

Patient Information	Acct. #
First Name: _____ MI: _____ Last Name: _____ Suffix: _____ Called Name: _____ Address: _____ City: _____ State: _____ Zip Code: _____ Home Ph: (_____) _____ Work Ph: (_____) _____ Cell Ph: (_____) _____ Email: _____ Sex: M F Marital Status: Single / Leg. Separated / Married / Widowed / Divorced Date of Birth: _____ Who Referred You To Our Office? _____ If the patient is a minor, please list the name(s) of the parent(s)/guardian(s): _____ Person to Contact In Case of An Emergency: _____ Relationship: _____ Ph: (_____) _____	

**CONSENT TO TREAT**  
 I, being the patient or legal guardian of the above patient, authorize Dr. Clinton Frye and/or Dr. Brooke Frye and whomever he/she may designate as assistants to administer treatment as necessary to myself/son/daughter/grandchild/other.

I am the  Patient  Parent  Legal Guardian Signature: \_\_\_\_\_

**HIPAA – NOTICE OF PRIVACY POLICIES**  
 Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. By signing this form, you understand and agree to the following:

- Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurances, public health research, and law enforcement activities.
- Disclosure of your protected health information is allowed for the purpose of treatment, payment, or practice operations.
- This provision does not apply to the transfer of medical records for treatment. We maintain a history of protected health information disclosures that is accessible to you. You may inspect and receive copies of your records within 30 days of a request to do so. You may also request that we disclose specific portions of your protected health information with other providers. There may be a reasonable cost-based fee for photocopying, postage, and preparation.
- In the future, we may contact you by mail, email, or telephone for appointment reminders or office announcements. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

According to HIPAA, we are not allowed to release any health information to spouses, significant others, parents (unless patient is a minor), children, friends, employers, and/or other family members unless we have your written consent. Please list the name of the person/ persons with whom FRYE Functional Health Center can share your health information with or check the box below:

Person #1: \_\_\_\_\_ Person #2: \_\_\_\_\_ Person #3: \_\_\_\_\_

OR  At this time there is no one in which my health information should be shared with. Signature: \_\_\_\_\_

**FINANCIAL AGREEMENT**  
 By signing this form, I understand and agree to the following:

- I understand that all services are my full and complete responsibility and must be rendered on a cash, check, or credit card basis.
- I understand that if I present with insurance, as a courtesy, FRYE Functional Health Center will contact my insurance company to verify my benefits, but the benefits quoted are not a guarantee of payment. Payment from my insurance company will be determined at the time of processing based on the policy coverage I carry with my insurance company. I understand that any services denied or deemed non-covered, investigational, or not medically necessary by my insurance company are my full responsibility.
- I understand that after FRYE Functional Health Center verifies my benefits, they will attempt to contact me either via phone or at my next visit (so long as it is within the next 4 weeks). If I do not answer my phone, I consent to allow them to leave a message outlining the benefits as they were quoted to them. If I do not respond to their phone call within 7 days, they will automatically bill my insurance for any services quoted to be covered by my insurance policy. They will not bill my insurance for any services quoted to be non-covered, investigational, or not medically necessary.
- I authorize payment of any medical benefit from third parties for benefits submitted for my claim to be paid directly to this office. I authorize the direct payment to this office of any sum I now or hereafter owe this office, by my attorney out of proceeds of any settlement of my case, and by any insurance company obligated to make payment to me or you based in whole, or in part, upon the charges made for your services.
- In the event any insurance company obligated by contractual agreement to make payment to me, or to you, for the charges made for your services refuses to make such payment upon demand by you, I hereby assign and transfer to you the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize you to prosecute said action either in my name as you see fit and further authorize you to compromise, settle, or otherwise resolve said claim as you see fit. I understand that whatever amounts you do not collect from insurance company proceeds, whether it be all or part of what is due, I personally owe you.
- I further agree that this Financial Agreement is irrevocable until all monies owed FRYE Functional Health Center are paid in full. In the event that an unpaid balance is sent to a collection agency, I agree to pay all other costs incidental to collection including but not limited to attorney fees, court costs, processor fees, interest and late fees.
- I understand that I will be responsible for an Insufficient Funds Fee of \$20 should any payment I make not go through due to insufficient funds.

