INTAKE QUESTIONNAIRE FOR ADULTS

Full Name _____ Occupation _____

Home Address _____ Company _____

City _____ State _____ Zip _____ Date of Birth _____ Gender M F

Emergency Contact _____ Relationship _____ Phone _____

Phone (home) _____ (work) _____ (cell) _____ Email _____

Whom may we thank for referring you? _____ Social Security # _____

I, _____, understand that I am personally responsible for payment at the time when services are rendered.

Signature _____ Date _____

. . . . . .

If you know which services you are interested in, please check all that apply:

☐ Whole Body Cryotherapy	☐ Whole Body Photobiomodulation	☐ Laser Therapy
☐ Clinical Nutrition	☐ Chiropractic Care	☐ Massage
☐ Childhood Development & Learning Functional Neurology		

☐ I have an issue I would like to address through the use of Cryotherapy or Whole Body Photobiomodulation ***without consultation*** with the doctor.
<u>you may skip to page 12**</u>

☐ Childhood Development and Learning Functional Neurology Assessment
(request Childhood Development intake form)

☐ I do not know what I need, but I would like to find out! *(continue below)*

☐ I have no current health issues, but would like preventative / wellness care
(continue below-if under the age of 15 please request the pediatric intake form)

PRIMARY CONCERN

What is your **primary** health problem? _____

_____

Date of original problem: _____ Date of most recent recurrence: _____

Was there an event that created the problem? _____

Have you had this or similar conditions in the past? _____ Is the problem worsening? _____

What makes it better? _____ Worse? _____

Is the problem interfering with work? _____ Sleep? _____ Activity? _____ Other?_____

What can you not do now that you would like to do? _____

What do you believe is wrong with you? _____

_____

What are your goals for treatment? _____

HEALTH HISTORY

List all other **CURRENT** problems **in their order of importance** _____

_____

_____

_____

List other practitioners seen, treatments, self care activities, and results _____

_____

_____

_____

_____

Have you ever seen a chiropractor? No / Yes (Name: _____ Result:_____)

Do you have any spinal abnormalities that you are aware of? _____

List **ALL** significant PAST illnesses _____

_____

_____

Please list **ALL** surgeries you have had, with approximate dates and results _____

_____

Have you ever been hospitalized other than for surgery? _____

Have you ever been in an accident or seriously injured? List dates and describe_____

_____

Have you ever had: Whiplash? No / Yes Hard fall on your tailbone? No / Yes Seizure? No / Yes

Describe your worst injury ever, and any long lasting effects it has had on your health _____

_____

Describe any travel related illnesses _____

How many doses of antibiotics have you had in your lifetime?_____

How many times **per month** do you take aspirin? ____ Ibuprofen? ____ Tylenol? ____ Antacids? ____ Laxatives? ____

For what purpose do you take these? _____

FAMILY HISTORY

Have any of your blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with you.

Condition	**Yes**	**No**	**Age**	**Relationship**
Alcoholism/Drug Addiction				
Allergies/Asthma				
Arthritis				
Blood Disorders				
Cancer (typ)				
Diabetes				
Digestive Disorders (type)				
Heart attack before age 55				

Have any of your blood relatives (parents, brothers, sisters, aunts, uncles, grandparents, or children), living or deceased, had any of the following problems? **For each YES**, state the age of the person when the problem occurred and their relationship with you.				
Heart attack before after age 55				
High blood pressure				
Kidney or Liver disease				
Lung disease/tuberculosis				
Mental health problems/depression				
Seizure Disorder				
Stroke				
Thyroid Disease				
Uterine/Ovarian problems				

List other problems that run in your family _____

HABITS

Describe your use of cigarettes/tobacco _____ Alcohol _____ Other drugs _____

Describe your exercise habits (activity/times per week/intensity) _____

Describe your current sleeping pattern (when you usually go to sleep, wake up, napping, difficulty with sleep) _____

Do you have enough energy for your normal activities? No / Yes

PREVENTIVE MEASURES AND SCREENING

Have you ever had an MRI or CT scan? No / Yes If so, what for? _____

Have you ever had x-rays? No / Yes If so, what for? _____

Have you ever had an EKG or other heart study? No / Yes If so, what for? _____

Please list any abnormal labs or other test results: (OK to attach copies instead) _____

ALLERGIES AND SENSITIVITIES

Please list any allergies you are aware of (foods/medications/other): _____

Please list any chemical sensitivities you are aware of: (bleach, solvents, perfumes, etc.) _____

Are you particularly sensitive to the effects of alcohol or medications? No / Yes

Have you ever reacted to a medication in an unexpected way (for example, feeling more calm if you took a stimulant)? No / Yes If yes, please describe _____

Have you had problems with damp or moldy places? No / Yes Problems with new building materials? No / Yes

NUTRITION

What do you usually eat and drink on a **typical weekday**?

