



# Natural Elements Health Center

14094 9th Ave SE Milaca, MN 56353

Date: \_\_\_\_\_

Children's Intake Form: Ages 1-16

Child's Name: \_\_\_\_\_ Name the child prefers to be called: \_\_\_\_\_

Name of Mom, Dad, or guardian: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: M F

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

SS#: \_\_\_\_\_-\_\_\_\_\_ Family E-mail: \_\_\_\_\_

Best place to reach you:  Home  Cell  Work: ( ) \_\_\_\_\_ ext: \_\_\_\_\_

Children's Siblings and ages (if applicable): \_\_\_\_\_

Who is your child's primary care doctor? \_\_\_\_\_  
(Please list the name of your child's doctor and the facility)

May we contact him or her about your care? Y N Were you referred by him or her? Y or N

How did you hear about us? \_\_\_\_\_

### Insurance Information

Are your child's symptoms related to an accident? Y N  Automobile  Work  Other Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### Current Complaints

Major complaints and symptoms: 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_

How do you believe the child's problem or pain began? \_\_\_\_\_

**Has your child seen any provider for this condition?**

**What did they do, and did it help?**

1. \_\_\_\_\_ Y N

2. \_\_\_\_\_ Y N

**On a Scale of 0—10,**

**I rate my discomfort as follows:**

(Zero being no pain, 10 being the worst pain I have ever felt)

**Neck-Shoulder-Arm Pain**



**Mid Back Pain**



**Low Back- Leg Pain**



**Vitamins and Supplements**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

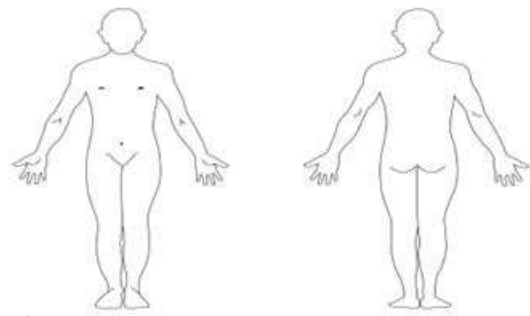
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Medications (please write additional on separate sheet of paper)**

\_\_\_\_\_  
\_\_\_\_\_

**SHOW AREA(S) OF PAIN OR SYMPTOMS**

Mark the areas on this body where your child feels pain or symptoms.



**TRAUMA** (if answer is yes- please list the approximate age of occurrence)

Has your child had any recent falls or injuries? N Y: \_\_\_\_\_  
Has your child ever fallen downstairs or fallen from any height? N Y: \_\_\_\_\_  
Has your child ever been in a motor vehicle collision? N Y: \_\_\_\_\_  
Has your child ever had a bone fracture or joint dislocation? N Y: \_\_\_\_\_  
Has your child ever fallen from a bicycle, skateboard, scooter, rollerblades, or similar? N Y: \_\_\_\_\_  
Has your child had any other trauma or injuries? N Y: \_\_\_\_\_

**NUTRITION** (if answer is yes- please describe)

Do you have any concerns about your child's diet? N Y: \_\_\_\_\_  
Does your child take vitamin supplements? N Y (see front section of listed supplements)  
Does your child eliminate stools each day? N Y If no, how often? \_\_\_\_\_  
How many glasses of water does your child drink each day? \_\_\_\_\_  
How many cans of soda does your child drink each day? \_\_\_\_\_ Or, per week? \_\_\_\_\_  
How much cow's milk does your child drink each day? \_\_\_\_\_  
Does your child eat fruits and vegetables? N Y \_\_\_\_\_