Signature: \_\_\_\_\_

**CANCELLATION, MISSED APPOINTMENT, & TARDINESS POLICY**  
 By signing this form, I understand and agree to the following: Out of respect and consideration to your Physician(s) and other patients, we kindly ask that you honor your scheduled appointment time. Please note that our office schedules back to back appointments while managing a wait list. We understand that unanticipated events occasionally do happen in everyone's life. In our desire to be effective and fair to all of our patients' time, we kindly ask that you give at least 24 hour advance notice when cancelling and/or rescheduling an appointment. This allows the opportunity for someone else to schedule an appointment. It is advisable to arrive approximately 15 minutes prior to your first visit and 10 minutes prior to your subsequent visits. In the event that you arrive late to your appointment, we will do our best to accommodate and honor your full scheduled time, but your appointment may be shortened in order to accommodate others whose appointments follow yours. Regardless of the length of the treatment actually given, you will be responsible for the "full" appointment booked. Please plan accordingly. Anyone who either forgets or consciously chooses to forgo their scheduled appointment time will be considered a "no show/misled appointment" and FRYE Functional Health Center reserves the right to charge 100% of the fee for the "missed appointment". Insurance will not be billed for these charges. Missed appointment fees are the responsibility of the patient and must be paid in full before the next visit.

Signature: \_\_\_\_\_

**PATIENT HEALTH QUESTIONNAIRE**

**MAIN HEALTH ISSUES/COMPLAINTS**

Please list the top 5 reasons for seeking care in our office:

- 1.
- 2.
- 3.
- 4.
- 5.

Who makes up your current healthcare team? (Primary Care, OB/GYN, Specialists, Alternative Providers):

Name: _____	Type of Provider: _____	Contact Ph: (____) _____
Name: _____	Type of Provider: _____	Contact Ph: (____) _____
Name: _____	Type of Provider: _____	Contact Ph: (____) _____
Name: _____	Type of Provider: _____	Contact Ph: (____) _____

When was the last time you felt well? \_\_\_\_\_

Did something specific happen to trigger the change in your health? \_\_\_\_\_

Please mark which of the following testing you have had within the last year:

- |  |   |                                       |                                     |
|--|---|---------------------------------------|-------------------------------------|
| <input type="checkbox"/> Bloodwork       | <input type="checkbox"/> Stool Analysis | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Saliva Testing  | <input type="checkbox"/> Urine Analysis | <input type="checkbox"/> Thermography | <input type="checkbox"/> CT Scan    |
| <input type="checkbox"/> Allergy Testing | <input type="checkbox"/> Hair Analysis  | <input type="checkbox"/> X-Ray        | <input type="checkbox"/> MRI        |

**Medications:**

**Why Prescribed?**

**Hospitalizations:**

**Surgeries/Traumas:**

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

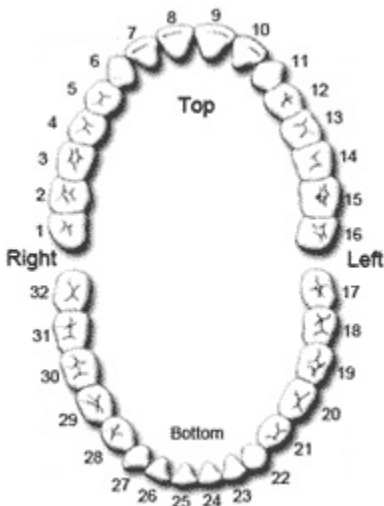
Is your job associated with any potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) YES NO

If yes, what is your occupation? \_\_\_\_\_ What is your blood type?  A  B  AB  O  I do not know

Have you ever been vaccinated? YES NO If yes, was it:  as a child  as an adult

If you were vaccinated, what, if any, adverse reactions did you experience? \_\_\_\_\_

Please note below which teeth you have had dental work on and what type of dental work was done:



(C) Cavity (F) Filling (I) Implant (R) Root Canal (A) Abscess

Right Top	Left Top	Left Bottom	Right Bottom
1 _____	9 _____	17 _____	25 _____
2 _____	10 _____	18 _____	26 _____
3 _____	11 _____	19 _____	27 _____
4 _____	12 _____	20 _____	28 _____
5 _____	13 _____	21 _____	29 _____
6 _____	14 _____	22 _____	30 _____
7 _____	15 _____	23 _____	31 _____
8 _____	16 _____	24 _____	32 _____

