

Natural Care Chiropractic
New Patient Information Form
Page 1 of 2

Please print clearly

Name _____ Date _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Shipping Address _____

Home Phone () _____ Work Phone () _____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M/F _____ Height _____ Weight _____

Overall health (circle one): Excellent / Fair / Poor / Other: _____

Chief Complaint (reason you are here): (use separate sheet if more room is needed)

Previous treatments for this complaint: _____

Other complaints or problems: (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: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

Office Use Only:

Natural Care Chiropractic
New Patient Information Form cont.
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Name: _____ Date _____

HISTORY:

List any major illnesses (with approx. dates):

List any surgery or operations with approx. dates):

Past Accidents or injuries:

Marital Status: S M D W Name of Spouse
Describe health of spouse:

Number of children if any
Name of Child(ren) Age Sex Any physical conditions or concerns?

M/F

M/F

M/F

Any family history of serious illness (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?

SIGNED: _____ DATE _____

AGREEMENT TO DO A “NUTRITION RESPONSE TESTING™” PROGRAM

I specifically authorize Natural Care Chiropractic to use a Nutrition Response Testing™ health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and not for the treatment, or “cure” of any disease.

I understand that Nutrition Response Testing is a safe, non-invasive, natural method of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that this is not a method for “diagnosing” or “treating” of any disease including conditions of cancer, AIDS, infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of this testing or any natural health, nutritional or dietary programs recommended, but rather I understand that it is a means by which the body’s natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I understand that I am to adhere to the program guidelines. These guidelines have been fully laid out before me and discussed in detail. If I do not fully comply, I understand that this will greatly impact my results and success.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

_____	_____	_____
PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
_____	_____	_____
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

WAIVER OF LIABILITY TO DECLINE DOING A “NUTRITION RESPONSE TESTING™” PROGRAM

I understand that my health status is significantly diminished. It has been thoroughly explained to me by Natural Care Chiropractic why I should do a nutritional program in order to improve my health. I hereby state that I am of sound mind and I am making a conscious decision to DECLINE care. I will not hold Natural Care Chiropractic or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Natural Care Chiropractic from any liability regarding my health matters.

I have read and understand the foregoing.

_____	_____	_____
PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
_____	_____	_____
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

NOT A “NUTRITIONAL CASE” WAIVER OF LIABILITY

I understand that my health status is declining. I have been encouraged by Natural Care Chiropractic to seek medical attention for my health issues. I understand that doing a program at Natural Care Chiropractic would not successfully address my current health situation. I will not hold Natural Care Chiropractic or any of its associates responsible for any outcome which may result from any symptom or disease process that could occur or be diagnosed by a medical professional. I hereby release Natural Care Chiropractic from any liability regarding my health matters.

I have read and understand the foregoing.

_____	_____	_____
PATIENT PRINT NAME	PATIENT SIGN NAME	DATE
_____	_____	_____
WITNESS PRINT NAME	WITNESS SIGN NAME	DATE

Natural Care Chiropractic
2118 East Grand Avenue
Lindenhurst, IL 60046
847 265 0600

PROGRAM GUIDELINES

1. You are expected to keep all appointments as scheduled in order to ensure maximum progress in your case. If for some reason you cannot make an appointment, please call at least 24 hours in advance. You will need to reschedule that appointment for the SAME week and not fall into the following week.
2. Follow-up visits generally take 10 minutes or less. Extended visits, though rarely needed, are charged proportionally. To save time on your visits, write down your questions and let doctor know about these at the beginning of the visit. In between visits, it is highly recommended that you take up any questions with the Patient Advocate, either by phone or in person, since there is no charge for time spent with the Patient Advocate.
3. Fill out your Daily Record of Food Intake form as you eat each meal, snack, etc. between visits. Make it a habit to do it this way and not wait until the end of the day or later. This will ensure accurate information for the doctor.
4. TRY NOT to miss any doses of your supplements. Missed doses will slow down improvement and extend the time it takes to complete your program. If you miss a dose, you can make it up at your next dose. If this happens repeatedly, let the doctor know so your supplement schedule can be modified.
5. Please keep in mind that our nutritional products DO NOT cause “side effects” as they are not drugs. Occasionally after starting a nutritional program, you may feel a temporary worsening or even feel “sick.” If this occurs, do NOT cancel your appointment. Immediately call the office. Sometimes these “flare-ups” are actually a “Healing Crisis” which indicates your body is starting to heal by throwing off toxins that have been keeping you sick. By fine-tuning your program, we can help you get through these types of situations much more smoothly, if they even occur. When you are not doing well is when it is often most important to come in so we can fine-tune your program and help you correct the underlying cause of the problem more rapidly.
6. Please consider all the factors in your life that could interfere with or prevent you from doing or completing your health improvement program. If you need assistance in working out how to handle any obstacles in your quest for better health, please stay in communication with the clinic.

