New Life Chiropractic Center

Entrance Form

Name _____ **Date** _____

Nickname _____ **Date of Birth** _____ **Age** _____

Married Y / N Spouse's Name _____ **Health Status**_____

Children Y / N Name _____ **Age** _____

Name _____ **Age** _____

Address _____**City** _____ **Zip code** _____

Home Phone # _____ **Cell Phone #** _____

E-Mail address _____

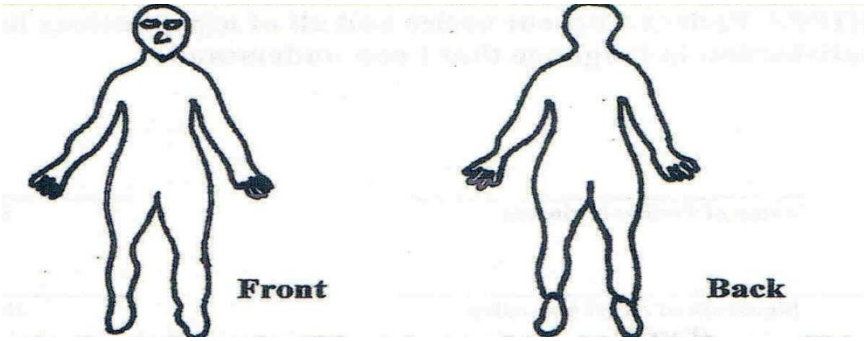
Occupation _____**Easiest Place to reach you** _____ **Leave Message Y/N**
How did you hear about us?(Who referred you?)_____

Emergency Contacts 1. _____ **phone #** _____

2. _____ **phone #** _____

Chief Complaint/Problem (Reason you are here)_____

Key: Pain= P Numbness=N Burning=B Sharp=S Throbbing=T



I, _____, consent to a full examination to determine if there is a need for chiropractic care. This includes, but is not limited to, an orthopedic, neurological, radiological, postural, and/or nutritional evaluation. Dr. Shields will only use what is necessary to determine the best course of treatment for my care.

I, _____, understand that New Life has a cancellation/reschedule policy. Appointments must be rescheduled at least 24 hours prior to your appointment or you WILL BE CHARGED $35 on your next visit.

I, _____, understand that NLCC does not accept any insurance plans and I am responsible for payment in full when services are rendered.

I, _____, am NOT a Medicare/Medicaid patient.

New Life Chiropractic Center

Are you currently under the care of a Physician? If Yes, Please give name and location

_____

_____

Current Medications and reason for taking them:_____

_____

_____

Current Supplements /Herbs/ Vitamins _____

_____

_____

List any major illnesses, injuries, surgeries (w/approximate dates)_____

_____

_____

List any major scars or body piercings _____

_____

Personal Habits: Do you use any of the following and if so, how much?

Cigarettes _____ **Coffee** _____ **Alcohol** _____ **Soda** _____

Sugar _____ **Non-prescription drugs** _____

Do you have any problems with sleep? Falling asleep _____ **Staying asleep** _____

Family History: Is there any family history of: cancer/ diabetes/ heart/ strokes/ kidney/ liver/ arthritis

_____

_____

Are there any household pets or other animals you are in close contact with daily?_____

_____

Are you here for just pain relief/ corrective care/ or wellness care? _____

How can we help you? _____

_____

Sign:_____ **Date:**_____

Patient Case # _____

RELEASE OF PROTECTED PATIENT INFORMATION

PATIENT NAME _____

This notice serves as an official authorization for the release of protected information regarding the treatment of the aforementioned patient. I, hereby, allow those individuals employed by New Life Chiropractic Center to release any and all information affiliated with the treatment rendered to me. I accept full liability regarding release of such information to the listed individuals.

NAMES OF AUTHORIZED INDIVIDUALS:

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

HIPPA NOTICE RECEIPT

By signing below, I acknowledge that I have received and reviewed the HIPPA Patient Consent notice and all of my questions have been answered to my satisfaction in language that I can understand.

