healthcarecomplete

NUTRITION NEW PATIENT INFORMATION FORM

Name_____ Date _____
Address _____ Apt.#_____
City _____ State_____ ZIP _____
Shipping Address _____
_____
Home Phone (____) ____-_____ Work Phone (____) ____-_____
e-mail address: _____
REFERRED BY:_____
Occupation _____ Employer_____
Date of Birth _____ Age ____ Sex: M/F Height _____ Weight _____
Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____
Chief complaint (reason you are here): (use separate sheet if more room needed)
_____
_____
_____
_____
_____
Previous treatments for this complaint _____
_____
Other complaints or problems: (use back if needed)_____
_____
Current medications/drugs being taken: (use separate sheet if needed) _____
_____
Are you currently under the care of a physician or other health care professionals?
(If yes, please give name and date of last visit):
_____
Nutritional supplements you are taking: _____
Do you smoke, drink coffee or alcohol? (if yes indicate how much per week)
Cigarettes _____ Coffee _____ Alcohol _____

1. **Dietary Intake for 2 days before appointment:**

Breakfast:	**Breakfast:**
Lunch:	**Lunch:**
Dinner:	**Dinner:**
Snacks:	**Snacks:**

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PAST HEALTH HISTORY

Please Check and Describe:

Major Surgery/Operations: □ Appendectomy □ Tonsillectomy □ Gall Bladder □ Hernia □ Back Surgery □ Broken Bones

□ Other (please list details)_____

Major Accidents Or Falls: _____

Hospitalization (Other Than Above): _____
Previous Chiropractic Care: □ None □ Doctor's Name & Approximate Date of Last Visit: _____
Date of Last: Spinal X-ray _____MRI _____(region:_____) Physical Exam:_____

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

CHECK ANY OF THE FOLLOWING DISEASES or SYMPTOMS YOU HAVE HAD:

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer (type: _____)
- ☐ Heart Disease
- ☐ Thyroid
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorders
- ☐ Lumbago
- ☐ Eczema

Have you been tested HIV Positive? ☐ Yes ☐ No

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

MUSCULO-SKELETAL

- ☐ Low Back Pain
- ☐ Pain Between Shoulders
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain/Stiffness
- ☐ Walking Problems
- ☐ Difficult Chewing/Clicking Jaw
- ☐ General Stiffness
- ☐ Gas/Bloating After Meals
- ☐ Heartburn/Reflux
- ☐ Black/Bloody Stool
- ☐ Irritable Bowel/Colitis/Chron's

NERVOUS SYSTEM

- ☐ Weakness in arms/legs/body
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Cold or discolored extremities
- ☐ Fainting
- ☐ Convulsions or Seizures
- ☐ Tingling Extremities

GENITO-URINARY

- ☐ Bladder Trouble
- ☐ Painful/Excessive Urination
- ☐ Discolored Urine
- ☐ Kidney Stones

C-V-R

- ☐ Chest Pain
- ☐ Short Breath
- ☐ Blood Pressure Problems
- ☐ Irregular Heartbeat
- ☐ Heart Problems or congenital defect
- ☐ Lung Problems/Congestion
- ☐ Varicose Veins
- ☐ Ankle Swelling
- ☐ Stroke

EENT

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches or Infection
- ☐ Hearing Difficulty
- ☐ Stuffed Nose or Sinus Infection
- ☐ Ringing in the ears

FEMALES ONLY

When was your last period?

_____

Are you Pregnant?

☐ Yes ☐ No

MENTAL/EMOTIONAL

- ☐ Anxiety
- ☐ Psychotic episodes
- ☐ Attempted suicide in lifetime
- ☐ Anger/aggression
- ☐ Attention Deficit
- ☐ Depression

MALE/FEMALE

- ☐ Menstrual Irregularity
- ☐ Menstrual Cramps
- ☐ Vaginal Pain/Infection
- ☐ Breast Pain/Lumps
- ☐ Prostate/Sexual Dysfunction
- ☐ Other Problems

PAST HEALTH HISTORY (cont.)

GENERAL

- ☐ Fatigue
- ☐ Loss of Sleep
- ☐ Fever
- ☐ Headaches
- ☐ Allergies: List: _____

GASTRO-INTESTINAL

- ☐ Poor/Excessive Appetite
- ☐ Excessive Thirst
- ☐ Frequent Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver Problems
- ☐ Gall Bladder Problems
- ☐ Weight Trouble
- ☐ Abdominal Cramps

FAMILY HISTORY

List family members with the following illnesses:

- ☐ Heart Disease _____
- ☐ Cancer _____
- ☐ Diabetes _____
- ☐ Stroke _____
- ☐ Neurological Disorder _____
- ☐ Other _____

EXERCISE

- ☐ None
- ☐ Mild 1-2x/wk
- ☐ Moderate 3x/wk
- ☐ Daily
- ☐ Heavy (daily and intense)

HABITS

- ☐ Smoking Pack/day _____
- ☐ Alcohol Drinks/wk _____
- ☐ Coffee/Caffeine Cups/day ___
- ☐ High Stress Level
  Reason _____

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Marital Status: S M D W Name of Spouse_____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	____	M/F	_____
_____	____	M/F	_____
_____	____	M/F	_____

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

Any household pets or other animals you or family members are in close contact with:

_____

What can we do to make you happier? _____

_____

During the initial visit, the doctor will be evaluating your body for signs of nutritional deficiencies using the Nutrition Response Testing (NRT) technique. The doctor's analysis and recommended treatment is not intended to diagnose or treat any disease or dysfunction. During the second office visit, the doctor's findings and recommendations will be reported to you. Dietary and supplement recommendations are intended to support your body's normal physiology and biochemistry. Recommended nutritional supplementation is customized for your individual needs and should not be self-prescribed. Supplements in this office consist of high quality whole food concentrates, herbs and homeopathic remedies and require the doctor's expertise to determine their necessity. I understand the purpose of the initial visit and authorize the doctor to perform an examination and consultation utilizing the NRT technique.

SIGNED:_____ DATE _____

CREDIT CARD PREAUTHORIZATION

Healthcare Complete
260 Merrimac Street-The Towle Building
Newburyport, MA 01950
978-499-WELL (9355)

To better serve our patients, and to give the best care to everyone, we are requiring a credit/debit card to be kept confidentially in each individual's file. Please complete the information below:

Patient Name: _____

I authorize Healthcare Complete to charge my credit card account for patient care under the following circumstances (check off each one that you authorize):

- ☐ Please charge my credit card weekly in pre-payment of my appointments
- ☐ Please charge my credit card after each visit
- ☐ My bill is over 90 days past due, and an attempt to reach me by phone or mail has been made, without response.
- ☐ My insurance didn't cover a service I received, and an attempt to reach me by phone or mail has been made, without response.

Circle one: MasterCard Visa Other _____

Charge Account Number: _____ Exp. Date _____

Cardholder Name: _____

I understand that this form is valid for one year unless I cancel the authorization with written notice to Healthcare Complete.

Cardholder Signature _____ Date _____