**GROWTH and HEALTH HISTORY** (if the answer is yes, please describe briefly)

Was your child born premature? N Y If yes, at what month / week was your child born? \_\_\_\_\_  
Does your child ever complain of neck or back pain? N Y: \_\_\_\_\_  
Does your child ever complain of pain in his/her arms or legs? N Y: \_\_\_\_\_  
Does your child ever complain of headaches? N Y: \_\_\_\_\_  
Does your child have a problem with bedwetting (if potty-trained)? N Y: \_\_\_\_\_  
Does your child have excessive belching or passing gas? N Y: \_\_\_\_\_  
Does your child have any known food allergies? N Y (See the front box listed Allergies)  
Does your child have frequent or occasional skin rashes? N Y: \_\_\_\_\_  
Has your child ever had an upper respiratory infection? N Y If yes, at what age(s)?: \_\_\_\_\_  
Has your child had asthma? N Y If yes, what age was it diagnosed? \_\_\_\_\_  
Does your child have frequent earaches? N Y If yes, when did they start? \_\_\_\_\_  
Has your child had any other significant illnesses? N Y: Chickenpox | Strep Throat | RSV | Bronchitis | Pneumonia  
Has your child taken antibiotics? N Y If yes, how many treatments? \_\_\_\_\_  
Is your child presently on any medications? N Y (See front box of listed medications)  
Has your child been recently vaccinated? N Y Has your child been following the vaccination schedule? N Y  
Has your child previously had chiropractic care? N Y If yes, date of last treatment? \_\_\_\_\_  
Do you have any other concerns about your child's health? \_\_\_\_\_

**TERMS OF ACCEPTANCE**

**VERTEBRAL SUBLUXATION:** A misalignment of one or more of the 24 vertebra in the spine, or within the extremities, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

**\*\* Possible Adverse Reactions to an Adjustment:**

**Soreness:** I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

**Dizziness:** Temporary symptoms like dizziness and nausea can occur but are relatively rare.

**Fractures/Joint Injury:** I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

**Stroke:** Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

**Nutritional Supplements:** If I have a medical condition and taking prescription medication, I agree to discuss with my medical doctor any nutritional supplement that has been prescribed or taken from Natural Elements.

**I, have read and fully understand the above statements.**

**All questions regarding the doctor's objectives pertaining to the care in this office have been answered to my complete satisfaction.**

**I, therefore, accept chiropractic care on this basis.**

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature \_\_\_\_\_

**HIPPA Regulations Natural Elements will Follow to Ensure your Protection**

**Your Rights**

- The right to request restrictions on certain uses and disclosure of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

In 2009 all healthcare professionals are required by law to send their bills, correspondence, and related billing information electronically. Natural Elements uses the billing services of **Medical Business Consulting**, a company also required to follow HIPPA regulations noted by the Dept. Of Health and Human Services (federal level). Information that will be electronically submitted is:

*Beneficiary's name, date of birth, address, Beneficiary's health insurance identification and claim number, Date(s) of service, Diagnosis/nature of illness, Procedure/services performed*

**Contact Information**

If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Ave. S.W., Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-9775

I have received a read copy of the notice of privacy practices. This acknowledgement applies to:

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

**Natural Elements Chiropractic & Massage Cancellation Policy**

**NEW PATIENTS: Must give a 24 hour notice** to cancel your appointment. If a 24 hour notice is not given you will be charged the rate of service for the appointment scheduled, \$125.00 for chiropractic and \$60.00 for massage.

**ESTABLISHED PATIENTS:**

**Morning appointments must be called in by 4:30 pm the day before** your appointment.

**Afternoon appointments must be called in by 9:00 am** on the day of your appointment.

If you do not call in by the designated times or "no show" for your appointment, you will be charged the rate of service for the appointment and will be required to pay for the missed appointment before scheduling another.

**Exceptions:** Medical Emergencies, illness & funeral

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**Natural Elements Health Center** is a cash based practice. Payment is due at the time of service.

**Payment Plan:** If you are suffering a financial hardship and need to set up a payment plan, please speak to our office manager at the front desk.

**Returned Check Policy:** All returned check's will be a \$30.00 non-sufficient funds charge.

**Signature of Patient:** \_\_\_\_\_ **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

### Client Bill of Rights for Massage

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

**Please check the box indicating that you have read this policy and sign.**

### Client

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

#### \*\*For Doctor Use Only\*\*

##### PATIENT STATUS AT TIME OF INFORMED CONSENT AND TERMS OF ACCEPTANCE PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- |     |                                                                         |     |              |     |                    |
|-----|-------------------------------------------------------------------------|-----|--------------|-----|--------------------|
| [ ] | Of legal age                                                            | [ ] | Oriented x 3 | [ ] | Coherent and lucid |
| [ ] | Proficient in understanding the English language                        |     |              |     |                    |
| [ ] | Assisted in understanding by an interpreter (Interpreter's name: _____) |     |              |     |                    |
| [ ] | Unable to give legal consent                                            |     |              |     |                    |
| [ ] | Consent given thru legal guardian _____                                 |     |              |     |                    |

I certify that the above accurately describes the above named patient's status during the informed consent process.

