\_**

Patients are financially responsible for the cost of supplements, herbal products, supplies and equipment - to be paid at the time of pick up. Special orders, however, must be paid at the time the order is placed. Where applicable, consider using your health savings account for the purchase of these items. We can supply you with an itemized receipt to provide proof of purchase. We are unable to give refunds or credits on any supplements or herbal products, opened or unopened. We cannot re-sell products that have left the office as we cannot guarantee that these items were protected from conditions that might affect their quality or integrity.

**Please initial here \_\_\_\_\_**

Gift cards/certificates are valid for a specified dollar amount and are not redeemable for cash. They must be presented at the time of service to be redeemed. We are not responsible for lost or stolen gift cards/certificates.

**Please initial here \_\_\_\_\_**

For your convenience, we accept the following forms of payment: cash, check, Visa, and MasterCard. It is not our policy to accept out-of-state checks. Please note, there is a \$30 fee for each returned check.

**Please initial here \_\_\_\_\_**

As a courtesy to our patients, we ask that you silence your cell phone and other personal devices when entering the center and step outside to take a phone call. We also ask that you use a soft voice while in the building, so as not to disturb other patients receiving treatment.

**Please initial here \_\_\_\_\_**

As a patient of North Portland Wellness Center, I acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Relationship to Patient (if not self)

\_\_\_\_\_  
Patient Signature (or Guardian if Patient is a minor)

\_\_\_\_\_  
Date

# Informed Consent to Treatment

**The purpose of this form is to present risks and benefits of the therapies offered at North Portland Wellness Center. While the chances of experiencing most of these complications listed below are small, it is the practice of this clinic to inform patients about them. This form must be signed before treatment is rendered. Please discuss any questions/concerns you may have with our staff or your practitioner.**

## ACUPUNCTURE

Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Side effects may include bruising, minor bleeding, discomfort, and on the rare occasion, fainting. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

## CHIROPRACTIC CARE/MANIPULATION

Chiropractic examinations and therapeutic procedures (including chiropractic manipulation, ultrasound, heat and cold application, electrotherapy and manual muscle therapy) are considered safe and effective methods of care. However, there are occasions when a procedure intended to help may have complications. These complications may include but are not limited to soreness, inflammation, soft tissue injury, dizziness, burns, and temporary worsening of symptoms. More serious complications, such as strokes and disc herniations, are extremely rare.

## NATUROPATHIC MEDICINE

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. Naturopathy treats a variety of conditions including women's health, stress, pain, organ dysfunction, infections, and more. There is risk of pharmaceutical/supplement interaction, so inform your practitioner of current medications. Your practitioner may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigue, detoxification reactions and irritated skin.

## MASSAGE THERAPY

The purpose of massage/soft tissue therapy is to decrease pain, tension and tenderness, while increasing blood and lymph flow. Your health concern may be caused by poor body mechanics and/or repetitive stress, in which case, exercises or stretches may be indicated. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased mobility, and relaxation are experienced.

## STEAM/HEAT/HYDROTHERAPY & DETOXIFYING BODY TREATMENTS

Steam, heat, hydrotherapy and other detoxifying body treatments (i.e. bodywraps) are helpful for many conditions, but may not be appropriate for everyone. With steam therapy, there is risk of scalding or serious burns if the patient comes into close proximity of the steam head. Patients should not touch or attempt to move/hold any body part over the steam head, as it releases very hot water. Patients with diabetes, heart disease, multiple sclerosis, abnormally high or low blood pressure, impaired temperature sensation, or who are pregnant or have any other recurrent or persistent medical condition should always consult their primary care physician before utilizing a steam shower or other body treatment. Steam therapy and body treatments can cause people to become tired. Elderly people and young children are more susceptible to exhaustion caused by heat and should avoid lengthy full-body treatments.

## SUPPLEMENTS, HERBALS, HOMEOPATHICS, ETC.

Your practitioner may suggest a product to aid your healing. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly, allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, and/or orthotics may be suggested for your particular health issue.

## IMAGING, REFERRALS

Further lab work (x-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors, and if there is a chance of pregnancy at any time during your care. If you would like additional information on side effects/complications that could result from treatment or product use, please discuss these with your practitioner.

I have read and understand the above statements concerning treatment side effects and risks, and I also understand that there is no guarantee for a specific cure or result. I understand both my rights and responsibilities in this practitioner/patient relationship.

