



healthcarecomplete

- Individualized Family Chiropractic Care
- Customized Nutritional Counseling
- Pediatric & Perinatal Certified
- Rehabilitative Exercise

NUTRITION NEW PATIENT INFORMATION FORM

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address (if different) _____

Home Phone (____) ____ - _____ Work Phone (____) ____ - _____

E-mail address: _____

Name of Individual with whom you authorize us to share your health information/appointment scheduling/financial information: _____

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: _____

How much of the following do you consume per day?

Cigarettes (packs) _____ Coffee (cups) _____ Alcohol (glasses) _____ Water (glasses) _____

1. Dietary Intake for 2 days before appointment:

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

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 your overall course of care.

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

- | | | |
|--|---|---|
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Mumps | <input type="checkbox"/> Influenza |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Small Pox | <input type="checkbox"/> Pleurisy |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Whooping Cough | <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Mental Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Lumbago |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid | <input type="checkbox"/> 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

GENERAL

- Fatigue

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

- 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

- High Stress Level
Reason _____
- Things you do to handle stress

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? _____

For Electronic Health Records:

- I choose to decline receipt of my clinical summary after every visit (These summaries are often blank as a result of the nature and frequency of care)

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.

Patient Signature _____ Date _____