_____ **Name of Patient (Printed)**

_____ **Signature of Patient**

_____ **Signature of Legal Guardian (Parent)**

_____ **Relationship to Patient**

_____ **Date**

_____ **Witness**

New Life Chiropractic Center

Quick Nutrition Quiz

Here's a quick nutritional quiz to scan for possible vitamin/mineral deficiencies. This quiz is NOT meant to diagnose any specific medical condition, only AID the doctor in the overall evaluation of your nutritional needs. Blood work, BioMeridian, and Applied Kinesiology testing will also be utilized.

Record 0/1/2 accordingly. Please add up the total points from questions 1-16. Record your total score in the bottom right corner of section.

NO= 0 points **Sometimes= 1 point** **Often= 2 points**

1. Do you get infections like the flu, colds, and sore throats easily? ___
2. Do you have depression, irritability, or anxiety? Do you experience great physical or emotional stress? ___
3. Do you have a high homocysteine level or heart disease? Do you even know what homocysteine is? ___
4. Do you have pernicious anemia? ___
5. Do you bruise easily, have varicose veins, or bleeding gums? ___
6. Do you have problems with your teeth? Do you have soft nails or bones (rickets)? ___
7. Do you have fibrocystic breast disease? ___
8. Do you have trouble with blood clotting? ___
9. Do you have twitching muscles or leg cramps? ___
10. Do you have hypoglycemia or sugar cravings? ___
11. Do you have high cholesterol (related to a zinc imbalance)? ___
12. Do you have thyroid problems? ___
13. Do you crave chocolate? ___
14. Do you have arthritis, joint pain, or clicking joints? ___
15. Do you have edema (swelling/inflammation)? ___
16. Do you have prostate problems or low resistance to colds/flu? ___ Score: _____

The Healthy Liver Quiz

Answer Y/N to each question. Add up the total 'yes' from questions 1-17. Record your score in the bottom right corner of section.

1. Do you suffer regular headaches or migraines? ___
2. Do you suffer from sinus issues, such as excessive mucus, stuffy nose or hay fever? ___
3. Do you have dark circles under your eyes? ___
4. Do you have red, swollen, or itchy eyes? ___
5. Do you have skin issues, such as acne, itchy rashes, hives or general dermatitis? ___
6. Do you experience joint pain; arthritis; puffy feet, ankles or hands; or inflammation? ___
7. Do you have excessive body heat or heavy perspiration? ___
8. Do you have strong body odor? ___
9. Do you wake up with a coated tongue, a bitter taste in your mouth, or bad breath? ___
10. Do you suffer from bloating, gas, indigestion, or nausea, particularly after eating fatty foods? ___
11. Do you suffer from constipation or diarrhea? ___
12. Do you experience sugar cravings, mood swings, fuzzy thinking, difficulty concentrating, poor memory or depression? ___
13. Do you feel lethargic? ___
14. Do you have difficulty controlling your weight, even when you eat less? ___
15. Do you suffer from high blood pressure or high cholesterol? ___
16. Do you experience hormonal imbalances, such as PMS or hot flashes? ___
17. Do you have a strong reaction to the effects of alcohol or coffee? ___ Score: _____

Name: Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0 1 2 3 4
b. Diarrhea	0 1 2 3 4
c. Constipation	0 1 2 3 4
d. Bloated feeling	0 1 2 3 4
e. Belching and/or passing gas	0 1 2 3 4
f. Heartburn	0 1 2 3 4

Total: ____

2. EARS

a. Itchy ears	0 1 2 3 4
b. Earaches or ear infections	0 1 2 3 4
c. Drainage from ear	0 1 2 3 4
d. Ringing in ears or hearing loss	0 1 2 3 4

Total: ____

3. EMOTIONS

a. Mood swings	0 1 2 3 4
b. Anxiety, fear, or nervousness	0 1 2 3 4
c. Anger, irritability	0 1 2 3 4
d. Depression	0 1 2 3 4
e. Sense of despair	0 1 2 3 4
f. Uncaring or disinterested	0 1 2 3 4

Total: ____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0 1 2 3 4
b. Hyperactivity	0 1 2 3 4
c. Restlessness	0 1 2 3 4
d. Insomnia	0 1 2 3 4
e. Startled awake at night	0 1 2 3 4

Total: ____

5. EYES

a. Watery or itchy eyes	0 1 2 3 4
b. Swollen, reddened, or sticky eyelids	0 1 2 3 4
c. Dark circles under eyes	0 1 2 3 4
d. Blurred or tunnel vision	0 1 2 3 4

