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

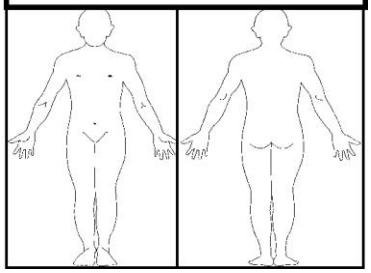
Spouse's/Partner's Name (if applicable): _____ Spouse's Birthdate (insurance purposes):____/____/___
Children's Names and ages (if applicable): _____
Emergency Contact Name:_____ Phone:_____
Are your symptoms related to an accident? Y N ____automobile _____work ____other date __/__/__
___I HAVE NO INSURANCE 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	No pain … Severe pain
Midback Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Low Back or Leg Pain	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain
Other:_____	0 1 2 3 4 5 6 7 8 9 10	No pain … Severe pain

Complaints:
1) _____
2) _____
3) _____
Date of Injury ____/____/_____ How did they start ?
_____
_____
_____

SHOW AREA(S) OF PAIN OR UNUSUAL FEELING BELOW



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): _____
_____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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
Other _____

Health Habits
__ Tobacco:
Cigarettes: #/day _____
Cigars: #/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

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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