\_\_\_\_\_  
Date Signature of Doctor

## **Bowel Transit Time**

How quickly you eliminate waste through your intestinal tract is an important indicator of your health. To feel your best and help prevent degenerative diseases, your bowel transit time (the time it takes to digest a particular food and eliminate the waste products) should be 12 to 24 hours. Shorter transit times suggest you may not be digesting properly. Longer transit times mean you are being exposed to toxins from your digestive tract. Interestingly, research shows a correlation between gallstones and longer transit times. Having a long transit time may make you feel bloated, constipated and /or lethargic.

### **Directions:**

1. Have a bowel movement
2. After a bowel movement, take all 10 charcoal capsules or 2 beets all at once.  
Children 12 and under take 5 charcoal capsules (all at once) or 1 beet.
3. Document the date and time that you take the charcoal capsules.
4. Document the date and time that you see the same charcoal color as the capsule in your stool.
5. Total transit time in hours: \_\_\_\_\_

### **Things to consider:**

1. Children/adults who have difficulty swallowing capsules you may open all the capsules and put into a single serving of pudding or yogurt. The charcoal is tasteless and harmless; it will turn the pudding or yogurt black.
2. **DO NOT PANIC** if the transit time is longer than listed above, it just means Dr. Christine will help you get your bowel running in a more efficient way. Call our staff @ [320-983-2333](tel:320-983-2333) with any questions.



# Natural Elements Health Center

Dr. Christine Schlenker  
www.NaturalElementsHealth.com  
320-983-2333

## Daily Record of Food Intake

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to our office for evaluation.

Name: \_\_\_\_\_

**DAY ONE** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Mid-Day Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

\_\_\_\_\_

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**Nighttime Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Quality of Sleep:** (best) 1 2 3 (poor)

**DAY TWO** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Quality of Sleep:** (best) 1 2 3 (poor)

**DAY THREE** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Quality of Sleep:** (best) 1 2 3 (poor)

**DAY FOUR** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

\_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

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**Hours of Sleep:** \_\_\_\_\_

\_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Quality of Sleep:** (best) 1 2 3 (poor)

\_\_\_\_\_

**DAY FIVE** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

\_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

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**Hours of Sleep:** \_\_\_\_\_

\_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Quality of Sleep:** (best) 1 2 3 (poor)

\_\_\_\_\_

**DAY SIX** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

\_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

\_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

\_\_\_\_\_

**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

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**Quality of Sleep:** (best) 1 2 3 (poor)

\_\_\_\_\_

**DAY SEVEN** DATE: \_\_\_\_\_

**Breakfast** (time: \_\_\_\_\_ )

Meat & Dairy \_\_\_\_\_

Vegetables & Fruit \_\_\_\_\_

Breads, Cereals, Grains \_\_\_\_\_

Fats (Butter, Oils, etc) \_\_\_\_\_

Candy, Sweets, Junkfood \_\_\_\_\_

Water Intake \_\_\_\_\_

Other Drinks \_\_\_\_\_

**Mid-Morning Snack** (time: \_\_\_\_\_ )

Snack \_\_\_\_\_

**Bowel Movements** (# and type): \_\_\_\_\_

\_\_\_\_\_

**Lunch** (time: \_\_\_\_\_ )

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**Mid-Day Snack** (time: \_\_\_\_\_ )

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**Hours of Sleep:** \_\_\_\_\_

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**Dinner** (time: \_\_\_\_\_ )

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**Nighttime Snack** (time: \_\_\_\_\_ )

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**Quality of Sleep:** (best) 1 2 3 (poor)

\_\_\_\_\_