Breakfast _____

Morning snack _____

Lunch _____

Afternoon snack _____

Dinner _____

Evening snack _____

Desserts _____

How many glasses of water do you drink a day? _____

How many servings do you have per day of the following:

Fruits & Vegetables _____ Coffee _____ Tea _____ Soda _____ Diet Soda _____

List the oils or fats you use in the cooking/preparing of food: _____

Do you enjoy eating cheese? No / Yes Do you drink milk? No / Yes If so, how much per day? _____

Do you like sweets, pastries, cakes, donuts, etc? No / Yes How many servings per day?_____

Do you consume artificial sweeteners with coffee and food? No / Yes How many servings per day?

When you have a snack, what type of food do you prefer? _____

Is there one food that you like the most, eat a lot of, and crave when you don't have it? _____

Are there days you do not eat any vegetables? No / Yes

What foods do you especially like? _____

What foods do you dislike? _____

Are there particular foods that seem to irritate you in any way? No / Yes If yes, name the foods and describe the problem: _____

Please describe any ways in which you feel your diet is excessive: _____

_____

Please describe any ways in which you feel your diet is deficient: _____

_____

List all hormones that you take now or have taken in the past. Please indicate form (pill, cream, injection etc.)

_____

MEDICATIONS

The treatment that the Doctors provide is intended to improve all aspects of your health. As your care progresses, your body may be better able to heal itself in all respects. Because of this, your blood pressure, blood sugar levels, blood clotting characteristics, and other important bodily functions may improve. If this occurs, it is possible that the doses of medications you are taking will have to be modified, to account for your improvement. It is your responsibility to monitor or have monitored those functions that relate to medications you are currently taking, to ensure that your current dose does not become excessive or deficient in its effect on you. These and any other changes to your regimen of medications must be made in coordination with, and under the instructions of, the physician who prescribed them.

Please list the names of **medications** you are currently taking as well as the reason for them.

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

Please list the names of **supplements** you are currently taking and reason for them.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Brain Health and Nutrition Assessment

please circle the appropriate number below 0 (least/never) - 3 (most/always)

Section 1					**Section 3**				
Low brain endurance for focus and concentration	0	1	2	3	Fatigue after meals	0	1	2	3
Cold hands and feet	0	1	2	3	Sugar and sweet cravings after meals	0	1	2	3
Must exercise or drink coffee to improve brain function	0	1	2	3	Need for a stimulant, such as coffee, after meals	0	1	2	3
Poor nail growth	0	1	2	3	Difficulty losing weight	0	1	2	3
Fungal growth on toenails	0	1	2	3	Increased frequency of urination	0	1	2	3
Must wear socks at night	0	1	2	3	Difficulty falling asleep	0	1	2	3
Nail beds are white instead of pink	0	1	2	3	Increased appetite	0	1	2	3
The tip of nose is cold	0	1	2	3					
Section 2					**Section 4**				
Irritable, nervous, shaky, or light headed between meals	0	1	2	3	Always have projects and things that need to be done	0	1	2	3
Feel energized after meals	0	1	2	3	Never have time for yourself	0	1	2	3

Difficulty eating large meals in the morning	0	1	2	3	Not getting enough sleep or rest	0	1	2	3
Energy level drops in the afternoon	0	1	2	3	Difficulty getting regular exercise	0	1	2	3
Crave sugar and sweets in the afternoon	0	1	2	3	Feel that you are not accomplishing your life's purpose	0	1	2	3
Wake up in the middle of the night	0	1	2	3					
Difficulty concentrating before eating	0	1	2	3					
Depend on coffee to keep going	0	1	2	3					
Section 5					**Section 7**				
Dry and unhealthy skin	0	1	2	3	Brain fog (unclear thoughts or concentration)	0	1	2	3
Dandruff or flaky scalp	0	1	2	3	Pain and inflammation	0	1	2	3
Consumption of processed foods that are bagged or boxed	0	1	2	3	Noticeable variations in mental speed	0	1	2	3
Consumption of fried foods	0	1	2	3	Brain fatigue after meals	0	1	2	3
Difficulty consuming raw nuts or seeds	0	1	2	3	Brain fatigue after exposure to chemicals, scents, or pollutants	0	1	2	3
Difficulty consuming fish (not fried)	0	1	2	3	Brain fatigue when the body is inflamed	0	1	2	3
Difficulty consuming olive oil, avocados, flax seed oil, or natural fats	0	1	2	3					
The tip of nose is cold	0	1	2	3					
Section 6					**Section 8**				
Difficulty digesting foods	0	1	2	3	Grain consumption leads to tiredness	0	1	2	3
Constipation or inconsistent bowel movements	0	1	2	3	Grain consumption makes it difficult to focus and concentrate	0	1	2	3
Increased bloating or gas	0	1	2	3	Feel better when bread and grains are avoided	0	1	2	3

