HEALTH & WELLNESS CENTER
NEW CLIENT INFORMATION/HISTORY SHEET

PLEASE PRINT

Name: _____ Date: _____

Home phone: _____ Work phone: _____ Cell:_____

Address: _____

City: _____State: _____ Zip: _____

Age: _____ Birth date: _____ Sex: [ ]Female [ ]Male

Occupation: _____ Email: _____

How did you find out about us or who referred you? _____

Current Physician:

Name: _____ Phone _____

Address: _____ City _____

State: _____ Zip: _____

Last seen: _____ For what condition?: _____

State specifically what problem you are trying to handle.

_____

_____

List history of medical illnesses/surgeries/removed organs, etc, the treatment and result.

Condition Date Treatment Result

_____

_____

_____

_____

_____

Social History:

History of smoking? [ ]No [ ]Yes Explain: _____

History of alcohol? [ ]No [ ]Yes Explain: _____

Current dietary caffeine? [ ]No [ ]Yes Explain: _____

Current dietary refined sugar? [ ]No [ ]Yes Explain: _____

History of excessive grains (breads, pasta, etc.)? [ ]No [ ]Yes Explain: _____

History of low calorie diets? [ ]No [ ]Yes Explain: _____

History of excessive salty foods? [ ]No [ ]Yes Explain: _____

History of family illness or genetic issues? Explain: _____

Allergies / Sensitivities:

_____

_____

_____

Please list the <u>five main complaints, in order of importance</u>:

1. _____ When did this start?_____
Office notes:_____
_____
Intermittent / Constant
Sharp / Dull / Achy
Mild / Mod / Severe

2. _____ When did this start?_____
Office notes:_____
_____
Intermittent / Constant
Sharp / Dull / Achy
Mild / Mod / Severe

3. _____ When did it start?_____
Office notes:_____
_____
Intermittent / Constant
Sharp / Dull / Achy
Mild / Mod / Severe

4. _____ When did it start?_____
Office notes:_____
_____
Intermittent / Constant
Sharp / Dull / Achy
Mild / Mod / Severe

5. _____ When did it start?_____
Office notes _____
_____
Intermittent / Constant
Sharp / Dull / Achy
Mild / Mod / Severe

List all medications you are currently taking and for what.
_____
_____
List 10 foods you eat most often: _____
_____
_____
List all cravings that you have:_____
_____ _____
List processed/fast foods you eat, even occasionally: _____
_____
List vitamins/supplements you are taking: _____
_____
_____

========== **Skip this section and continue onto next page**==========

<u>BODY CONDITION NOTES</u> (*For Practitioners Use*)

Energy Level: _____
Cognitive: _____
Sleep Level:_____
Digestion:_____
Cravings: _____
Cravings: _____
Inflammation: _____
Pain: _____
Menstrual Cycle: _____

Body Injury Sheet

Patient to mark clearly and completely.

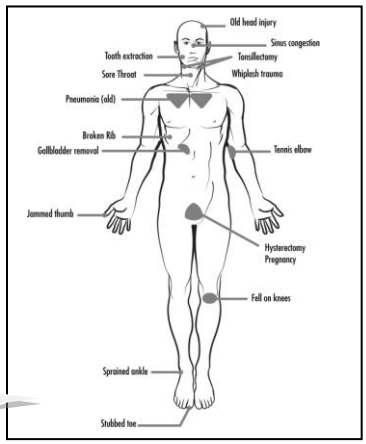
Name: _____ Date:_____

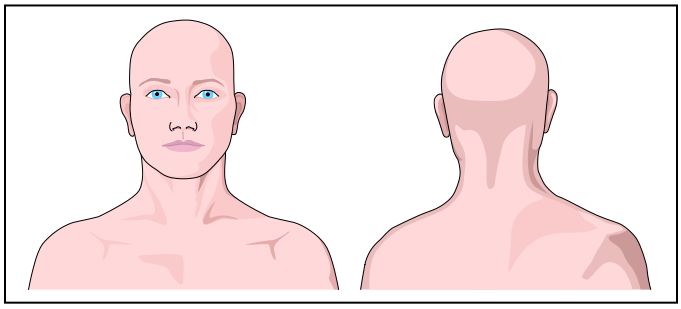
LABEL AREAS of old injuries and location in body of past infection.

Injury Examples: scars, whiplash from auto accident injuring neck or chin hitting dashboard, head injury, blows to the body from falls or hits (ex. falling on your tail bone, hit in the nose or on the head), surgeries, broken bones , muscle/ tendon / ligament tears, organs removed, etc.