<p><b>Medical History (Global Issues)</b></p> <input type="checkbox"/> Anemia (type: _____) <input type="checkbox"/> Arthritis (type: _____) <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Diabetes <input type="checkbox"/> Environmental sensitivities <input type="checkbox"/> Food intolerance <input type="checkbox"/> Genetic disorder <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Infection, chronic <input type="checkbox"/> Obesity <input type="checkbox"/> Parasite Infestation <input type="checkbox"/> Polycythemia vera <input type="checkbox"/> Thalassemia <input type="checkbox"/> Other: _____	<p><b>Medical (Men)</b></p> <input type="checkbox"/> Benign prostatic hyperplasia (BPH) Prostate cancer <input type="checkbox"/> Infertility <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Other: _____	<p><b>Digestive &amp; Glycemic Management (Continued)</b></p> <input type="checkbox"/> Bouts of blurred vision <input type="checkbox"/> Fatigue after meals <input type="checkbox"/> Frequent urination <input type="checkbox"/> Increased thirst <input type="checkbox"/> Difficulty losing weight <input type="checkbox"/> Lower bowel gas / flatulence <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Appendicitis <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Pain or cramps <input type="checkbox"/> Rectal pain <input type="checkbox"/> Bloody / black / tarry stool <input type="checkbox"/> Sensitive abdomen <input type="checkbox"/> Bloating after eating <input type="checkbox"/> Ulcers / Ulcerative colitis <input type="checkbox"/> Swollen/ distended / bloody anus <input type="checkbox"/> Burning or itchy anus <input type="checkbox"/> Diverticular disease <input type="checkbox"/> Takes laxative to regulate bowel <input type="checkbox"/> Uses suppositories <input type="checkbox"/> Enemas and/or colonics <input type="checkbox"/> Irritable bowel syndrome (IBS) <input type="checkbox"/> # of bowel movements/day: _____ <input type="checkbox"/> Consistency of bowel: <input type="checkbox"/> normal <input type="checkbox"/> soft <input type="checkbox"/> hard <input type="checkbox"/> pebbles <input type="checkbox"/> dry <input type="checkbox"/> ribbon-like <input type="checkbox"/> bulky <input type="checkbox"/> mucousy <input type="checkbox"/> Other: _____	<p><b>Bioterrain/ Mineral Pillar (Continued)</b></p> <input type="checkbox"/> Urination leakage <input type="checkbox"/> Other: _____
<p><b>Family Health History (Parents and Siblings)</b></p> <input type="checkbox"/> Arthritis (type: _____) <input type="checkbox"/> Asthma <input type="checkbox"/> Alcoholism <input type="checkbox"/> Alzheimer's disease <input type="checkbox"/> Cancer (type: _____) <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Drug addiction <input type="checkbox"/> Eating disorder <input type="checkbox"/> Genetic disorder <input type="checkbox"/> Glaucoma <input type="checkbox"/> Heart disease <input type="checkbox"/> Hemochromatosis <input type="checkbox"/> Infertility <input type="checkbox"/> Learning disabilities <input type="checkbox"/> Mental illness <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Neurological disorders (MS, Parkinson's, paralysis) <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Polycemia vera <input type="checkbox"/> Stroke <input type="checkbox"/> Suicide <input type="checkbox"/> Thalassemia Other: _____	<p><b>Medical (Women)</b></p> <input type="checkbox"/> Menstrual irregularities <input type="checkbox"/> Endometriosis <input type="checkbox"/> Infertility <input type="checkbox"/> Fibrocystic breasts <input type="checkbox"/> Fibroids/ovarian cysts <input type="checkbox"/> Premenstrual syndrome (PMS) <input type="checkbox"/> Breast cancer <input type="checkbox"/> Pelvic inflammatory disease <input type="checkbox"/> Vaginal infections <input type="checkbox"/> Breast pain with period <input type="checkbox"/> Sexually transmitted disease <input type="checkbox"/> Menopause <input type="checkbox"/> natural <input type="checkbox"/> surgical <input type="checkbox"/> Other recent changes in menstrual flow (e.g., heavier, large