Abdominal distention after meals	0	1	2	3	Grain consumption causes the development of any symptoms	0	1	2	3
Difficulty digesting protein rich foods	0	1	2	3	a 100% gluten-free diet	0	1	2	3
Difficulty digesting starch-rich foods	0	1	2	3					
Difficulty digesting fatty or greasy foods	0	1	2	3					
Difficulty swallowing supplements or large bites of food	0	1	2	3					
Abnormal gag reflex	0	1	2	3					
Section 9					**Section 11**				
Diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease	0	1	2	3	Feelings of worthlessness	0	1	2	3
Family members who have been diagnosed with an autoimmune disease	0	1	2	3	Feelings of hopelessness	0	1	2	3
Family members who have been diagnosed with celiac disease or gluten sensitivity	0	1	2	3	Self-destructive thoughts	0	1	2	3
Changes in brain function with stress, poor sleep, or immune activation	0	1	2	3	Inability to handle stress	0	1	2	3
Section 10					Anger and aggression while under stress	0	1	2	3
A loss of pleasure in hobbies	0	1	2	3	Feelings of tiredness, even after many hours of sleep	0	1	2	3
Feel overwhelmed with ideas to manage	0	1	2	3	A desire to isolate yourself from others	0	1	2	3
Feelings of inner rage or unprovoked anger	0	1	2	3	An unexplained lack of concern for family and friends	0	1	2	3
Feelings of paranoia	0	1	2	3	An inability to finish tasks	0	1	2	3

Feelings of sadness for no reason	0	1	2	3	Feelings of anger for minor reasons	0	1	2	3
A loss of enjoyment in life	0	1	2	3	**Section 12**				
A lack of artistic appreciation	0	1	2	3	A decrease in visual memory	0	1	2	3
Feelings of sadness in overcast weather	0	1	2	3	Decrease in verbal memory	0	1	2	3
A loss of enthusiasm for favorite activities	0	1	2	3	Occurrence of memory lapses	0	1	2	3
A loss of enjoyment in favorite foods	0	1	2	3	A decresae in creativity	0	1	2	3
A loss of enjoyment in friendships and relationships	0	1	2	3	A decresae in comprehension	0	1	2	3
Inability to fall into deep, restful sleep	0	1	2	3	Difficulty calculating numbers	0	1	2	3
Feelings of dependency on others	0	1	2	3	Difficulty recognizing objects and faces	0	1	2	3
Feelings of susceptibility to pain	0	1	2	3	A change in opinion about yourself	0	1	2	3
					Slow mental real	0	1	2	3
Section 13					**Section 14**				
A decrease in mental alertness	0	1	2	3	Feelings of nervousness or panic for no reason	0	1	2	3
A decrease in mental speed	0	1	2	3	Feelings of dread	0	1	2	3
A decrease in concentration quality	0	1	2	3	Feelings of a knot in your stomach	0	1	2	3
Slow cognitive processing	0	1	2	3	Feelings of guilt about everyday decisions	0	1	2	3
Impaired mental performance	0	1	2	3	Feelings of being overwhelmed for no reason	0	1	2	3
An increase in the ability to be distracted	0	1	2	3	A restless mind	0	1	2	3
Need coffee or caffeine sources to improve mental function	0	1	2	3	An inability to turn off the mind when relaxing	0	1	2	3

	Disorganized attention	0	1	2	3
	Worry over things never thought about before	0	1	2	3
	Feelings of inner tension and inner excitability	0	1	2	3

ADDITIONAL INFORMATION

Please arrange to have any other relevant information sent to our office. This might include medical records, lab results, consultation reports, and any other test or study results such as x-rays or CT scans. This will help the doctors evaluate your condition. Short documents like lab results or MRI reports may be faxed to (919) 759-9188. Longer documents like overall patient records should be copied and sent to the office at 206 E. Mulberry St., Goldsboro, NC 27530.

Please list the names of your primary care doctor, gynecologist (if applicable), and/or other doctors, so the doctors can send a report to them with the details of his findings in your case, should it become appropriate for him to do so. List each doctor's full name and as much of the address information as you know.

_____

_____

_____

_____

_____

_____

To the best of your knowledge, the detailed information that you have provided is accurate, and allows the doctors a more thorough understanding of you and your health concerns. Sharing these details helps you receive the highest quality care we are capable of providing.

If you would like to add any further information that you feel would be helpful to the doctors understanding of your condition, please attach a typed page and return along with this material.

Signature _____ Date _____

FINANCIAL OFFICE POLICY

Patient Care Services.
We require that charges on the date of service be paid in full, except If you have a documented worker's compensation case or accident with all appropriate forms and liens signed. We do reserve the right to charge 1.5 percent monthly interest on all account balances over 60 days.

Our Policy on Health Insurance.
Today most policies do cover alternative health care however there is a large number that have copays that are much greater than our fees, therefore we will not submit those claims. We cannot take responsibility for what your health insurance will or will not cover.

Appointments.
In order to better serve our patients, we ask that you call in advance if you are unable to make your appointment, or if you will be late. Your appointment time is reserved especially for you. If you fail to notify our office, it leaves an appointment time that could have been used by someone in need. Please help us help others.

Questions and Answers.
Please feel free to ask any available staff member questions regarding your account. We will make every effort to answer your inquiries.

Signature _____ Date _____