New Patient Intake Form Dr. Robert Weissfeld Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| **Name (last, first)**  | **Email**   |
| **Address**   | **Occupation**  |
| **City / State / Zip**  | **Work phone**  |
| **Home phone**  | **Cell phone** | **How did you find out about Dr. Weissfeld?** |
| **Emergency contact** (name & phone) | **Date of birth** |

**Please list areas of your life in which you would like to improve your health, ease or well-being**

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|  |  |

**Briefly, what do you feel are some of the causes of the above difficulties?**

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|  |

Are you currently under the care of a physician? If so, who, and for what condition(s)?

|  |  |
| --- | --- |
|  |  |
|  |  |

Have you ever seen a chiropractor before? \_\_\_YES \_\_\_NO

List all current medications, prescribed or otherwise, including vitamins & supplements

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| --- | --- | --- | --- |
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|  |  |  |  |
|  |  |  |  |

**Illnesses: Me**: mark column if you have had illness **F**=Family: mark column if it is in your family

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Me | F |  | Me | F |  | Me | F |  | Me | F |  |
|  |  | Cancer |  |  | Thyroid  |  |  | Rheumatic Fever |  |  | HIV / Aids |
|  |  | Diabetes |  |  | Asthma |  |  | Depression |  |  | Hepatitis |
|  |  | Pneumonia |  |  | Stomach Ulcers |  |  | Seizures |  |  |  |
|  |  | Tuberculosis |  |  | Chronic Fatigue |  |  | Stroke |  |  |  |
|  |  | Multiple Sclerosis |  |  | Herpes Shingles |  |  | Heart Disease |  |  |  |

 **Surgeries & major physical or emotional traumas** including dental, tonsils, appendix etc. use back if needed

|  |  |
| --- | --- |
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**Lifestyle (please check all that apply, and note frequency of use)**

|  |  |  |
| --- | --- | --- |
|  Tobacco  |  Recreational drugs |  Diet soda, artificial sweeteners |
|  Alcohol |  Caffeinated beverages |  |

OVER**🢧**

**Emotional stress scale (please circle)**

1 2 3 4 5 6 7 8 9 10

no stress moderate extremely stressed

**Briefly, what are your major stresses?**

|  |
| --- |
|  |
|  |

**Social history (check those that apply)**

 Single

 Significant Other

 Divorced

 Married

 Caregiver for dependent

# of children and ages \_\_\_\_\_\_\_\_\_\_\_

**D**o you have high blood pressure or are you on blood pressure medications? \_\_\_\_YES \_\_\_\_NO

Do you have diabetes? \_\_\_\_YES \_\_\_\_NO

# Check the first checkbox if you presently have symptom, the second box if you have had it in the past

# I have this symptom now

# I had symptom in the past

|  |  |  |
| --- | --- | --- |
| X | X | Symptom  |

# General symptoms –

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Fatigue |  |  | Fever / chills |  |  | Bleed / bruise easily |
|  |  | Sweat without exertion |  |  | Dizziness / vertigo |  |  |  |
|  |  | Night sweats |  |  | Low immunity |  |  |  |

# Digestion

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Extreme appetite |  |  | Cravings |  |  | Tired after eating |
|  |  | No appetite |  |  | Dieting |  |  | Bloating |
|  |  | Gas |  |  | Acid regurgitation |  |  | Heartburn |
|  |  | Irritability or low energy between meals |  |  | Nausea |  |  | Vomiting, Bulimia |

# Gastrointestinal

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Diarrhea |  |  | Bloody stool |  |  | Irritable bowel syndrome |
|  |  | Constipation |  |  | Mucous in stool |  |  | Colitis |
|  |  | Hemorrhoids |  |  | Laxative use |  |  | Intestinal pain / cramping |
|  |  | Anal itching / burning |  |  | Anal fissures |  |  | Incomplete evacuation |
|  |  | Gout |  |  | Gallstones |  |  |  |

# EENT

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Dry eyes |  |  | Spots / flowery vision |  |  | Bleeding gums |
|  |  | Difficulty swallowing |  |  | Swollen glands |  |  | Headaches |
|  |  | Earaches |  |  |  Poor vision |  |  | Eye strain |
|  |  | Blurred vision |  |  |  Cataracts |  |  | Macular degeneration |
|  |  |  Night blindness |  |  |  TMJ Problems |  |  | Sores on tongue or mouth |
|  |  |  Dry mouth |  |  |  Excess saliva |  |  | Sinus problems |
|  |  |  Post-nasal drip |  |  |  Sore throat, frequent or severe |  |  | Tinnitus / ringing in ears |
|  |  | Deafness |  |  | Nosebleed frequent or severe |  |  |  |

Cardiovascular / respiratory

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Heart palpitations |  |  | Chest pain |  |  | Difficulty breathing |
|  |  | High cholesterol |  |  | Varicose veins |  |  | Blood clots |
|  |  | Swollen ankles |  |  | Heart valve abnormality |  |  | Shortness of breath |
|  |  | Cold hands / feet |  |  | Dry cough |  |  | Wheezing |
|  |  | Chest tightness |  |  | Difficult inhalation |  |  | Difficult exhalation |
|  |  | Productive cough  |  |  |  |  |  |  |

# Musculoskeletal

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Tendonitis |  |  | Spinal pain |  |  | Joint pain/ Arthritis |
|  |  | Limited range of motion |  |  | Swelling |  |  | Carpal tunnel |
|  |  | Numbness |  |  | Vertebral disc degeneration |  |  | Osteoporosis |