clots, scanty): _____ Age of first period: _____ Start date of last menstrual cycle: _____ _____ Length of last menstrual cycle: _____ days Length of time between cycles: _____ days _____ Date of last gyno exam: _____ Last mammogram <input type="checkbox"/> + <input type="checkbox"/> - Last PAP <input type="checkbox"/> + <input type="checkbox"/> - # of Children: _____ # of Pregnancies: _____ # of Births: ___C-Section/___Natural	<p><b>Digestion &amp; Glycemic Management</b></p> <input type="checkbox"/> Nausea / vomiting <input type="checkbox"/> Gas: belching <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Anorexia / bulimia <input type="checkbox"/> Gout <input type="checkbox"/> Change in appetite <input type="checkbox"/> Peptic ulcers <input type="checkbox"/> High cholesterol / triglycerides <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> Headache at the base of the skull <input type="checkbox"/> Greasy, fatty foods cause distress <input type="checkbox"/> Dry, itchy skin <input type="checkbox"/> Yellow cast to eyes <input type="checkbox"/> Clay colored stool <input type="checkbox"/> History of Gallbladder attacks <input type="checkbox"/> Foul smelling sweat <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> SIBO (small intestine bacterial overgrowth) <input type="checkbox"/> Gluten sensitivity <input type="checkbox"/> Irritable when skips a meal <input type="checkbox"/> Light-headed when skips a meal <input type="checkbox"/> Eating relieves fatigue	<p><b>Cardiovascular &amp; Respiratory</b></p> <input type="checkbox"/> Chest tension <input type="checkbox"/> Chest tightness <input type="checkbox"/> Chest pressure <input type="checkbox"/> Chest heaviness <input type="checkbox"/> Chest heart pain <input type="checkbox"/> Heart palpitations / fluttering <input type="checkbox"/> Skipped heartbeat <input type="checkbox"/> Heart racing <input type="checkbox"/> Slowed heartrate <input type="checkbox"/> Constant shortness of breath <input type="checkbox"/> Sleep apnea <input type="checkbox"/> Mitral valve prolapse <input type="checkbox"/> Murmur <input type="checkbox"/> Bleed & Bruise easily <input type="checkbox"/> Other: _____
		<p><b>Bioterrain/ Mineral Pillar</b></p> <input type="checkbox"/> Twitching around eyes <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Restlessness <input type="checkbox"/> Don't remember dreams <input type="checkbox"/> Nail spots or weakness <input type="checkbox"/> Air hunger / frequent sighs <input type="checkbox"/> Cramps: <input type="checkbox"/> legs <input type="checkbox"/> feet <input type="checkbox"/> arms <input type="checkbox"/> hands <input type="checkbox"/> Aches: <input type="checkbox"/> legs <input type="checkbox"/> feet <input type="checkbox"/> arms <input type="checkbox"/> hands <input type="checkbox"/> Fevers <input type="checkbox"/> Restless: <input type="checkbox"/> legs <input type="checkbox"/> feet <input type="checkbox"/> arms <input type="checkbox"/> hands <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Shallow rapid breathing <input type="checkbox"/> Poor muscle endurance <input type="checkbox"/> Swelling in ankles and wrists <input type="checkbox"/> Uterine cramps (women)	<p><b>Neuropsychology</b></p> <input type="checkbox"/> Seizures / epilepsy <input type="checkbox"/> Poor memory <input type="checkbox"/> Bad temper <input type="checkbox"/> Muscle tremor / twitching <input type="checkbox"/> Poor coordination <input type="checkbox"/> Depression <input type="checkbox"/> Multiple Sclerosis (MS) <input type="checkbox"/> Concussion <input type="checkbox"/> Mood swings <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Anxiety <input type="checkbox"/> Easily stressed <input type="checkbox"/> Parkinson's <input type="checkbox"/> Suicidal attempt(s) <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug addiction <input type="checkbox"/> Eating disorder <input type="checkbox"/> Learning disability <input type="checkbox"/> Seasonal affective disorder <input type="checkbox"/> Under current treatment for emotional imbalance <input type="checkbox"/> Other: _____