I have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Relationship to Patient (if not self)

\_\_\_\_\_  
Patient Signature (or Guardian if Patient is a minor)

\_\_\_\_\_  
Date

# Privacy Practices

**As our patient, you have the right to know how your private, confidential healthcare and personal information is being protected. Below are the methods in which we secure your information confidentially in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).**

## **In-Office Security**

Notes that are taken during appointments are kept in your chart and are secured in our clinic at all times. If patient charts are in public areas, they are kept private with the names covered. Access to this office is limited to practitioners, employees, preceptors, and supervised guests.

## **Public Interaction**

Should we see you socially, by coincidence or intent, we will not acknowledge how we are acquainted unless you infer consent through introduction, etc. It is our preference to discuss your health only in the office setting to protect your privacy and to ensure that important information is kept in your chart.

## **Consultations**

North Portland Wellness Center practitioners consult with other healthcare practitioners and clinical/laboratory specialists while working on patient cases and treatment plans. These conversations and transfers of information by phone, fax, or email are confidential and names are not used unless necessary and consent is provided from you either verbally or in writing.

## **Records Released**

Your confidential healthcare information is private and cannot be copied and shared with anyone else without your written, signed consent. In some cases, if time does not permit, your verbal approval may be accepted after proper identification is acquired. Copies of released records are sent by mail or fax and are accompanied by a confidential patient information cover sheet, if faxed.

## **Definitions and Penalties to Comply**

Protected health information is any information, whether oral or recorded, in any form or medium that: 1) Is created or received by a healthcare provider, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse in the normal course of business, and 2) Related to the past, present, or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual. This information may reside in any medium: paper, disc, fax, email, and/or digital voice message.

I have read and understand my right to privacy, as stated above, and agree to have the practitioners/staff of North Portland Wellness Center maintain my records confidentially in accordance with the law. I agree to inform the practitioners and/or staff of North Portland Wellness Center if I need any special arrangements pertaining to this issue.

North Portland Wellness Center has the right to update the terms described in this Privacy Practices notice. I may obtain a revised Privacy Practices notice by calling the office and requesting a revised copy be sent in the mail, or by asking for one at my next appointment.

\_\_\_\_\_  
Patient Name (Please Print)

\_\_\_\_\_  
Relationship to Patient (if not self)

\_\_\_\_\_  
Patient Signature (or Guardian if Patient is a minor)

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY:** WE ATTEMPTED TO OBTAIN THE PATIENT'S SIGNATURE IN ACKNOWLEDGEMENT OF THIS NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WERE UNABLE TO DO SO AS DOCUMENTED BELOW:

Date: \_\_\_\_\_ Reason: \_\_\_\_\_ Staff Initials: \_\_\_\_\_

# Health History

Below you will find a number of questions related to your health history. For your convenience, we have tailored this information to be applicable to all modalities available at our clinic. While not all of the questions may seem directly related to your main complaint or reason for seeking care, your answers to these questions will inform your treatment throughout the course of your care at North Portland Wellness Center. Therefore, we ask you to be as thorough and thoughtful as possible as you consider the questions below.

## GENERAL INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**What are your current expectations in seeking treatment?**

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## HEALTH CONCERNS

**Primary Health Concern or Complaint:**

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How long have you had this complaint? \_\_\_\_\_

What caused the condition (if known)? \_\_\_\_\_

What have you done to address it? \_\_\_\_\_

Is it getting worse?  Yes  No

Is it aggravated by:  Standing  Sitting  Driving  Stress

Does it bother you:  Sleep  Work  Other: \_\_\_\_\_

**Other Concerns or Complaints:**

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Name of Your Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Seen for what condition? \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

**I hereby authorize North Portland Wellness Center to contact my primary care physician, as needed:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## DIAGNOSTICS

Which diagnostic studies have you had in the past **year**?

Electrocardiogram (EKG)  X-Ray  Bone Density Scan (DEXA)  CT Scan  
 Electroencephalogram (EEG)  Mammogram  MRI  Blood Drawn  Other: \_\_\_\_\_

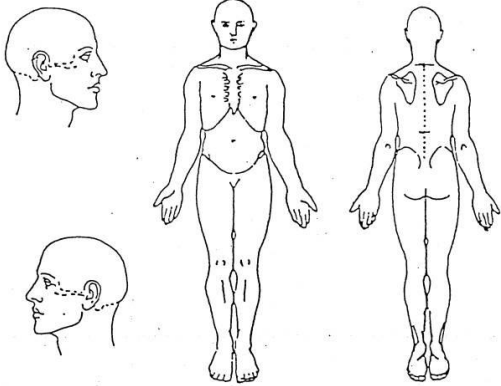
Have you been diagnosed with a particular condition?

