Natural Elements Health Center

Dr. Christine Schlenker

14094 9th Ave SE Milaca, MN 56353
Tel: 320.983.2333 or TEXT
staff@naturalelementshealth.com
Fax: 1- 855-932-4905

Today's Date:_____/____/_____

Your Name:_____ Name you prefer to be called:_____

Address:_____ Apt#:_____ City _____, St._____ Zip_____

Sex: ____M ____F Birthdate: _____/_____/_____ E-mail:_____

Occupation:_____ ☐Text Message Reminder For Appt. ☐Verizon ☐AT&T ☐Sprint ☐T-Mobile

Best Place to reach you: ◊Home ◊Work ◊Cell ( )_____

Children's Names and ages (if applicable):_____

Emergency Contact Name:_____ Phone:_____

How did you hear about us?:_____

What type of care are you looking for?

- ☐ Fix me Fast!
- ☐ What is wrong with me?
- ☐ Maintenance care
- ☐ Mentorship

What bothers you?

Neck Headaches Shoulders Upper Back
Low Back Hips Knees Feet
Other:

1) _____ ____

2) _____ ____

3) _____ ____

Date of Injury or Pain Onset: ____/____/__ ____

How often do you experience your symptoms?

- ☐ Constantly (76-100% of day)
- ☐ Frequently (51-75% of day)
- ☐ Occasionally (26-50% of day)
- ☐ Intermittently (0-25% of day)

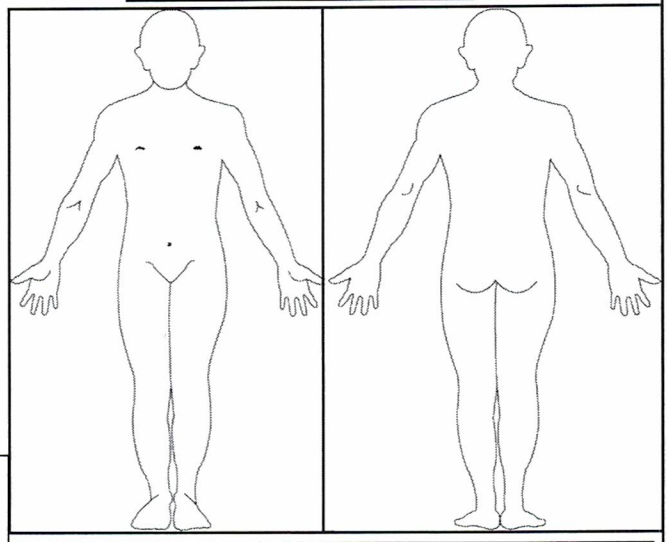
How would you describe your symptoms?

☐ Sharp ☐ Shooting ☐ Dull Ache ☐ Burning
☐ Numb ☐ Tingling

How are your symptoms changing?

☐ Getting better ☐ Not Changing ☐ Getting Worse

SHOW AREA(S) OF PAIN BELOW



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
Mid-back 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

What Type of Services are you interested in or open to trying?

- ☐ Homework / Self Care
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Nutrition / Muscle Testing
- ☐ Massage
- ☐ Yoga Therapy
- ☐ Craniosacral Therapy
- ☐ Counseling
- ☐ Physical Therapy

Please Rate the Categories Below:

1 = Poor 10 = Great

I am experiencing:

Sleep Quality 1 2 3 4 5 6 7 8 9 10

Sleep # of hours 1 2 3 4 5 6 7 8 9 10

Intentional Daily Body Movement 1 2 3 4 5 6 7 8 9 10

Quality intake of whole food 1 2 3 4 5 6 7 8 9 10

Mental or Emotional Health 1 2 3 4 5 6 7 8 9 10

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 ___massage therapy __conventional drugs ___ Physical Therapy

How long have you tried to work on this problem? Days Weeks Months Years

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/OTC Pain reliever and/or Supplements:

_____

_____

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

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

Patient Signature:_____ **Date:**____/____/_____

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

__ Loose 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

7/00, Rev 1/03, Rev 3/06

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:)

_____

_____

_____

_____

_____

_____

_____

Mid-Day Snack (time:)

_____

Hours of Sleep:

_____

Dinner (time:)

_____

_____

_____

_____

_____

_____

_____

Nighttime Snack (time:)

_____

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

_____

Natural Elements Health Medical Symptoms Questionnaire HAQ Detoxification Indicator (MSQ)

Patient Name: _____ Date: _____ Week: _____

Rate each of the following symptoms based upon your typical health profile for: ☐ Past 30 days ☐ Past 48 hours

Point Scale
0 - Never or almost never have the symptom
2 - Occasionally have it, effect is severe
3 - Frequently have it, effect is not severe
4 - Frequently have it, effect is severe

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total: _____

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near or far-sightedness)
Total: _____

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
Total: _____

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
Total: _____

MOUTH THROAT
_____ Chronic Coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores
Total: _____

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
Total: _____

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
Total: _____

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total: _____

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
Total: _____

JOINTS MUSCLES
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
Total: _____

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total: _____

ENERGY ACTIVITY
Fatigue, sluggishness
Apathy, lethargy
Hyperactivity
Restlessness
Total:

POOR MEMORY
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total: _____

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
Total: _____

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
Total: _____

GRAND TOTAL: _____

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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.

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 and read a copy of the notice of privacy practices.

This acknowledgement applies to:

Signature: _____ ***Date:*** _____

Natural Elements Cancellation & Missed Appointment Policy

Must give a 24 hour notice to cancel your appointment.

NEW PATIENTS:

If a 24 hour notice is not given you will be charged the rate of service which has been scheduled
$100-$200

ESTABLISHED PATIENTS:

You must call 24 hours before the time of your scheduled appointment.
If you do not call, call to close to your appointment time, are running 10 min or more late or "no show" for your appointment you will be charged the below fees:

Missed appointment Fees:

5 - 20 min	**$25.00**
40 min	**$50.00**
60 min	**$85.00**

Exceptions: Medical Emergencies, illness.

If we experience excessive cancelled or missed appointments, we reserve the right to dismiss you from our care.

Signature:_____ ***Date:***_____

FINANCIAL POLICY

Payment due at the time of service;
A super bill can be provided to you to submit to your insurance company for reimbursement.

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

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