<p><b>Sleeping Patterns/Habits</b></p> <p><input type="checkbox"/> Trouble falling asleep</p> <p><input type="checkbox"/> Trouble staying asleep</p> <p><input type="checkbox"/> Wakes at a specific time each night:  <input type="checkbox"/> 9-11pm <input type="checkbox"/> 11-1am  <input type="checkbox"/> 1-3am <input type="checkbox"/> 3-5am  <input type="checkbox"/> 5-7am</p> <p><input type="checkbox"/> Feels tired throughout the day:  <input type="checkbox"/> 7-9am <input type="checkbox"/> 9-11am  <input type="checkbox"/> 11-1pm <input type="checkbox"/> 1-3pm  <input type="checkbox"/> 3-5pm <input type="checkbox"/> 5-7pm  <input type="checkbox"/> 7-9pm</p> <p><input type="checkbox"/> Must take some form of medication/supplement to help go to/stay asleep</p> <p><input type="checkbox"/> Use CPAP or BiPAP</p>	<p><b>Genito-Urinary</b></p> <p><input type="checkbox"/> Pain while urinating</p> <p><input type="checkbox"/> Burning while urinating</p> <p><input type="checkbox"/> Unable to hold urine</p> <p><input type="checkbox"/> Wakes up to urinate</p> <p><input type="checkbox"/> Urgency to urinate</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Kidney stones</p> <p><input type="checkbox"/> Bladder infection</p> <p><input type="checkbox"/> Impotency</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> STDs</p> <p><input type="checkbox"/> Kidney disease</p> <p><input type="checkbox"/> Prostate problems</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Eating Habits</b></p> <p><input type="checkbox"/> Skip breakfast</p> <p><input type="checkbox"/> Graze</p> <p>Avg. # Meals/Day: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4</p> <p><input type="checkbox"/> Fast eater</p> <p><input type="checkbox"/> Erratic eating pattern</p> <p><input type="checkbox"/> Eat too much</p> <p><input type="checkbox"/> Late night eater</p> <p><input type="checkbox"/> Dislike "healthy" food</p> <p><input type="checkbox"/> Eat out often</p> <p><input type="checkbox"/> Travel frequently</p> <p><input type="checkbox"/> Does not meal plan</p> <p><input type="checkbox"/> Rely on convenience foods</p> <p><input type="checkbox"/> Poor snack choices</p> <p><input type="checkbox"/> Other family members have special dietary needs</p> <p><input type="checkbox"/> Love to eat</p> <p><input type="checkbox"/> Eat because I have to</p> <p><input type="checkbox"/> Have a negative food relationship</p> <p><input type="checkbox"/> Binge eat</p> <p><input type="checkbox"/> Chronic dieter</p> <p><input type="checkbox"/> Emotional eater</p> <p><input type="checkbox"/> Eat too much under stress</p> <p><input type="checkbox"/> Eat too little under stress</p> <p><input type="checkbox"/> Don't like to cook</p> <p><input type="checkbox"/> Cravings:  <input type="checkbox"/> Sweet <input type="checkbox"/> Salty  <input type="checkbox"/> Protein <input type="checkbox"/> Fruit  <input type="checkbox"/> Carbohydrates  <input type="checkbox"/> Vegetables</p> <p><input type="checkbox"/> Confused about what to eat</p>	<p><b>Skin &amp; Hair</b></p> <p><input type="checkbox"/> Hair loss /alopecia</p> <p><input type="checkbox"/> Dandruff</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> Eczema / rashes</p> <p><input type="checkbox"/> Hives / itching</p> <p><input type="checkbox"/> Vitiligo</p> <p><input type="checkbox"/> Acne (location: _____)</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>HEENT</b></p> <p><input type="checkbox"/> Dizziness / Vertigo</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Poor hearing</p> <p><input type="checkbox"/> Earaches</p> <p><input type="checkbox"/> Eye strain</p> <p><input type="checkbox"/> Color/ night blindness</p> <p><input type="checkbox"/> Blurry vision</p> <p><input type="checkbox"/> Glasses / contacts</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Macular degeneration</p> <p><input type="checkbox"/> Cataracts</p> <p><input type="checkbox"/> Spots in eyes / floaters</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Grinding teeth</p> <p><input type="checkbox"/> Gum problems</p> <p><input type="checkbox"/> Sores on lips / tongue</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Facial pain</p> <p><input type="checkbox"/> Tongue coating/cracks/swelling</p> <p><input type="checkbox"/> Bad breath</p> <p><input type="checkbox"/> Clicking jaw</p> <p><input type="checkbox"/> Dry mouth / dry throat</p> <p><input type="checkbox"/> Concussions</p> <p><input type="checkbox"/> Headaches:(type: _____)</p> <p><input type="checkbox"/> Migraines:(type: _____)</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Health Habits</b></p> <p><input type="checkbox"/> Tobacco:  Cigarettes: #/day _____  Chew: #/day _____  Cigars: #/day _____  Vaping: #/day _____</p> <p><input type="checkbox"/> Alcohol:  Wine: #glasses/day or wk _____  Liquor: #glasses/day or wk _____  Beer: #glasses/day or wk _____</p> <p><input type="checkbox"/> Caffeine:  Coffee: #6 oz cups/day _____  Tea: #6 