SYMPTOM SURVEY FORM

NAME _____ DOCTOR _____ DATE _____

AGE _____ SEX M ___ F ___

Phone # (____) _____

INSTRUCTIONS:

Circle the number that applies to you. **If a symptom does not apply, leave it blank.**

(1) for **MILD** symptoms (occurs rarely)

(2) for **MODERATE** symptoms (occurs several times a month)

(3) for **SEVERE** symptoms (occurs almost constantly)

GROUP ONE

- | | | |
|------------------------------------|---|------------------------------------|
| 1 -- 1 2 3 Acid foods upset | 8 -- 1 2 3 Gag Easily | 15 -- 1 2 3 Appetite reduced |
| 2 -- 1 2 3 Get chilled, often | 9 -- 1 2 3 Unable to relax, startles easily | 16 -- 1 2 3 Cold sweats often |
| 3 -- 1 2 3 "lump" in throat | 10 -- 1 2 3 Extremities cold, clammy | 17 -- 1 2 3 Fever easily raised |
| 4 -- 1 2 3 Dry mouth-eyes-nose | 11 -- 1 2 3 Strong light irritates | 18 -- 1 2 3 Neuralgia-like pains |
| 5 -- 1 2 3 Pulse speeds after meal | 12 -- 1 2 3 Urine amount reduced | 19 -- 1 2 3 Staring, blinks little |
| 6 -- 1 2 3 Keyed up – fall to calm | 13 -- 1 2 3 Heart pounds after retiring | 20 -- 1 2 3 Sour stomach frequent |
| 7 -- 1 2 3 Cuts heal slowly | 14 -- 1 2 3 "Nervous" stomach | |

GROUP TWO

- | | | |
|--|---|---|
| 21 -- 1 2 3 Joint stiffness after arising | 29 -- 1 2 3 Digestion rapid | 37 -- 1 2 3 "Slow starter" |
| 22 -- 1 2 3 Muscle-leg-toe cramps at night | 30 -- 1 2 3 Vomiting frequent | 38 -- 1 2 3 "Chilled" infrequently |
| 23 -- 1 2 3 "Butterfly" stomach, cramps | 31 -- 1 2 3 Hoarseness frequent | 39 -- 1 2 3 Perspire easily |
| 24 -- 1 2 3 Eyes or nose watery | 32 -- 1 2 3 Breathing irregular | 40 -- 1 2 3 Circulation poor,
sensitive to cold |
| 25 -- 1 2 3 Eyes blink often | 33 -- 1 2 3 Pulse slow; feels "irregular" | 41 -- 1 2 3 Subject to colds,
asthma, bronchitis |
| 26 -- 1 2 3 Eyelids swollen, puffy | 34 -- 1 2 3 Gagging reflex slow | |
| 27 -- 1 2 3 Indigestion soon after meals | 35 -- 1 2 3 Difficult swallowing | |
| 28 -- 1 2 3 Always seem hungry;
feels "lightheaded" often | 36 -- 1 2 3 Constipation,
diarrhea alternation | |

