Initial Nutrition Patient Intake Form

Patient Name:_______________________________________ **Date:**_______________

Address:___________________________________ **City/State/Zip:**_________________________

Primary Phone: ____________________________ **Secondary Phone:** __________________________

DOB:__________________________ **Sex:** Male or Female **SSN#:**__________________________

Occupation: ___________________________ **Employer:**________________________________

Primary diagnosis/chief complaint: ____

What is your goal or what are you hoping to achieve from this appointment:

____

____

Have you received professional treatment for this condition: YES NO

If yes, with whom: ____

Date of Last Physical Exam: _________________________

Date of Last Lab Panel: _____________________________

Has this condition affected your sleep quality or your ability to sleep? YES NO

Has this condition affected your appetite? YES NO

List anything that aggravates your condition: ____

____

List anything that relieves or improves your condition:____

____

When did you first notice this condition OR when were you first diagnosed with this condition: ________

____

Height: ________________ **Weight:** ________________

Activity Level (check only one) **Blood Type:** A B AB O

- Sedentary (little or no exercise, desk job or bed ridden)
- Lightly Activity (light exercise- sports 1-3 days a week)
- Moderate Activity (moderate exercise- sports 3-5 days a week)
- Very Active (hard exercise- sports 6-7 days a week)
- Extra Active (hard daily exercise- sports and physical job)

Non-Medication Allergies: ____

Current Vitamins, Minerals, Supplements, etc…. ______________________________

____

Current Medications (name & reason) ______________________________________

____

Medication Allergies : NO YES if yes, please list______________________________

Surgeries (birth to present)____

____

Social History and Life Choices (select the best answer):

Alcohol:
Daily Weekly Occasionally Never

Caffeinated Drinks:
Daily Weekly Occasionally Never

Energy Products/Stimulants:
Daily Weekly Occasionally Never

Drugs:
Daily Weekly Occasionally Never

Fresh/Homemade Foods:
Daily Weekly Occasionally Never

Packaged/Processed Foods:
Daily Weekly Occasionally Never

Restaurant/Takeout Foods:
Daily Weekly Occasionally Never

Tobacco
Daily Weekly Occasionally Never

Water (include how many glasses): _______
Daily Weekly Occasionally Never

Carbonated Beverages:
Daily Weekly Occasionally Never

For Women Only (only for women over 16 years of age):

Are you pregnant? YES NO

Are you nursing? YES NO

Are you taking birth control? YES NO

If yes, is it an oral one? YES NO

Do you have irregular periods? YES NO

Are your periods painful? YES NO

Are you in perimenopause? YES NO

Are you in menopause? YES NO

Do you take hormone replacement therapy? YES NO

Medical History (if multiple choices, please select all that apply):

General: ◯ allergies ◯ fatigue ◯ fainting ◯ anemia ◯ HIV/AIDS ◯ gallbladder problems

◯ weight loss/weight gain ◯ eating disorder ◯ thyroid problems ◯ liver problems

◯ cancer (type)____________________________ ◯ diabetes (type) ________________

◯ rash/Rosacea ◯ eczema/dermatitis/psoriasis/dry skin ◯ acne

Muscle/Joint: ◯ arthritis ◯ rheumatoid arthritis (RA) ◯ neck pain ◯ mid back pain ◯ lower back pain

◯ joint pain (i.e. knee, wrist) ________________________ ◯ fibromyalgia ◯ gout

◯ scoliosis ◯ osteopenia/osteoporosis

Cardiovascular: ◯ high blood pressure ◯ heart attack ◯ stroke ◯ rapid heartbeat ◯ chest pains

◯ aneurysm ◯ poor circulation ◯ high cholesterol ◯ congestive heart failure

Neurological: ◯ concussion ◯ ADD/ADHD ◯ OCD ◯ seizures ◯ drug/alcohol dependence

◯ arm/hand tingling (which side) _____________ ◯ balance problems ◯ loss of smell

◯ loss of taste ◯ foggy brain/poor concentration ◯ headaches/migraines

◯ dizziness ◯ anxiety ◯ depression

GI: ◯ constipation/irregular bowel habits ◯ diarrhea ◯ IBS ◯ Crohn's ◯ Celiac's ◯ ulcer

◯ heartburn/acid reflux ◯ abdominal pain ◯ hemorrhoids ◯ "Leaky Gut" ◯ gas/bloating

Respiratory: ◯ asthma ◯ emphysema ◯ chronic cough ◯ shortness of breath ◯ COPD

Genitourinary: ◯ frequent/painful urination ◯ bladder infection ◯ kidney stones ◯ prostate problems

◯ loss of bladder control ◯ PMS ◯ endometriosis ◯ breast lumps

◯ Profuse/irregular menstrual flow ◯ chronic yeast infections ◯ kidney infection

EENT: ◯ chronic sinusitis ◯ difficulty swallowing ◯ ringing in the ears/tinnitus ◯ vision problems

◯ chronic ear infections ◯ glaucoma ◯ macular degeneration

Any other health concern not listed: ____

**I affirm that the information I have given is correct to the best of my knowledge, and that is my responsibly to inform this office of any changes in my medical status.

____

Signature Date

STEELE CHIROPRACTIC
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INFORMED CONSENT AND BUSINESS ARRANGEMENTS FOR NUTRITIONAL COUNSELING AND NOTICE OF PRIVACY PRACTICES

Patient Name: **Account #:**

I acknowledge that I am obtaining the nutritional counseling services of Steele Chiropractic and Dr. Marcus A Steele DC, CCN so that I may obtain more information and better insight into my health care needs (diet, nutrition, exercise, etc.) in order to help encourage and support my own personal health and wellness goals. I also understand that he will be providing me with the education necessary to help strengthen my understanding of my health as it relates to foods, dietary supplements, and exercise. I also understand that this is not a substitute for the diagnosis, treatment, or care of any disease by a medical provider. Any testing performed or requested is intended as a guide to help develop my specific nutritional health care plan and to monitor my progress in achieving my specific health and wellness goals. I also understand that it is my responsibility to provide complete and accurate information regarding my health and wellness. Any inaccurate or omitted information may affect the recommendations given. It is also my responsibility to keep Steele Chiropractic and all other members of their healthcare team informed of any changes to my healthcare needs or wellness programs.

Steele Chiropractic, and Dr. Marcus A Steele provide these nutritional services as a non-billable service that I, the patient, am financially liable for at the time of service. By signing below, I acknowledge that I am responsible for the services provided to me.

I also acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Steele Chiropractic and have read and understood its content.

____

Patient Signature **OR** Parent/Guardian/Personal Representative Signature Date

____

Printed Name and Relationship to Patient

Patient Consent for Electronic Reminders

Patients at Steele Chiropractic may be contacted via text messaging to be reminded of an appointment. If at any time I provide a phone number at which I may be contacted, I consent to receive appointment reminders via text from Steele Chiropractic.

______ (Patient initials) I consent to receive text messages from Steele Chiropractic on my cell phone. I understand that this request to receive text messages will apply to all future appointment reminders unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders is________________________________.

Steele Chiropractic does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Printed Name and Chart #: ____

Parent/Representative Signature: ____________________________Date_____________________________

Patient Signature ____ Date ____________________________

Revocation:

__I hereby revoke my request to receive any future appointment reminders via text messages.
NOTE: This revocation only applies to communications from this Practice.