oz cups/day _____  Diet soda w/caffeine:  #cans/day _____  Reg. soda w/caffeine:  #cans/day _____</p> <p><input type="checkbox"/> Water: #glasses/day _____</p>	<p><b>Exercise</b></p> <p><input type="checkbox"/> 5-7 days per week</p> <p><input type="checkbox"/> 3-4 days per week</p> <p><input type="checkbox"/> 1-2 days per week</p> <p><input type="checkbox"/> 45 minutes or more duration per workout</p> <p><input type="checkbox"/> 30-45 minutes duration per workout</p> <p><input type="checkbox"/> Less than 30 minutes duration per workout</p> <p><input type="checkbox"/> Walk</p> <p><input type="checkbox"/> Run, jog, jump rope</p> <p><input type="checkbox"/> Weight lift</p> <p><input type="checkbox"/> CrossFit</p> <p><input type="checkbox"/> Swim</p> <p><input type="checkbox"/> Box</p> <p><input type="checkbox"/> Yoga/Pilates</p> <p><input type="checkbox"/> HIIT</p> <p><input type="checkbox"/> Circuit training</p> <p><input type="checkbox"/> Other: _____</p>	<p><b>Current Supplements</b></p> <p><input type="checkbox"/> Multivitamin/mineral</p> <p><input type="checkbox"/> Fish oil/DHA/EPA</p> <p><input type="checkbox"/> Vitamin C</p> <p><input type="checkbox"/> Vitamin D</p> <p><input type="checkbox"/> Vitamin E</p> <p><input type="checkbox"/> Calcium</p> <p><input type="checkbox"/> Magnesium</p> <p><input type="checkbox"/> Zinc</p> <p><input type="checkbox"/> Pro/Prebiotic</p> <p><input type="checkbox"/> Amino Acids</p> <p><input type="checkbox"/> Protein powders</p> <p><input type="checkbox"/> CoQ10</p> <p><input type="checkbox"/> Digestive enzymes</p> <p><input type="checkbox"/> Herbs (teas, pills)</p> <p><input type="checkbox"/> Homeopathy</p> <p><input type="checkbox"/> Other: _____</p>
<p><b>Emotions</b></p> <p><input type="checkbox"/> Frustration, anxiety, or anger</p> <p><input type="checkbox"/> Lack of or excessive joy</p> <p><input type="checkbox"/> Excessive need for sympathy, excessive introspection, or obsessional thinking</p> <p><input type="checkbox"/> Grief, sadness, or melancholia</p> <p><input type="checkbox"/> Fear</p>	<p><b>Nutrition &amp; Diet</b></p> <p><input type="checkbox"/> Vegan</p> <p><input type="checkbox"/> Vegetarian</p> <p><input type="checkbox"/> Paleo</p> <p><input type="checkbox"/> Primal</p> <p><input type="checkbox"/> Pescatarian</p> <p><input type="checkbox"/> Ketogenic</p> <p><input type="checkbox"/> GAPS</p> <p><input type="checkbox"/> FODMAP</p> <p><input type="checkbox"/> Intermittent Fasting</p> <p><input type="checkbox"/> Salt (sodium) restriction</p> <p><input type="checkbox"/> Fat restriction</p> <p><input type="checkbox"/> Starch/carb restriction</p> <p><input type="checkbox"/> Total calorie restriction</p> <p><input type="checkbox"/> Do you eat foods that contain any of the following:  <input type="checkbox"/> wheat <input type="checkbox"/> corn  <input type="checkbox"/> soy <input type="checkbox"/> MSG  <input type="checkbox"/> food coloring / dyes  <input type="checkbox"/> artificial sweeteners such as sucralose and aspartame</p> <p><input type="checkbox"/> Specific food restrictions:  <input type="checkbox"/> dairy <input type="checkbox"/> wheat <input type="checkbox"/> eggs  <input type="checkbox"/> soy <input type="checkbox"/> corn <input type="checkbox"/> all gluten  <input type="checkbox"/> other _____</p>	<p><b>Seasonal Preferences</b></p> <p><b>Is there a specific season in which you tend to feel the best/worst?</b></p> <p><b>Best:</b> <input type="checkbox"/> Summer <input type="checkbox"/> Fall  <input type="checkbox"/> Winter <input type="checkbox"/> Spring</p> <p><b>Worst:</b> <input type="checkbox"/> Summer <input type="checkbox"/> Fall  <input type="checkbox"/> Winter <input type="checkbox"/> Spring</p>	<p><b>Would you like to:</b></p> <p><input type="checkbox"/> Have more energy</p> <p><input type="checkbox"/> Be stronger</p> <p><input type="checkbox"/> Have more endurance</p> <p><input type="checkbox"/> Increase sex drive</p> <p><input type="checkbox"/> Be thinner</p> <p><input type="checkbox"/> Be more muscular</p> <p><input type="checkbox"/> Improve complexion</p> <p><input type="checkbox"/> Have stronger hair/nails</p> <p><input type="checkbox"/> Be less moody</p> <p><input type="checkbox"/> Be less depressed</p> <p><input type="checkbox"/> Be less indecisive</p> <p><input type="checkbox"/> Feel more motivated</p> <p><input type="checkbox"/> Be more organized</p> <p><input type="checkbox"/> Think more clearly and be more focused</p> <p><input type="checkbox"/> Improve memory</p> <p><input type="checkbox"/> Do better on tests</p> <p><input type="checkbox"/> Not use over-the-counter medications</p> <p><input type="checkbox"/> Stop using laxatives or stool softeners</p> <p><input type="checkbox"/> Be free of pain</p> <p><input type="checkbox"/> Have better breath</p> <p><input type="checkbox"/> Have less body odor</p> <p><input type="checkbox"/> Get less colds/flu</p> <p><input type="checkbox"/> Get rid of allergies</p>

