



Natural Elements Health Center
Dr. Christine Schlenker

14094 9th Ave SE, Milaca, MN 56353
Tel: 320.983.2333 Fax: 320.983.5444

Today's Date: \_\_\_/\_\_\_/\_\_\_

Your Name: \_\_\_\_\_ Name you prefer to be called: \_\_\_\_\_
Address: \_\_\_\_\_ Apt#: \_\_\_\_\_ City \_\_\_\_\_, St. \_\_\_\_\_ Zip \_\_\_\_\_
Sex: \_\_\_M \_\_\_F Birthdate: \_\_\_/\_\_\_/\_\_\_ E-mail: \_\_\_\_\_
SS # (insurance purposes): \_\_\_\_\_ Occupation: \_\_\_\_\_

Best Place to reach you: Home Work Cell ( ) AM PM Anytime

Spouse's/Partner's Name (if applicable): \_\_\_\_\_ Spouse's Birthdate (insurance purposes): \_\_\_/\_\_\_/\_\_\_
Children's Names and ages (if applicable): \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Are your symptoms related to an accident? Y N \_\_\_automobile \_\_\_work \_\_\_other date \_\_\_/\_\_\_/\_\_\_
I HAVE NO INSURANCE COVERAGE AT THIS TIME

Relationship to insured: \_\_\_self \_\_\_spouse \_\_\_child \_\_\_other: \_\_\_\_\_

Primary Care Doctor- name and 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?: \_\_\_\_\_

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=ER visit)
Neck or Shoulder Pain 0 1 2 3 4 5 6 7 8 9 10
Midback Pain 0 1 2 3 4 5 6 7 8 9 10
Low Back or Leg Pain 0 1 2 3 4 5 6 7 8 9 10
Other: \_\_\_\_\_
Complaints: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_
Date of Injury \_\_\_/\_\_\_/\_\_\_ How did they start? \_\_\_\_\_
SHOW AREA(S) OF PAIN OR UNUSUAL FEELING BELOW
[Two human figures for marking pain areas]

What types of therapies have you tried for these problem(s) or to improve your health over-all:
\_\_\_diet modification \_\_\_fasting \_\_\_vitamins/minerals \_\_\_herbs \_\_\_homeopathy \_\_\_chiropractic \_\_\_acupuncture \_\_\_conventional drugs
\_\_\_other: \_\_\_\_\_

Do you experience any of these general symptoms EVERY DAY?
\_\_\_Debilitating fatigue \_\_\_Shortness of breath \_\_\_Insomnia \_\_\_Constipation \_\_\_Chronic pain/inflammation \_\_\_Change in wart or mole
\_\_\_Depression \_\_\_Panic attacks \_\_\_Nausea \_\_\_Fecal incontinence \_\_\_Bleeding \_\_\_Nagging cough/ hoarseness
\_\_\_Disinterest in sex \_\_\_Headaches \_\_\_Vomiting \_\_\_Urinary incontinence \_\_\_Discharge \_\_\_Blood in stool or urine
\_\_\_Disinterest in eating \_\_\_Dizziness \_\_\_Diarrhea \_\_\_Low grade fever \_\_\_Itching/rash

Current medications (prescription or over-the-counter): \_\_\_\_\_

Table with 3 columns: Year, Surgery, Illness, Injury, Outcome. For listing major hospitalizations, surgeries, and injuries.

Do you consider yourself: \_\_\_underweight \_\_\_overweight \_\_\_just right Your weight today: \_\_\_\_\_

How often do you experience your symptoms? \_\_\_Constantly (100% of day) \_\_\_Frequently (51-75% of day) \_\_\_Occasionally (26-50% of day) \_\_\_Intermittently (0-25% of day)
How would you describe your symptoms? \_\_\_Sharp \_\_\_Shooting \_\_\_Dull Ache \_\_\_Burning \_\_\_Numb \_\_\_Tingling
Other: \_\_\_\_\_
How are your symptoms changing? \_\_\_Getting Better \_\_\_Not Changing \_\_\_Getting Worse
Does your pain ever wake you from a sound sleep? Yes \_\_\_ No \_\_\_
Are you losing weight now without trying? Yes \_\_\_ No \_\_\_
Do you have a headache or head pain that is unlike any you have had before?. Yes \_\_\_ No \_\_\_
Have you even been or are you now being pressured or forced to engage in any type of Sexual activity? Yes \_\_\_ No \_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

\*\* By signing above, all information on this intake form is true and accurate to the best of my knowledge.