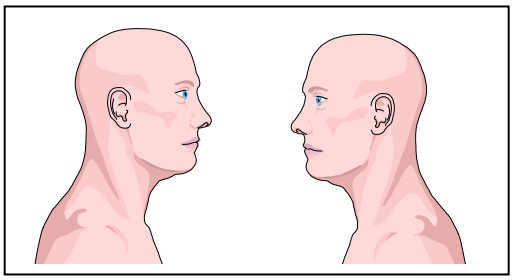
Infection Examples: sore throat, tonsils swollen, ear infections, lung infection, brochial infections, bladder infections, sinus infection, appendix, etc.

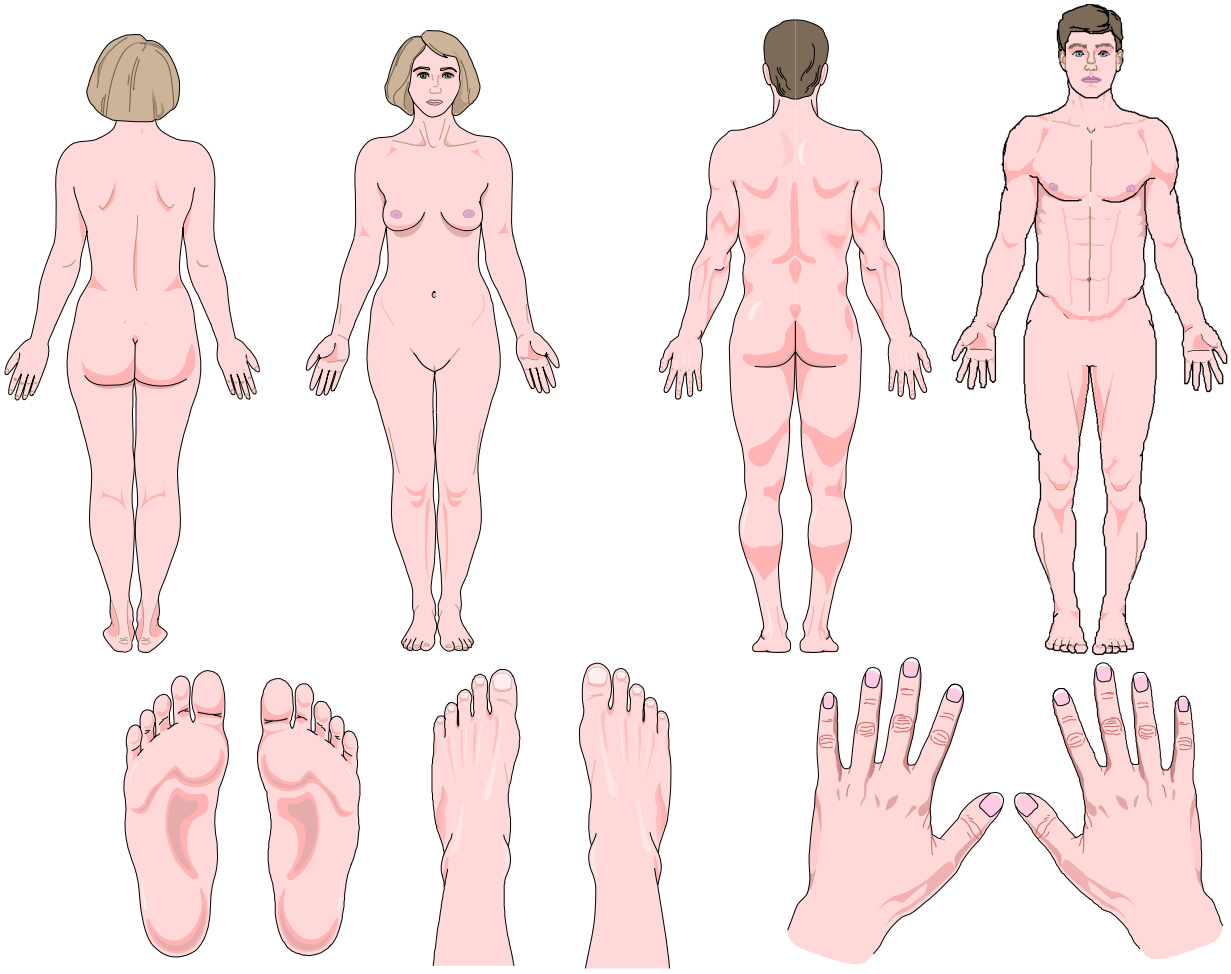
SEE EXAMPLE TO THE RIGHT





Example:





Please check off the ones that apply

Section 1

- ☐ **Cravings for junk food**
- ☐ **Drinks wine in evenings**
- ☐ **Craves refined carbohydrates**
- ☐ **Frustrating stubborn weight**
- ☐ **History of low-calorie diets**
- ☐ **History of up and down weight**
- ☐ **Fluid retention**
- ☐ **History of birth control pills**
- ☐ **History of Hormones Replacement Therapy**
- ☐ **High protein diets don't work**
- ☐ **Poor willpower**
- ☐ **Can't lose weight despite exercise**
- ☐ **History of blood sugar problems**
- ☐ **History of menstrual problems**

Section 2 (female only)

- ☐ **PMS**
- ☐ **Irregular periods**
- ☐ **Depression during menstruation**
- ☐ **Bloating and cramping during menstruation**
- ☐ **Weight gain during menstruation**
- ☐ **Weight gain during ovulation**
- ☐ **Difficulty losing weight after pregnancy**
- ☐ **Heavy bleeding during menstruation**
- ☐ **Enlarged swollen breasts during menstruation**
- ☐ **Hot flashes**
- ☐ **Night Sweats**
- ☐ **Vaginal Dryness**
- ☐ **Leaky bladder**
- ☐ **Frequent urination at night**
- ☐ **Itchiness or hives**
- ☐ **Nervousness**
- ☐ **Fluid retention**
- ☐ **Dehydrated despite amount of fluid consumed**
- ☐ **Swollen ankles**
- ☐ **Craving salt (chips, pretzels)**
- ☐ **Enlarged abdomen**
- ☐ **Enlarged bump in upper back/lower neck**
- ☐ **Hands and feet go to sleep easily**
- ☐ **Chest pain**
- ☐ **Muscle cramps, worse during exercise**
- ☐ **Dull pain in chest or radiating in left arm**

Section 3

- ☐ **Out of breath when walking up stairs**
- ☐ **Dizziness**
- ☐ **Excessive facial hair - female**
- ☐ **Perspiring after getting out of shower**
- ☐ **Fatigue during the day**
- ☐ **Difficulty getting out of bed in morning**
- ☐ **Waking up in the middle of the night**
- ☐ **Difficulty falling to sleep**
- ☐ **Afternoon headaches**
- ☐ **Arthritis or stiff and painful joints**
- ☐ **Bursitis**
- ☐ **Tendonitis**
- ☐ **Twitch under eye lid**
- ☐ **Heel spurs**
- ☐ **Low back weakness or pain**

- ☐ **Itchiness or hives**
- ☐ **Nervousness**
- ☐ **Fluid retention**
- ☐ **Dehydrated despite amount of fluid consumed**
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NOTES:

The Health & Wellness Center

Informed Consent and Policies Form

Print Full Name _____ Date_____

1. Acupressure is the primary service delivered at this center. It is a simple, safe, non-invasive and natural method of normalizing the transmission of energy flows in the body and or stress reduction. This is not a method for preventing, diagnosing, treating, healing, relieving or curing symptoms, disease or medical conditions of any kind. I understand that should I receive acupressure, manual therapy, deep tissue work, exercise advice, diet advice, or nutritional advice, there may be temporary side-effects such as fatigue, flu-like symptoms and possible aggravation of the symptoms presented after a treatment, and that other solutions may be available to address my current condition.

_____
Initials

2. I agree not to wear perfumes or scented deodorants at the Center, due to the potential of other client sensitivities. I also understand that being well fed and hydrated is necessary to facilitate benefits from our services and it is my responsibility to see that I have adequate nourishment each day.

_____
Initials

3. I understand the practitioners are Chiropractors, Massage Therapists, Health Coaches and Personal Trainers and there is no medical care provided of any kind. No cures are guaranteed. I understand that the initial visit includes a history, exam and testing as directed in order to evaluate ***if*** the services of the Center are right for me and determine if I am eligible for our services.

_____
Initials

4. I understand that if I see a practitioner for an exam and initial consultation, that practitioner may not be my long term practitioner. I understand that multiple practitioners may deliver the remainder of my care.

_____
Initials

5. I understand that once nutritional supplements are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless the Center determines that the order was filled incorrectly. I also understand the Dietary Supplement called Organic Cruciferous Food and Organic Cruciferous Sprouts Food is developed and sold by Eric Berg DC in this office.

_____
Initials

7. I understand that in order to ensure excellent customer service, my phone call may be monitored or recorded. From time to time, Dr. Berg also uses video and voice recording for quality control purposes as well as practitioner supervision. If you object to this, simply let us know when you arrive at the office.