**Stress related issues**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Insomnia |  |  | Anxiety |  |  |  Irritability |
|  |  | Poor memory |  |  | Depression |  |  |  Easily stressed |
|  |  | Tremors |  |  | Seasonal mood disorder |  |  | Tics |
|  |  | Recent divorce |  |  | Currently in psychotherapy |  |  | Job stress |
|  |  |  |  |  | Death of someone close |  |  | Financial setback |

# Skin / hair

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|   |  | Eczema |  |  | Dry skin |  |  |  Rashes / hives / acne |
|  |  | Fungal infections |  |  | Psoriasis |  |  | Dandruff |
|  |  | Hair loss |  |  | Brittle nails |  |  | Ridged nails |

# Genito-urinary

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  Dribbling when laughing or sneezing |  |  | Incomplete urination / retention |  |  | Decreased libido / sexual desire |
|  |  | Burning urination |  |  | Blood in urine |  |  | Frequent urination |
|  |  | Kidney stones |  |  | Bedwetting |  |  | Wake frequently to urinate |
|  |  | Herpes |  |  | Infertility |  |  |  |

# Men only

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | Impotency |  |  | Prostate problems |  |  | Erectile dysfunction |

# Women only

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  | Age menses ended |  |  | hormone replacement therapy |
|  |  | Date of last ob/gyn exam? |  |  | Hysterectomy? partial full |  |  | Live births |
|  |  | Abortion(s) |  |  | Miscarriage |  |  | Fibroids |
|  |  | Birth control pills |  |  | Ovarian cysts |  |  |  |
|  |  | Candida / yeast |  |  | Discharge or odor |  |  | Human Papilloma Virus positive |
|  |  | Vaginal sores |  |  | Herpes |  |  | Fibrocystic breast |
|  |  | STD history (chlamydia, PID, etc) |  |  |  Breast cancer |  |  | Acne associated with period |
|  |  | Pain at ovulation |  |  | Cramps / low back pain |  |  | \_\_\_\_\_\_ days between periods |
|  |  | Constipation or diarrhea associated with period |  |  | Emotional irritability or de-pression associated w period |  |  | Bleeding outside of regular menstrual cycle |
|  |  | No period / skipped cycles |  |  | Irregular cycle |  |  | Period lasts \_\_\_\_\_\_ days |
|  |  | Headache before menstrual cycle during cycle after cycle |

**Terms of Acceptance of Care and Consent for Treatment**

In the course of care, it is essential for the practitioner and client to work towards the same objectives. Here is a brief explanation of goals and methods of treatment that will be used, and risks of treatment.

## Health:

A state of optimal physical, mental, emotional and social well being, not just the absence of disease or infirmity.

## Chiropractic Adjustment:

The chiropractic method of correction is by specific adjustments of the spine, extremities, and/or cranium. An adjustment is the specific application of forces to facilitate the body’s correction of vertebral subluxation, a misalignment or fixation of one or more of the vertebra in the spinal column (which causes alteration of nerve function and interference to the transmission of nerve impulses), which can impair the body’s ability of achieve maximum health potential.

As in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. Chiropractic treatments rank among the safest and most effective form of health care, and chiropractors' malpractice insurance rates remain among the lowest in the health professions.

## Functional holistic treatment:

Functional holistic treatment endeavors to correct those things that are actually found to be dysfunctional, not a disease label. As such, I do not offer treatment based on diagnosis or treat any specific disease or condition. (Disease is defined here as a collection of symptoms and other findings that are labeled with a name – arthritis or pneumonia for example.) If during the course of examination and treatment I encounter findings that suggest a pathology or that I feel are beyond my area of expertise or that I cannot treat, I will advise you.

If you desire further advice, diagnosis, or treatment for those findings, I recommend that you seek the services of a health care provider who specializes in diagnosis and treatment based on diagnosis.

The therapeutic objective is to eliminate chemical, structural, neurological or other interference to the expression of the body’s innate healing ability. The elimination of interference leads to improved health. My methods are: adjusting to correct vertebral subluxations, specific muscle work, acupuncture or laser or electro-acupuncture, techniques to support self-awareness and nutritional supplementation, all provided as needed.

Feel free to ask whatever questions you need to fulfill your understanding. You may at any time refuse or decline a specific treatment or test that you feel uncomfortable with.

Because the treatment provided relaxes compensations that may be keeping symptoms at bay, temporary aggravation of symptoms, or new symptoms may be experienced. Should this occur, it is important that you call me if the symptoms feel intense or you are concerned.

I treat all patients equally, regardless of age, sex, race, nationality or sexual orientation.

## Payment

Unless previous arrangements are made, payment in full is due at the time of the visit, as check, cash, or Credit Card. Despite efforts to be assured of insurance coverage before treatment, at times the insurance will not cover some or all of the examinations and treatment. A promise of payment by your insurance does not eliminate your personal responsibility for payment. **Missed appointments not canceled at least 24 hours prior to the visit will be charged full price**.

## Privacy Notice

This Practice is committed to maintaining the privacy of your protected health information. A Privacy Notice is posted at DenverHolisticChiropractic.com that provides a more complete description of information uses and disclosure. You have the right to review the notice prior to signing this consent.

Sincerely,



Robert Weissfeld D.C., C.N.T.

I, (Print name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understand the above statements.

I understand that all questions regarding the doctor’s objectives pertaining to my care in this office will be answered to my satisfaction.

I do not expect that physician to be able to anticipate and explain all risks and complications. I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts then known. I therefore accept and authorize care on this basis.

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 (Signature) (Date)