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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**MUSCULO-SKELETAL/PAIN**

Please circle any areas where you currently experience **pain**.



**Please list the area of pain and circle level of pain severity**  
(0= no pain, 10= worst pain imaginable)

1. Area: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

2. Area: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

3. Area: \_\_\_\_\_ 0 1 2 3 4 5 6 7 8 9 10

**DO YOU HAVE ANY OF THE FOLLOWING?:**

<input type="checkbox"/> Generalized muscle pain or stiffness	<input type="checkbox"/> Numbness or tingling	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Swollen, painful, stiff joints	<input type="checkbox"/> Loss of strength	<input type="checkbox"/> Prosthesis
<input type="checkbox"/> Bone pain	<input type="checkbox"/> Hernia	<input type="checkbox"/> Breast Implants
<input type="checkbox"/> Tremors, twitches	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Body Jewelry

**CURRENT MEDICATIONS**

Do you take or use?

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Laxatives     | <input type="checkbox"/> Pain relievers     | <input type="checkbox"/> Antacids                     | <input type="checkbox"/> Oral Contraceptives       |
| <input type="checkbox"/> Cortisone     | <input type="checkbox"/> Hormones           | <input type="checkbox"/> Sleep Aids                   | <input type="checkbox"/> Blood Pressure medication |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Antidepressants/anti-anxiety | <input type="checkbox"/> Cholesterol medication    |
| <input type="checkbox"/> Coumadin      |   |   |  |

If you take or use the following, please list (use back of page, if necessary):

Prescription Medications:

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

Vitamins/Supplements/Herbals/Homeopathics

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

**HOSPITALIZATION, SURGERIES, & ACCIDENTS**

Have you had any of the following removed? List the date.

- |   |  |
|---|--|
| <input type="checkbox"/> Tonsils: _____     | <input type="checkbox"/> Cysts/Tumors: _____   |
| <input type="checkbox"/> Appendix: _____    | <input type="checkbox"/> Uterus/Ovaries: _____ |
| <input type="checkbox"/> Gallbladder: _____ | <input type="checkbox"/> Other: _____          |

What other hospitalizations, surgeries, or accidents have you had (use back of page, if necessary)?

\_\_\_\_\_ year: \_\_\_\_\_ year:

\_\_\_\_\_ year: \_\_\_\_\_ year:

**SYMPTOM SURVEY**

Please place a **check mark** next to all symptoms are you **CURRENTLY** experiencing or have experienced in the past **YEAR**. If there are multiple symptoms listed on one line, please **circle** all that apply.

<p><b>GENERAL SYMPTOMS</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nervousness, irritability, anxiety</li> <li><input type="checkbox"/> Mental tension</li> <li><input type="checkbox"/> Moodiness, depression, melancholy</li> <li><input type="checkbox"/> Tired, weak, lack of energy</li> <li><input type="checkbox"/> Sleeplessness, sleep too much</li> <li><input type="checkbox"/> Frequent colds or other illness</li> <li><input type="checkbox"/> Headaches</li> <li><input type="checkbox"/> Don't sweat enough</li> <li><input type="checkbox"/> Sweat too much</li> <li><input type="checkbox"/> Night sweats</li> <li><input type="checkbox"/> Dizziness, convulsions, fainting, seizures</li> <li><input type="checkbox"/> Loss or gain of weight</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p>Height: _____</p> <p>Current Weight: _____</p> <p>Weight 1 Year Ago: _____</p> <p>Max Weight: _____ When: _____</p> <p><b>GASTROINTESTINAL</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Loss of appetite</li> <li><input type="checkbox"/> Gagging, difficulty swallowing</li> <li><input type="checkbox"/> Nausea, vomiting</li> <li><input type="checkbox"/> Bad breath, taste in mouth</li> <li><input type="checkbox"/> Food cravings – i.e. sweet, salty, other</li> <li><input type="checkbox"/> Difficulty digesting fats</li> <li><input type="checkbox"/> Heartburn, indigestion or distress</li> <li><input type="checkbox"/> Heaviness or fatigue after eating</li> <li><input type="checkbox"/> Gas, belching, bloating</li> <li><input type="checkbox"/> Stomach or abdomen tender or painful</li> <li><input type="checkbox"/> Symptoms relieved/worsened after eating</li> <li><input type="checkbox"/> Sensitivity/avoid certain foods</li> <li><input type="checkbox"/> Headache, dizziness, irritability if meals are skipped</li> <li><input type="checkbox"/> Diarrhea or loose stools</li> <li><input type="checkbox"/> Constipation</li> <li><input type="checkbox"/> Light colored or greasy stools</li> <li><input type="checkbox"/> Dark stools, blood in stools</li> <li><input type="checkbox"/> Undigested food in stools</li> <li><input type="checkbox"/> Feeling of incomplete evacuation</li> <li><input type="checkbox"/> Foul odor of stool or gas</li> <li><input type="checkbox"/> Hemorrhoids, anal fissure</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>URINARY</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Difficulty urinating</li> <li><input type="checkbox"/> Urinate frequently at night</li> <li><input type="checkbox"/> Bed-wetting</li> <li><input type="checkbox"/> Incomplete urination or dribbling</li> <li><input type="checkbox"/> Pain when urinating</li> <li><input type="checkbox"/> Bladder infections</li> <li><input type="checkbox"/> Kidney infections</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Other: _____</li> </ul>	<p><b>CARDIOVASCULAR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Irregular or fast heart beat</li> <li><input type="checkbox"/> Pacemaker</li> <li><input type="checkbox"/> Chest tightness</li> <li><input type="checkbox"/> Discomfort at high altitudes</li> <li><input type="checkbox"/> Dizziness or weakness on standing</li> <li><input type="checkbox"/> Swollen feet, ankles or legs</li> <li><input type="checkbox"/> Cold hands or feet</li> <li><input type="checkbox"/> Hands or feet turn blue, blue fingernails</li> <li><input type="checkbox"/> Leg pains when walking, varicose veins</li> <li><input type="checkbox"/> Tendency to anemia</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Low blood pressure</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>EYE, EAR, NOSE, AND THROAT</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Nearsightedness, farsightedness</li> <li><input type="checkbox"/> Blurred, failing vision, night blindness</li> <li><input type="checkbox"/> Dryness, burning, itching</li> <li><input type="checkbox"/> Eyes water excessively</li> <li><input type="checkbox"/> Sensitivity to light, floaters</li> <li><input type="checkbox"/> Bloodshot, puffy eyes</li> <li><input type="checkbox"/> Earaches</li> <li><input type="checkbox"/> Noises, ringing in ears</li> <li><input type="checkbox"/> Ear discharge, excessive wax</li> <li><input type="checkbox"/> Loss of hearing</li> <li><input type="checkbox"/> Difficulty breathing</li> <li><input type="checkbox"/> Shortness of breath on exertion</li> <li><input type="checkbox"/> Spitting up mucus or blood</li> <li><input type="checkbox"/> Chest pain</li> <li><input type="checkbox"/> Hay fever, sinusitis, runny nose</li> <li><input type="checkbox"/> Dry mouth or nose, dry or chapped lips</li> <li><input type="checkbox"/> Nosebleeds, bleeding gums</li> <li><input type="checkbox"/> Sore throats, tonsillitis</li> <li><input type="checkbox"/> Clear throat a lot</li> <li><input type="checkbox"/> Sore, red, cracked tongue</li> <li><input type="checkbox"/> Cold sores, herpes</li> <li><input type="checkbox"/> Loss of smell or taste</li> <li><input type="checkbox"/> Hoarseness</li> <li><input type="checkbox"/> Other: _____</li> </ul> <p><b>SKIN AND HAIR</b></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Acne, pimples</li> <li><input type="checkbox"/> Skin rashes, hives</li> <li><input type="checkbox"/> Skin ulcers or sores</li> <li><input type="checkbox"/> Flush easily</li> <li><input type="checkbox"/> Hair loss, thinning</li> <li><input type="checkbox"/> Dry, course hair, split ends</li> <li><input type="checkbox"/> Bruise easily</li> <li><input type="checkbox"/> Brown spots, browning of skin</li> <li><input type="checkbox"/> Moles, warts, skin tags</li> <li><input type="checkbox"/> Sunburn easily</li> <li><input type="checkbox"/> Cuts heal slowly, scar badly</li> <li><input type="checkbox"/> Dryness, roughness, scaling: _____</li> <li><input type="checkbox"/> Athlete's Foot, toe fungus</li> </ul>
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Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

<p><b>FEMALE - SPECIFIC</b></p> <p>1<sup>st</sup> Day of Last Period: _____</p> <p>Typical # of bleeding days: _____</p> <p>Typical Length of cycle: _____</p> <p>Date of last pap smear: _____</p> <p>Was it normal? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Number of pregnancies: _____</p> <p>Number of live births: _____</p> <p>Number of miscarriages: _____</p> <p>Number of abortions: _____</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>How many weeks? _____</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Depressed, tense, irritability w/ periods</p> <p><input type="checkbox"/> Painful or swollen breasts</p> <p><input type="checkbox"/> Discharge from breasts</p> <p><input type="checkbox"/> Lumps in breasts</p> <p><input type="checkbox"/> Irregular cycles</p> <p><input type="checkbox"/> Pain during intercourse</p> <p><input type="checkbox"/> Diminished or excessive sexual desire</p> <p><input type="checkbox"/> Difficulty having orgasm</p> <p><input type="checkbox"/> Painful menses, clotting</p> <p><input type="checkbox"/> Excessive flow</p> <p><input type="checkbox"/> Vaginal discharge/dryness</p> <p><input type="checkbox"/> Pain, discomfort, itching in genital area</p> <p><input type="checkbox"/> Use birth control: _____</p> <p><input type="checkbox"/> Difficulty conceiving</p> <p><input type="checkbox"/> Menopausal symptoms</p> <p><input type="checkbox"/> STDs</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>MALE - SPECIFIC</b></p> <p><input type="checkbox"/> Difficult or unusual urination</p> <p><input type="checkbox"/> Discomfort or pain in genital area</p> <p><input type="checkbox"/> Diminished or excessive sexual desires</p> <p><input type="checkbox"/> Difficulty in maintaining an erection</p> <p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Prostate problems</p> <p><input type="checkbox"/> Hernias</p> <p><input type="checkbox"/> STDs</p> <p><input type="checkbox"/> Other: _____</p> <p><b>MISCELLANEOUS</b></p> <p><input type="checkbox"/> Traveled outside the USA within the last two years to: _____</p> <p>Have you ever been diagnosed or exposed to the following:</p> <p><input type="checkbox"/> HIV                      Diagnosis &amp; Treatment Dates: _____</p> <p><input type="checkbox"/> Hepatitis                Diagnosis &amp; Treatment Dates: _____</p> <p><input type="checkbox"/> Tuberculosis          Diagnosis &amp; Treatment Dates: _____</p> <p>Have you ever been exposed in significant or long-term doses to:</p> <p><input type="checkbox"/> Chemicals                      <input type="checkbox"/> Toxins</p> <p><input type="checkbox"/> Radiation                      <input type="checkbox"/> Other: _____</p> <p><b>HABITS/LIFESTYLE</b></p> <p>How do you rate your stress level on a scale of 1-10? 0 = lowest, 10 = highest: _____</p> <p>Do you consume:</p> <p><input type="checkbox"/> Cigarettes or tobacco        _____ packs a day</p> <p><input type="checkbox"/> Coffee/tea/soda                _____ cups a day</p> <p><input type="checkbox"/> Sugar                                _____ times a day</p> <p><input type="checkbox"/> Processed/Fast foods        _____ times a day</p> <p><input type="checkbox"/> Alcohol                            _____ drinks per week</p> <p><input type="checkbox"/> Marijuana/other drugs        _____ times per week</p> <p>How much water do you drink a day? _____</p> <p>Do you exercise regularly? What and how often? _____</p>
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**TYPICAL FOOD INTAKE**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

Drinks: \_\_\_\_\_

Do you strongly desire any particular foods?  
\_\_\_\_\_

Do you strongly dislike any particular foods?  
\_\_\_\_\_

Are there any foods that aggravate any of your symptoms or make you feel bad?  
\_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**ALLERGIES**

Are you hypersensitive or allergic to any of the following? Please list.

Medications: \_\_\_\_\_ Environmental: \_\_\_\_\_  
 Foods: \_\_\_\_\_ Chemicals: \_\_\_\_\_  
 Plants: \_\_\_\_\_ Latex: \_\_\_\_\_  
 Animals: \_\_\_\_\_ MSG: \_\_\_\_\_  
 Pollens: \_\_\_\_\_ Other: \_\_\_\_\_

**FAMILY HISTORY**

Please check here if you are adopted or otherwise unaware of your family’s medical history

Please Check All that Apply	Self	Mother	Father	Grandpar.	Siblings	Children	Spouse
Cancer							
Heart Disease							
Digestive Problems							
Respiratory Problems							
Urinary Tract Problems							
Diabetes							
Hypoglycemia							
Thyroid Disease							
Gall Bladder Problems							
Low/High Blood Pressure							
Anemia							
Migraines							
Stroke							
Epilepsy							
Tuberculosis							
Allergies							
Asthma							
Arthritis/Rheumatoid Arthritis							
Blood Disorder							
Kidney Disease							
Lupus							
Mental Health Issues/Concerns							
Birth Defects							
Substance Dependency							
Age at death, if applicable	NA						
Cause of death	NA						
Other							

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

# MVA Supplemental Intake

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## DESCRIPTION OF ACCIDENT

Describe your vehicle involved in this accident (type, make, model):

\_\_\_\_\_

State the location/address where the accident took place:

\_\_\_\_\_

Describe your experience of the accident:

\_\_\_\_\_

\_\_\_\_\_

**Driver**, which of your hands were on the steering wheel:  Right  Left  Both  None

**Passenger**, were you sitting in:  Front  Right Rear  Left Rear

Were you wearing a seat belt:  Yes  No

Approximate speed of your vehicle at the time of accident: \_\_\_\_\_ MPH      Approximate speed of other vehicle: \_\_\_\_\_ MPH

Did your vehicle strike another vehicle:  Yes  No, the other vehicle struck your vehicle

## COLLISION DETAILS

What was the angle of impact of the first collision:  Front  Back  Right  Left

If applicable, what was the angle of impact of the second collision:  Front  Back  Right  Left

Did you brace for impact, and how:  Yes, with my hands  Yes, with my feet  No

Which way were you facing at the time of impact:  Straight ahead  Right  Left

Did your body strike any of the following at the time of impact:

Steering Wheel       Dashboard       Right-side Door       Right-side Window       Other: \_\_\_\_\_  
 Windshield       Roof       Left-side Door       Left-side Window       No, I didn't strike anything

Did the seat back bend or break:  Yes  No

## HOSPITALIZATION & TREATMENT FOLLOWING ACCIDENT

Immediately following the accident, how did you feel:

Dizzy/Dazed       Nervous       Upset       Unconscious  
 Disoriented       Nauseous       Weak       Other: \_\_\_\_\_

Did you go to the hospital:  At the time of accident  Next day  No, did not go to the hospital

How were you transported to the hospital:  Ambulance  Police car  Private transportation

Were you admitted to the hospital:  Yes  No

If yes, how long were you there: \_\_\_\_\_

Name of Hospital: \_\_\_\_\_ Attended by Dr. \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

What treatment did you receive at the hospital:

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> Cervical collar    | <input type="checkbox"/> Pain medication  | <input type="checkbox"/> Instructions on concussions             | <input type="checkbox"/> Instructions to call private physician |
| <input type="checkbox"/> X-rays             | <input type="checkbox"/> Bandages         | <input type="checkbox"/> Instructions on sprains/strains         | <input type="checkbox"/> Referred to this office for treatment  |
| <input type="checkbox"/> Stitches           | <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Instructions to call orthopedic surgeon | <input type="checkbox"/> Other: _____                           |
| <input type="checkbox"/> No treatment given |   |  |   |

**PREVIOUS ACCIDENTS & INJURIES**

Describe any accidents you have been involved in, previous to this one:

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Describe any injuries you have been sustained, previous to this accident:

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Were you still experiencing pain/symptoms from the above accidents and injuries **before** your current accident occurred?

- Yes    No, I felt 100% better

If yes, how much better did you feel **prior** to your current accident? For example, 80% better, 50% better, etc: \_\_\_\_\_

**POST-ACCIDENT**

Since the accident, do you fear driving in a car:  Yes    No

Have you lost any time from work due to your injuries:  Yes, list dates: \_\_\_\_\_  No

Type of employment:

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