Total: ____

6. HEAD

a. Headaches	0 1 2 3 4
b. Faintness	0 1 2 3 4
c. Dizziness	0 1 2 3 4
d. Pressure	0 1 2 3 4

Total: ____

7. LUNGS

a. Chest congestion	0 1 2 3 4
b. Asthma or bronchitis	0 1 2 3 4
c. Shortness of breath	0 1 2 3 4
d. Difficulty breathing	0 1 2 3 4

Total: ____

8. MIND

a. Poor memory	0 1 2 3 4
b. Confusion	0 1 2 3 4
c. Poor concentration	0 1 2 3 4
d. Poor coordination	0 1 2 3 4
e. Difficulty making decisions	0 1 2 3 4
f. Stuttering, stammering	0 1 2 3 4
g. Slurred speech	0 1 2 3 4
h. Learning disabilities	0 1 2 3 4

Total: ____

9. MOUTH/THROAT

a. Chronic coughing	0 1 2 3 4
b. Gagging or frequent need to clear throat	0 1 2 3 4
c. Swollen or discolored tongue, gums, lips	0 1 2 3 4
d. Canker sores	0 1 2 3 4

Total: ____

10. NOSE

a. Stuffy nose	0 1 2 3 4
b. Sinus problems	0 1 2 3 4
c. Hay fever	0 1 2 3 4
d. Sneezing attacks	0 1 2 3 4
e. Excessive mucous	0 1 2 3 4

Total: ____

11. SKIN

a. Acne	0 1 2 3 4
b. Hives, rashes, or dry skin	0 1 2 3 4
c. Hair loss	0 1 2 3 4
d. Flushing	0 1 2 3 4
e. Excessive sweating	0 1 2 3 4

Total: ____

12. HEART

a. Skipped heartbeats	0 1 2 3 4
b. Rapid heartbeats	0 1 2 3 4
c. Chest pain	0 1 2 3 4

Total: ____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0 1 2 3 4
b. Rheumatoid arthritis	0 1 2 3 4
c. Osteoarthritis	0 1 2 3 4
d. Stiffness or limited movement	0 1 2 3 4
e. Pain or aches in muscles	0 1 2 3 4
f. Recurrent back aches	0 1 2 3 4
g. Feeling of weakness or tiredness	0 1 2 3 4

Total: ____

14. WEIGHT

a. Binge eating or drinking	0 1 2 3 4
b. Craving certain foods	0 1 2 3 4
c. Excessive weight	0 1 2 3 4
d. Compulsive eating	0 1 2 3 4
e. Water retention	0 1 2 3 4
f. Underweight	0 1 2 3 4

Total: ____

15. OTHER:

a. Frequent illness	0 1 2 3 4
b. Frequent or urgent urination	0 1 2 3 4
c. Leaky bladder	0 1 2 3 4
d. Genital itch, discharge	0 1 2 3 4

Total: ____

Section I Total: ____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16. Circle the corresponding number for questions 16a-16f below.

0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily

a. How often are strong chemicals used in your home?
(disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.) 0 1 2 3 4

b. How often are pesticides used in your home? 0 1 2 3 4

c. How often do you have your home treated for insects? 0 1 2 3 4

d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office? 0 1 2 3 4

e. How often are you exposed to nail polish, perfume, hairspray, or other cosmetics? 0 1 2 3 4

f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes? 0 1 2 3 4

Total: _____

17. Circle the corresponding number for questions 17a-17b below.

0	No	1	Mild Change	2	Moderate Change	3	Drastic Change

a. Have you noticed any negative change in your health since you moved into your home or apartment? 0 1 2 3

b. Have you noticed any change in your health since you started your new job? 0 1 2 3

Total: _____

18. Answer yes or no and circle the corresponding number for questions 18a-18d below.

	No	Yes
a. Do you have a water purification system in your home?	2	0
b. Do you have any indoor pets?	0	2
c. Do you have an air purification system in your home?	2	0
d. Are you a dentist, painter, farm worker, or construction worker?	0	2

Total: _____

Section II Total: _____

Grand Total (Section I & Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a purification program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.