**Musculoskeletal Complaint(s)**

**Complaint(s):**

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When did it begin? \_\_\_\_\_ Is the condition getting progressively worse? \_\_\_\_\_

How did it begin? \_\_\_\_\_

How often do you experience the issue (pain/discomfort/etc.)? \_\_\_\_\_

Is it constant or does it come and go? \_\_\_\_\_

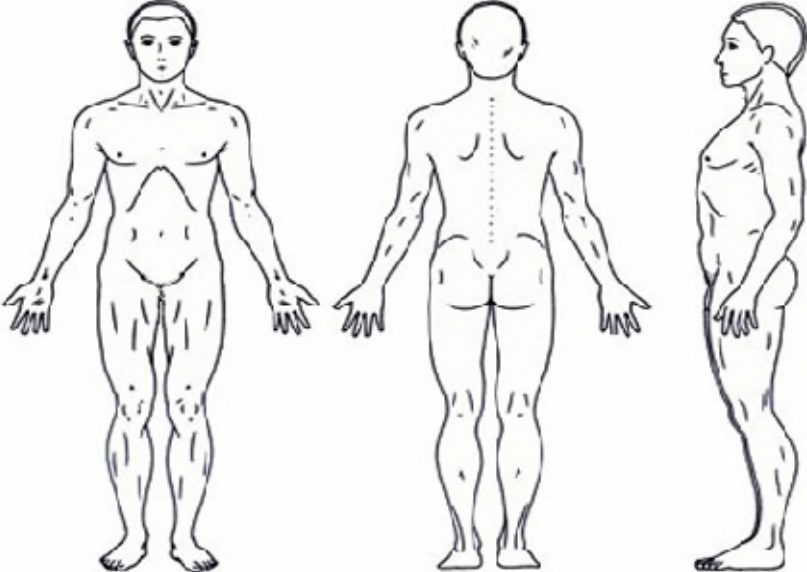
On a scale of 1 (least amount of pain) to 10 (most severe pain), what would you rate the pain? Circle one: 1 2 3 4 5 6 7 8 9 10