_____
Initials

8. **OFFICE FEES:**

I understand that the following Center office visit fees apply:

Initial Consult & Testing - No Charge
Chiropractic Adjustment - $30.00/visit
Manual Therapy Treatment: Visit packages available upon request
Mechanical Message $20/20 min session
Missed Appointment Charge (with no 24 hour advance notice) - $35.00
Bounced Check Fee per incident (Two max. then cash only) - $45.00
Records Copy Fee - $20.00/request (issued to client only, not sent to 3rd party)

The above fees do not reflect promotional discounts or pre-pay program fees offered by the Center when eligibility requirements are met. The promotional discounts or pre-pay program fees will be applied at the time of check out.

_____
Initials

8. Should I opt to take advantage of it, I understand that the discounted, flat-rate Pre-Pay Package offered is a non-refundable program and may not be altered, shared, transferred or combined with any other promotional special or discount. I understand that any unused portion of a Pre-Pay Package upon discharge from the Center may only be applied to product purchases or may be moved to another service (excluding complimentary visits that were issued as part of package rate) or is forfeited. I understand that I have 1 year to use any free visits (free visits can only be used for office visit treatments, not products) or it is forfeited.

_____
Initials

9. I understand that the Health and Wellness Center are pre-paid programs or paid in full at the time of service (or in advance with discounted, pre-pay programs) or product purchase and that the Center does no 3rd party or insurance billing, reporting, coding, processing, or annual expense reporting of any kind whatsoever,(this includes Doctor reports, records to insurance companies, insurance report forms, etc.) Postdated payments are not accepted.

_____
Initials

I have read and understand the above terms of service.

Patient Signature _____ Date_____

9. **CONSENT TO TREAT A MINOR (Under 18 years old)**

I, _____, do hereby request this center to evaluate and perform services for my _____ named_____, age _____, and consent on his or her behalf. I am a legal guardian of this child. I understand that while this child is in the center, he/she is to be with me at all times and may not be left alone, unsupervised or in the care of staff or other clients, and that I am fully financially responsible for him/her. I have read and agree to the Center's above terms.

Guardian Signature_____ Date _____

Staff Member _____ Date _____

==========PRACTITIONER EXAM SECTION ==========

Blood Pressure:
Lying down: _____Pulse:_____

Standing: _____ Pulse:_____

Weight: _____ Height: _____

Additional testing/diagnostics done and attached:

___Urine Analysis ___HRV ___Body Comp ___Stress/HRV ___Exc Recovery

ORTHOPEDIC EXAM
Lumbar

1. Valsalva: _____

2. Dejerine: _____

3. Straight Leg Rise: _____

Cervical

1. Cervical Comp: _____

2. Cervical Distraction: _____

3. Jackson's: _____

NEUROLOGICAL EXAM

1. **Muscle Test**: UE _____
   LE_____
2. **Deep Tendon Reflex**: UE_____ LE_____
3. **Sensory Test**: UE_____
   LE_____

Muscle-Joint Evaluation (W-weakness, P-pain, R-restricted in ROM))

Neck flexion/extension/R-lateral flexion/L-lateral flexion/R-rotation/L-rotation

R/L Shoulder adduction/abduction/elevation/depression/internal rotation/external rotation/extension/flexion

R/L Elbow flexion/extension/internal rotation/external rotation

R/L Wrist flexion/extension/ internal rotation/external rotation

Low back flexion/extension/R-lateral bending/L-lateral bending/R-rotation/L-rotation

R/L Hip flexion/extension/internal rotation/external rotation/abduction/adduction

R/L Knee flexion/extension/internal rotation/external rotation

R/L Ankle flexion/extension/inversion/eversion/internal rotation/external rotation

Key Hormonal Influences:

HRT, Birth Control Pills - time: _____

History of stress events: _____

_____

Other notes:

Strategy/ Plan:

- ☐ Reduce pain
- ☐ Decrease body stress to assist in restful sleep
- ☐ Decrease body stress to increase energy and vitality
- ☐ Increase range of motion and flexibility
- ☐ Weight loss program, eating plan: _____
- ☐ Exercise recovery training
- ☐ Acupressure Stress Elimination Technique
- ☐ Manual Therapy
- ☐ Nutritional assessment
- ☐ Other_____
- ☐ Exercise/Stretching instructions: _____
- ☐ Nutritional/Dietary recommendations:

  _____

  _____

Notes:

PRACTITIONER'S SUMMARY OF CASE

Client Name _____ Start Date_____

VITALS AT START:

Weight: _____ BP:_____ Pulse rate: _____ UA: _____

PRECAUTIONS:

ALLERGIES:

MEDS:

SURGERIES/ORGANS REMOVED:

SUPPLEMENTS:

NOTES:

MANAGEMENT PLAN: