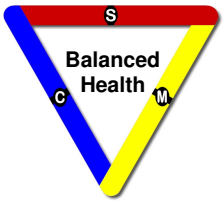
Natural Health Center

The Art & Science of Natural Healthcare



13384 Jones Road ◆ Houston, TX 77070
Phone: (281) 897-8818 ◆ www.nhchouston.com ◆ Fax: (281) 897-8817

New Structural Patient Instructions and Information

Thank you for choosing Natural Health Center for your natural healthcare needs. In order for you to get the most out of the new patient workup there are a few simple guildlines that should be followed:

1. Arrive 15 minutes earlier than your scheduled appointment time.
2. Have the all of the paperwork in this packet completed prior to arrival for your 1st appointment, and call the clinic in advance if you have any questions regarding any of the paperwork.
3. Bring all of your completed paperwork along with you.

That is it!

We look forward to meeting you,

Natural Health Center Staff

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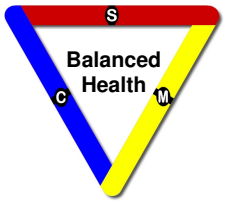

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Confidential Intake Form

CONTACT INFORMATION

Last Name | **First Name**

Address | **City** | **State** | **Zip**

Email Address

Home Phone ( ) | **Work Phone** ( ) | **Cell Phone** ( )

Employer | **Position**

OTHER INFORMATION

Birthday (mm/dd/yy) / / | **Age** | **Gender** M / F | **Social Security Number** - - | **Driver's License #**

Referred by

GENERAL HEALTH INFORMATION

Height ' " | **Weight** lbs | **Adult Min.** lbs | **Adult Max.** lbs

PURPOSE(S) AND/OR HEALTH CONCERN(S)

Instructions: List the purpose(s) of this appointment and/or each major health concern you have.

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

Current Health History

HEALTH CONCERN INFORMATION

Instructions: Fill out separate 'Current Health History' sheets for <u>each</u> health concern you listed above (there are multiple sheets provided for each). Mark the location of the concern or area pain on the diagram provided.

Purpose/Concern: _____

_____

_____

_____

_____

_____

When did this begin?_____

How (if known) did this begin?_____

_____

_____

_____

Have you had this before? ❑No ❑Yes, when: _____

What makes this worse? _____

_____

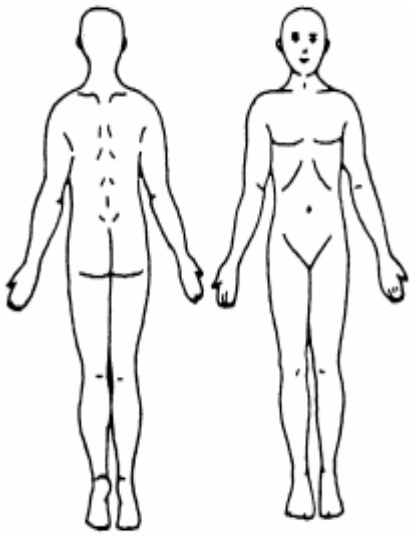
_____

What makes this better? _____

_____

_____

<u>Location of health concern</u>



Circle the current intensity of this on a scale of 0 (no problem) to 10 (the worst): 0 1 2 3 4 5 6 7 8 9 10

Is this getting worse? ❑No ❑Yes ❑Comes and goes ❑It is constant

Is this worse at a certain time of day/month? _____

What does this prevent you from doing?_____

_____

_____

Did you see other doctors for this? ❑No ❑Yes, Dr.'s name(s): _____

_____

Treatment:_____ Results:_____

Is this an accident related condition? ❑No ❑Work injury ❑Automobile injury ❑Other injury

NOTES

Past Health History – Page 1

PAST SURGERIES

Check any of the following surgeries you have had. Include approximate dates:

❑ Appendectomy_____ ❑ Tonsillectomy:_____ ❑ Gall Bladder:_____ ❑ Hernia:_____

❑ Back:_____ ❑ Neck:_____ ❑ Broken Bones:_____ ❑ Mastectomy: _____

List any others. Include approximate dates:

1. _____ Date: _____
2. _____ Date: _____

PAST DISEASES AND INFECTIONS

Check any of the following diseases or infections you have had:

			Notes:
❑ Pneumonia	❑ Mumps	❑ Influenza	
❑ Anemia	❑ Heart Disease	❑ High Blood Pressure	
❑ Measles	❑ Thyroid Disorder	❑ Eczema	
❑ Polio	❑ Chicken Pox	❑ Arthritis	
❑ Rheumatic Fever	❑ Small Pox	❑ Pleurisy	
❑ Tuberculosis	❑ Diabetes	❑ Epilepsy	
❑ Whooping Cough	❑ Cancer	❑ Mental Disorders	
❑ HIV +	❑ Hepatitis C	❑ High Cholesterol	

PAST TRAUMAS AND ACCIDENTS

List all previous traumas or accidents that might be related to your current health concern(s):

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

HOSPITALIZATIONS

List any/all previous hospitalization you have had, please include approximate dates:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

ALLERGIES

List any known allergies you have: _____

_____

HABITS AND SOCIAL HISTORY

Check any of the following that apply and describe the amount:

Intake	**Quantity**	**Intake**	**Quantity**
❑ **Coffee**		❑ **Sugar/Starches**	
❑ **Tea**		❑ **Soft Drinks**	
❑ **Alcohol**		❑ **Fast Food**	
❑ **Cigarettes**		❑ **Meals/Day**	
❑ **Cigars**		❑ **Exercise**	
❑ **Other Tobacco**		❑ **Sleep**	
❑ **Recreational Drugs**		❑ **Other**	

Past Health History – Page 2

MEDICATIONS AND NUTRITIONAL SUPPLEMENTS

Medication	Dose/Frequency	Purpose	Medication	Dose/Frequency	Purpose
1.	/		11.	/	
2.	/		12.	/	
3.	/		13.	/	
4.	/		14.	/	
5.	/		15.	/	
6.	/		16.	/	
7.	/		17.	/	
8.	/		18.	/	
9.	/		19.	/	
10.	/		20.	/	

FAMILY HISTORY

Instructions: Please indicate if any of the following family members have any disease(s), if they have passed on please indicate the cause of death and approximate age when they died.

Father:
Father's Mother:
Father's Father:
Father's Grandparents:
Father's Siblings:
Mother:
Mother's Mother:
Mother's Father:
Mother's Grandparents:
Mother's Siblings:
Your Siblings:
Your Children:

FEMALE ONLY SECTION

Are your periods regular? ❑Yes ❑No, explain: _____

Age of onset:_____ Date of last period:_____ How often do you have your cycle? Every _____ days.

Your period lasts for:_____ days (start to finish). Menstrual flow: ❑Light ❑Medium ❑Heavy ❑Other: _____

Do you take birth control pills or HRT? ❑No ❑Yes, what type:_____

Check all of the following premenstrual symptoms that apply:

❑ Anxiety	❑ Heavy Bleeding	❑ Bloating	❑ Depression	❑ Muscle Pains
❑ Irritability	❑ Prolonged Bleeding	❑ Breast Tenderness	❑ Headaches/Migraines	❑ Joint Pains
❑ Anger	❑ Clots	❑ Breast Enlargement	❑ Food Cravings	❑ Back Pain
❑ Agitation	❑ Water Retention	❑ Fibrocystic Breasts	❑ Sweet Cravings	❑ Acne
❑ Cramps	❑ Weight Gain	❑ Mood Swings	❑ Chocolate Cravings	❑ Foggy Thinking
❑ Fat Gain	❑ Cold Hands/Feet	❑ Blood Sugar Problems	❑ Irregular Periods	❑ Decreased Sex Drive
❑ Gall Bladder	❑ Infertility	❑ Insomnia	❑ Osteoporosis	❑ Endometriosis
❑ Polycystic Ovaries	❑ Fibroids	❑ Cervical Dysplasia	❑ Autoimmune Disorder	❑ Cancer

MALE ONLY SECTION

Do you have a history of prostate problems? ❑No ❑Yes, explain: _____

List any additional male related changes/issues/concerns: _____

Past Health History – Page 3

REVIEW OF SYSTEMS

1A Survey

1. Have you ever taken Pondimin (Fenfluramine) in the past? ❑Yes ❑No
2. In the last year, have you experienced any of the following problems? Check all that apply:

- ❑ Eating Disorders
- ❑ Compulsivity (including compulsive eating)
- ❑ Increased hunger & weight gain after dieting
- ❑ Myoclonus (twitching muscles or legs)
- ❑ Depression
- ❑ Anxiety
- ❑ Panic Attacks
- ❑ Irritable Bowel Syndrome
- ❑ Migraine Headaches
- ❑ PMS
- ❑ Insomnia (sleep <4 hours per night with wake ups)
- ❑ Anorexia
- ❑ Bulimia
- ❑ Impulsivity
- ❑ Obsessionality
- ❑ Fibromyalgia
- ❑ Neurodermatitis
- ❑ Sleep Apnea
- ❑ TMJ Syndrome
- ❑ Bipolar Disorder
- ❑ Mania
- ❑ Aggression
- ❑ Self-Injury
- ❑ Chronic Pain States

NOTES:

Natural Health Center Clinic Policies

NOTICE OF FINANCIAL RESPONSIBILITY

The Natural Health Center is very pleased to have you as a new patient. We are honored you have selected our clinic for your care.

In many cases, your insurance will pay for part or all of chiropractic care. We will work with you to insure that you have all necessary documentation to file with your insurance carrier, motor vehicle insurer, or work related insurer, so they can process and pay your claims in a timely manner. However, our relationship is directly with you and not with your insurance company. You are receiving the services, and therefore you have the final responsibility to pay for those services.

Should you be covered by Medicare, you will not be eligible to submit your claims to them since we are not a Medicare provider.

If you are receiving treatment as a result of a motor vehicle accident, you are responsible for paying all costs for treatment not reimbursed by the Personal Injury Protection (PIP) coverage under a motor vehicle insurance policy or other insurance policy. If your motor claim is in dispute and there is no other insurance coverage for your treatments, we may agree to wait for payment until your legal case is settled or we may agree to accept regular monthly payments on your account. In any event, you are ultimately responsible for payment in full for services that you receive.

If it is necessary to initiate action to collect any unpaid balance on your account, you agree to pay reasonable costs of collection, including necessary attorney fees and court costs.

COLLECTION POLICY

1. The office collection policy is to collect full payment for the services rendered at the time of service.

2. There will be a charge for appointments not cancelled 24 hours before the scheduled appointment.

3. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY UNPAID BALANCES.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Natural Health Center or its billing agent to relaease any information acquired in the course of my care to my insurance company or persons representing my case.

ACKNOWLEDGEMENT OF CLINIC POLICIES

My signature below is proof that I have read and understand the above policies for Natural Health Center.

Signature_____ **Date**_____

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name_____ **Date**_____

Please rate each of the following symptoms based upon your health profile for the past 30 days:

Point Scale:

0 = **Never** or **Almost Never** have the symptom
1 = **Occasionally** have it, effect is not severe
2 = **Occasionally** have it, effect is severe
3 = **Frequently** have it, effect is not severe
4 = **Frequently** have it, effect is severe

Digestive Systems:
_____ Nausea or vomiting
_____ Diarrhea
_____ Constipation
_____ Belching, passing gas
_____ Bloated Feeling
_____ Heartburn
_____ Intestinal/stomach pain

Ears:
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears
_____ Hearing loss

Emotions:
_____ Mood Swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Energy / Activity:
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Eyes:
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision

Head:
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Heart:
_____ Chest Pain
_____ Skipped Heartbeat
_____ Rapid heartbeat

Weight:
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Water retention
_____ Underweight
_____ Compulsive eating

Joint / Muscles:
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness, limited movement
_____ Weakness or tiredness on joints
_____ Pain or aches in muscles

Lungs:
_____ Chest Congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Mind:
_____ Poor memory
_____ Confusion
_____ Difficulty making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning Disabilities
_____ Poor concentration
_____ Poor Coordination

Mouth / Throat:
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness
_____ Swollen or discolored tongue, gums, lips
_____ Canker Sores

Nose:
_____ Stuffy Nose
_____ Sinus Problems
_____ Hay Fever
_____ Sneezing attacks
_____ Excessive mucus formation

Skin:
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Other:
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Grand Total: _____