GROUP THREE

- | | | |
|--|--|--|
| 42 -- 1 2 3 Eat when nervous | 49 -- 1 2 3 Heart palpitates if meals
missed or delayed | 53 -- 1 2 3 Crave candy or
coffee in afternoon |
| 43 -- 1 2 3 Excessive appetite | 50 -- 1 2 3 Afternoon headaches | 54 -- 1 2 3 Moods of depression
"blues" or melancholy |
| 44 -- 1 2 3 Hungry between meals | 51 -- 1 2 3 Overeating sweets upsets | 55 -- 1 2 3 Abnormal craving for
sweets or snacks |
| 45 -- 1 2 3 Irritable before meals | 52 -- 1 2 3 Awaken after few hours sleep
-hard to get back to sleep | |
| 46 -- 1 2 3 Get "shaky" if hungry | | |
| 47 -- 1 2 3 Fatigue, eating relieves | | |
| 48 -- 1 2 3 "lightheaded" if meals delayed | | |

GROUP FOUR

- | | | |
|---|--|---|
| 56 -- 1 2 3 Hand and feet go to sleep
easily, numbness | 63 -- 1 2 3 Get "drowsy" often | 68 -- 1 2 3 Bruise easily, "black
and blue" spots |
| 57 -- 1 2 3 Sigh frequently. "air
hunger" | 64 -- 1 2 3 Swollen ankles
worse at night | 69 -- 1 2 3 Tendency to anemia |
| 58 -- 1 2 3 Aware of "breathing
heavily" | 65 -- 1 2 3 Muscle cramp, worse
during exercise; get
'charley horses' | 70 -- 1 2 3 "Nose bleeds" frequent |
| 59 -- 1 2 3 High altitude discomfort | 66 -- 1 2 3 Shortness of breath
on exertion | 71 -- 1 2 3 Noises in head, or
"ringing in ears" |
| 60 -- 1 2 3 Opens windows in
closed room | 67 -- 1 2 3 Dull pain in chest or
radiating into left arm,
worse on exertion | 72 -- 1 2 3 Tension under the
breastbone, or feeling
of "tightness",
worse on exertion |
| 61 -- 1 2 3 Susceptible to colds
and fevers | | |
| 62 -- 1 2 3 Afternoon "yawner" | | |

SYMPTOM SURVEY FORM

GROUP FIVE

73 --	1	2	3	Dizziness	83 --	1	2	3	Feeling queasy; headache	91 --	1	2	3	Sneezing attacks
74 --	1	2	3	Dry skin					over eyes	92 --	1	2	3	Dreaming, nightmare type bad dreams
75 --	1	2	3	Burning feet	84 --	1	2	3	Greasy foods upset					
76 --	1	2	3	Blurred vision	85 --	1	2	3	Stools light-colored	93 --	1	2	3	Bad breath (halitosis)
77 --	1	2	3	Itching skin and feet	86 --	1	2	3	Skin peels on foot soles	94 --	1	2	3	Milk products causes distress
78 --	1	2	3	Excessive falling hair	87 --	1	2	3	Pain between shoulder blades	95 --	1	2	3	Sensitive to hot weather
79 --	1	2	3	Frequent skin rashes					Uses laxatives	96 --	1	2	3	Burning or itching anus
80 --	1	2	3	Bitter, metallic taste in mouth in morning	89 --	1	2	3	Stools alternate from soft to watery	97 --	1	2	3	Crave sweets
81 --	1	2	3	Bowel movements painful or difficult	90--	1	2	3	History of gallbladder attacks or gallstones					
82 --	1	2	3	Worrier, feels insecure										

GROUP SIX

98 --	1	2	3	Loss of taste for meat	101 -	1	2	3	Coated tongue	104 -	1	2	3	Mucous colitis or "irritable bowel"
99 --	1	2	3	Lower bowel gas several hours after eating	102 -	1	2	3	Pass large amount of foul-smelling gas	105 -	1	2	3	Gas shortly after eating
100 -	1	2	3	Burning stomach sensations, eating relieves	103 -	1	2	3	Indigestion ½ - 1 hr after eating; may be 3-4 hours	106 -	1	2	3	Stomach "bloating" after eating