**Medical History**

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other \_\_\_\_\_

**Medical (Men)**

- Benign prostatic hyperplasia
- Prostate cancer
- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other \_\_\_\_\_

**Medical (Women)**

- Menstrual irregularities
- Endometriosis
- Infertility

- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease

- Other \_\_\_\_\_
- Date of last GYN exam \_\_\_\_\_
- Mammogram q + q \_\_\_\_\_
- PAP q + q \_\_\_\_\_
- Form of birth control \_\_\_\_\_
- # of children \_\_\_\_\_
- # of pregnancies \_\_\_\_\_
- C-section \_\_\_\_\_
- Age of first period \_\_\_\_\_
- Date - last menstrual cycle \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days
- Interval of time between cycles \_\_\_\_\_ days

Any recent changes in normal menstrual

flow (e.g., heavier, large clots, scanty) \_\_\_\_\_

- Surgical menopause
- Menopause

**Family Health History (Parents and Siblings)**

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide

(Parkinson's, paralysis)

- Other \_\_\_\_\_

**Health Habits**

- Tobacco: Cigarettes: #/day \_\_\_\_\_
- Cigarettes: #/day \_\_\_\_\_
- Alcohol: Wine: #glasses/d or wk \_\_\_\_\_
- Liquor: #ounces/d or wk \_\_\_\_\_
- Beer: #glasses/d or wk \_\_\_\_\_
- Caffeine: Coffee: #6 oz cups/d \_\_\_\_\_
- Tea: #6 oz cups/d \_\_\_\_\_
- Soda w/caffeine: #cans/d \_\_\_\_\_
- Other sources \_\_\_\_\_
- Water: #glasses/d \_\_\_\_\_

**Exercise**

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per

- workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk \_\_\_\_\_

- Run, jog, other aerobic - #days/wk \_\_\_\_\_

- Weight lift - #days/wk \_\_\_\_\_

- Stretch - #days/wk \_\_\_\_\_

Other \_\_\_\_\_

**Nutrition & Diet**

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
  - dairy
  - wheat
  - eggs
  - soy
  - corn
  - all gluten

Other \_\_\_\_\_

**Food Frequency**

- Number of servings per day: \_\_\_\_\_
- Fruits (citrus, melons, etc.) \_\_\_\_\_
- Dark green or deep yellow/orange vegetables \_\_\_\_\_
- Grains (unprocessed) \_\_\_\_\_
- Beans, peas, legumes \_\_\_\_\_
- Dairy, eggs \_\_\_\_\_
- Meat, poultry, fish \_\_\_\_\_

**Eating Habits**

- Skip meals - which ones \_\_\_\_\_
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

**Current Supplements**

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source \_\_\_\_\_
- Magnesium
- Zinc
- Minerals, describe \_\_\_\_\_
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen,

phytonutrient blends)

- Liquid meals (Ensure)

Others \_\_\_\_\_

**I Would Like To:****ENERGY - VITALITY**

- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive

\_\_\_\_\_

**BODY COMPOSITION**

- Lose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible

**STRESS, MENTAL, EMOTIONAL**

- Learn how to reduce stress
- Think more clearly and be more-focused

- Improve memory

- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated

**LIFE ENRICHMENT**

- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

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.
• Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare.
• 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.
• 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 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.

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](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: \_\_\_\_\_ )

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_ )

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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: \_\_\_\_\_ )

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

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