Natural Elements Health Center

14094 9th Ave SE Milaca, MN 56353

Date: _____

Infant Intake Form: Newborn to 1 yr.

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**

Vitamins and Supplements	**Allergies**	**Medications**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

During the Pregnancy, Did you use or have any of the following:

Tobacco …… ☐ No ☐ Yes: _____

Alcohol …… ☐ No ☐ Yes: _____

High Blood Presure …… ☐ No ☐ Yes: _____

Diabetes (Type1, Type 2, or Gestational) …… ☐ No ☐ Yes: _____

Anemia …… ☐ No ☐ Yes: _____

Please Check Any of the Following that Occurred While Pregnant With This Child:

	No	Yes	Describe
Falls	☐	☐	_____
Motor Vehicle Accidents	☐	☐	_____
Morning Sickness/Nausea	☐	☐	_____
Indigestion	☐	☐	_____
Seizures	☐	☐	_____
Swollen Ankles	☐	☐	_____
Thyroid Problems	☐	☐	_____
Heart Problems	☐	☐	_____
Low Back Pain	☐	☐	_____
Headaches	☐	☐	_____
Rib / Breathing Pain	☐	☐	_____
Abnormal Bleeding	☐	☐	_____
Premature Contractions	☐	☐	_____
Bed Rest	☐	☐	_____
Pre-eclampsia	☐	☐	_____
Any Other Illnesses	☐	☐	_____

Please Answer the Following Questions: **(if the answer is yes, please describe briefly)**

Was this child born Premature? N Y If yes, at what week was your child born?_____

Were there complications with your child's health following delivery? N Y:_____

Has your child experienced any significant illnesses? N Y

If yes, please list the illnesses your child has experienced: _____

_____

Have you noticed any unusual rashes or markings? N Y: _____

Does your child experience ear aches or redness around the ears? N Y

Has your child had an ear infection? N Y If yes, how many?_____

Has your child had antibiotics? N Y If yes, how many treatments?_____

Has your child been vaccinated? N Y

If yes, when was your child's last vaccination?_____

Any problems with Constipation? N Y:_____

Any problems with Diarrhea? N Y:_____

Has your child received chiropractic care before? N Y If yes, when was their last treatment?_____

Has your child had any significant illnesses? N Y: RSV, Bronchitis, Pneumonia, Acid Reflux

Do you have any other concerns regarding your child's health?_____

_____

Natural Elements Health Center 14094 9th Ave SE Milaca, MN 56353
Phone: 320.983.2333 Fax: 320.983.5444 staff@naturalelementshealth.com

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.

Signature:_____ Date:_____

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:

Signature_____ Date:_____

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

Release of Information: My signature below authorizes Natural Elements Health Center, Inc. , it's employees, and/or agents to release any information concerning my health and healthcare services to my insurance companies, pre-paid health plan or Medicare. I authorize the use of the signature below and all insurance submissions.

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

Signature:_____ 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 coarse 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.

☐ 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 _____ _____
NAME RELATIONSHIP

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 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:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**: (best) 1 2 3 (poor)
_____	_____	_____

DAY TWO DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**: (best) 1 2 3 (poor)
_____	_____	_____

DAY THREE DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**: (best) 1 2 3 (poor)
_____	_____	_____

DAY FOUR DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

DAY FIVE DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

DAY SIX DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____

DAY SEVEN DATE:_____

Breakfast (time:)	**Lunch** (time:)	**Dinner** (time:)
Meat & Dairy _____	_____	_____
Vegetables & Fruit _____	_____	_____
Breads, Cereals, Grains _____	_____	_____
Fats (Butter, Oils, etc) _____	_____	_____
Candy, Sweets, Junkfood _____	_____	_____
Water Intake _____	_____	_____
Other Drinks _____	_____	_____
Mid-Morning Snack (time:)	**Mid-Day Snack** (time:)	**Nighttime Snack** (time:)
Snack _____	_____	_____
Bowel Movements (# and type):	**Hours of Sleep**:	**Quality of Sleep**:(best)1 2 3(poor)
_____	_____	_____