GROUP SEVEN

(A)														
107 -	1	2	3	Insomnia						(E)				
108 -	1	2	3	Nervousness						150 -	1	2	3	Dizziness
109 -	1	2	3	Can't gain weight	(C)					151 -	1	2	3	Headaches
110 -	1	2	3	Intolerance to heat	137 -	1	2	3	Failing memory	152 -	1	2	3	Hot flashes
111 -	1	2	3	Highly emotional	138 -	1	2	3	Low blood pressure	153 -	1	2	3	Increased blood pressure
112 -	1	2	3	Flush easily	139 -	1	2	3	Increased sex drive	154 -	1	2	3	Hair growth on face or body (female)
113 -	1	2	3	Night sweats	140 -	1	2	3	Headaches, "splitting or rendering" type					
114 -	1	2	3	Thin, moist skin	141 -	1	2	3	Decreased sugar tolerance		1	2	3	Sugar in urine (not diabetes)
115 -	1	2	3	Inward trembling	(D)					159 -	1	2	3	Masculine tendencies (female)
116 -	1	2	3	Heart palpitates	142 -	1	2	3	Abnormal thirst	(F)				
117 -	1	2	3	Increased appetite without weight gain	143 -	1	2	3	Bloating of abdomen	157 -	1	2	3	Weakness, dizziness
118 -	1	2	3	Pulse fast at rest	144 -	1	2	3	Weight gain around hips or waist	158 -	1	2	3	Chronic fatigue
119 -	1	2	3	Eyes and face twitch	145 -	1	2	3	Sex drive reduced or lacking	159 -	1	2	3	Low blood pressure
120 -	1	2	3	Irritable and restless	146 -	1	2	3	Tendency to ulcers, colitis	160 -	1	2	3	Nails, weak, ridged
121 -	1	2	3	Can't work under pressure	147 -	1	2	3	Increased sugar tolerance	161 -	1	2	3	Tendency to hives
(B)					148 -	1	2	3	Women: menstrual disorders	162 -	1	2	3	Arthritic tendencies
122 -	1	2	3	Increase in weight	149 -	1	2	3	Young girls: lack of menstrual function	163 -	1	2	3	Perspiration increase
123 -	1	2	3	Decrease in appetite						164 -	1	2	3	Bowel disorders
124 -	1	2	3	Fatigue easily						165 -	1	2	3	Poor circulation
125 -	1	2	3	Ringing in ears						166 -	1	2	3	Swollen ankles
126 -	1	2	3	Sleepy during day						167 -	1	2	3	Crave salt
127 -	1	2	3	Sensitive to cold						168 -	1	2	3	Brown spots or bronzing of skin
128 -	1	2	3	Dry or scaly skin						169 -	1	2	3	Allergies, tendency to asthma
129 -	1	2	3	Constipation						170 -	1	2	3	Weakness after colds, influenza
130 -	1	2	3	Mental sluggishness						171 -	1	2	3	Exhaustion - muscular and nervous
131 -	1	2	3	Hair coarse, falls out						172 -	1	2	3	Respiratory disorders
132 -	1	2	3	Headaches upon arising wearing off during day										
133 -	1	2	3	Slow pulse, below 65										
134 -	1	2	3	Frequency of urination										
135 -	1	2	3	Impaired hearing										
136 -	1	2	3	Reduced initiative										

SYMPTOM SURVEY FORM

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficulty or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequently
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings before menstruation	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs and heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscle soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression, long standing	
186 - 1 2 3 Hair is coarse and/or thinning		
187 - 1 2 3 Weakness		
188 - 1 2 3 Fatigue		
189 - 1 2 3 Skin sensitive to touch		
190 - 1 2 3 Tendency toward hives		
191 - 1 2 3 Nervousness		
192 - 1 2 3 Headache		
193 - 1 2 3 Insomnia		
194 - 1 2 3 Anxiety		
195 - 1 2 3 Anorexia		
196 - 1 2 3 Inability to concentrate; confusion		
197 - 1 2 3 Frequent stuffy nose; sinus infections		
198 - 1 2 3 Allergy to some foods		
199 - 1 2 3 Loose joints		

IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have
in order of their importance:

1. _____

2. _____

3. _____

4. _____

5. _____