Does anything make it feel better? If so, what? \_\_\_\_\_

Does anything make it feel worse? If so, what? \_\_\_\_\_

Does it interfere with any of the following? Circle those that apply: Work Sleep Daily Routine Recreation

Please circle those activities that are difficult/painful/uncomfortable to perform due to this condition:  
Sitting Standing Walking Bending Lying Down Turning your Head Coughing Sneezing Bearing Down

Musculoskeletal Symptoms	Please mark on the picture below where your problem areas are:
<input type="checkbox"/> Neck pain <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle pain/ spasms <input type="checkbox"/> Joint pain <input type="checkbox"/> Arthritis (type: _____) <input type="checkbox"/> Numbness <input type="checkbox"/> Tingling <input type="checkbox"/> Headaches (type: _____) <input type="checkbox"/> Prosthesis <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Shooting / Radiating pain <input type="checkbox"/> Fractures <input type="checkbox"/> Hernia (type: _____) <input type="checkbox"/> Other: _____	

Readiness										
<p>Rate the following on a scale of: 1 (not willing) to 5 (very willing)</p> <p>In order to improve your health, how willing are you to do the following:</p> <p>Significantly modify your diet: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Take nutritional supplements each day: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Keep a record of everything you eat each day: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Modify your lifestyle (e.g. work schedule, sleep habits): <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Practice relaxation techniques: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Engage in regular exercise: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Have periodic lab tests to assess progress: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Comments: _____</p>	<p><b>***As you will quickly learn, our practice is heavily focused on different aspects of alternative medicine and holistic healing. These include nutritional care and whole-food supplementation, acupuncture, chiropractic, and massage therapy. In the process of your initial history, consultation, exam, and/or future appointments the doctor may recommend any one (or a combination) of the following treatments and/or testing methods to properly evaluate and successfully treat your condition(s).***</b></p> <hr/> <p><b>Please designate below which of the following treatment/testing options you are open to and willing to explore should the doctor(s) recommend them for you:</b></p> <table border="0"> <tr> <td><input type="checkbox"/> Chiropractic Care</td> <td><input type="checkbox"/> Acupuncture</td> <td><input type="checkbox"/> Massage Therapy</td> </tr> <tr> <td><input type="checkbox"/> Hair Analysis</td> <td><input type="checkbox"/> Homeopathy</td> <td><input type="checkbox"/> Nutritional Supplementation</td> </tr> <tr> <td><input type="checkbox"/> Saliva Testing</td> <td><input type="checkbox"/> Far Infrared Sauna</td> <td><input type="checkbox"/> Food Sensitivity Testing</td> </tr> </table> <p><input type="checkbox"/> SHAPE Reclaimed Nanomolecular Health Transformation program for reducing inflammation, cleansing and detoxification, strengthening immunity, and releasing toxic weight.</p> <hr/> <p align="center">Please understand that even though you may not choose a certain option, if the doctor finds a specific treatment/ testing option necessary based on your body's needs, he/she will discuss this with you in more detail.</p> <p>I understand this and agree that all information I have provided is true to the best of my knowledge.</p> <p>Patient Name: _____</p> <p>Signature: _____</p> <p>Date: _____</p>	<input type="checkbox"/> Chiropractic Care	<input type="checkbox"/> Acupuncture	<input type="checkbox"/> Massage Therapy	<input type="checkbox"/> Hair Analysis	<input type="checkbox"/> Homeopathy	<input type="checkbox"/> Nutritional Supplementation	<input type="checkbox"/> Saliva Testing	<input type="checkbox"/> Far Infrared Sauna	<input type="checkbox"/> Food Sensitivity Testing
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