New Patient Intake Form

Dr. Robert Weissfeld Today's Date_____

Name (last, first)		**Email**	
Address		**Occupation**	
City / State / Zip		**Work phone**	
Home phone	**Cell phone**	**How did you find out about Dr. Weissfeld?**	
Emergency contact (name & phone)			**Date of birth**

Please list, in order of importance, life areas where you would like to improve your health, ease or well-being

Briefly, what do you feel are some of the causes of the above difficulties?

Are you currently under the care of a physician? If so, who, and for what condition(s)?

Have you ever seen a chiropractor before? YES NO

List all current medications, prescribed or otherwise, including vitamins & supplements

Illnesses: ☑CHECK all that apply to immediate family - CIRCLE those that apply to you

o Cancer	o Thyroid	o Rheumatic Fever	o Hepatitis
o Diabetes	o Asthma	o Depression	o HIV / Aids
o Pneumonia	o Stomach Ulcers	o Stroke	
o Tuberculosis	o Shingles/herpes	o Seizures	
o Multiple sclerosis	o Chronic Fatigue	o Heart Disease	

o **Surgeries & impactful physical or emotional traumas** including dental, tonsils, appendix etc. use back if needed

Lifestyle (please check all that apply, and note frequency of use)

o Tobacco	o Recreational drugs
o Alcohol	o Caffeinated beverages

Emotional stress scale (please circle)

1 2 3 4 5 6 7 8 9 10
no stress moderate extremely stressed

Briefly, what are your major stresses?

Social history (check those that apply)

o Single o Married # of children and ages
o Significant Other
o Divorced o Caregiver for dependent

Do you have high blood pressure or are you on blood pressure medications? YES NO
Do you have diabetes? YES NO

For the following symptoms, Check the first checkbox if you presently have symptom, the second box if you have had it in the past

Presently or recently had symptom

Had symptom in the past

Please fill this out as accurately as you can. It can help me to recognize patterns that may suggest causes

General symptoms –

		Fatigue			Fever / chills			Bleed / bruise easily
		Sweat without exertion			Dizziness / vertigo			
		Night sweats			Low immunity			

Digestion

		Extreme appetite			Cravings			Tired after eating
		No appetite			Dieting			Bloating
		Gas			Acid regurgitation			Heartburn
		Irritability or low energy between meals			Nausea			Vomiting, Bulimia

Gastrointestinal

		Diarrhea			Bloody stool			Irritable bowel syndrome
		Constipation			Mucous in stool			Colitis
		Hemorrhoids			Laxative use			Intestinal pain / cramping
		Anal itching / burning			Anal fissures			Incomplete evacuation
		Gout			Gallstones			

EENT

		Dry eyes			Spots / flowery vision			Bleeding gums
		Difficulty swallowing			Swollen glands			Headaches
		Earaches			Poor vision			Eye strain
		Blurred vision			Cataracts			Macular degeneration
		Night blindness			TMJ Problems			Sores on tongue or mouth
		Dry mouth			Excess saliva			Sinus problems
		Post-nasal drip			Sore throat, frequent or severe			Tinnitus / ringing in ears
		Deafness			Nosebleed frequent or severe			

Cardiovascular / respiratory

		Heart palpitations			Chest pain			Difficulty breathing
		High cholesterol			Varicose veins			Blood clots
		Swollen ankles			Heart valve abnormality			Shortness of breath
		Cold hands / feet			Dry cough			Wheezing
		Chest tightness			Difficult inhalation			Difficult exhalation
		Productive cough						

Musculoskeletal

		Tendonitis			Spinal pain			Joint pain/ Arthritis
		Limited range of motion			Swelling			Carpal tunnel
		Numbness			Vertebral disc degeneration			Osteoporosis

Psychological

		Insomnia			Anxiety			Irritability
		Poor memory			Depression			Easily stressed
		Tremors			Seasonal mood disorder			Tics
		Recent divorce			Currently in psychotherapy			Job stress
					Death of someone close			Financial setback

Skin / hair

		Eczema			Dry skin			Rashes / hives / ac OVER⇨
		Fungal infections			Psoriasis			Dandruff
		Hair loss			Brittle nails			Ridged nails

Genito-urinary

		Dribbling when laughing or sneezing			Incomplete urination / retention			Decreased libido / sexual desire
		Burning urination			Blood in urine			Frequent urination
		Kidney stones			Bedwetting			Wake frequently to urinate
		Herpes			Infertility			

Men only

		Impotency			Prostate problems			Erectile dysfunction

Women only

					Age menses ended			hormone replacement therapy
		Date of last ob/gyn exam?			Hysterectomy? partial full			Live births
		Abortion(s)			Miscarriage			Fibroids
		Birth control pills			Ovarian cysts			
		Candida / yeast			Discharge or odor			Human Papilloma Virus positive
		Vaginal sores			Herpes			Fibrocystic breast
		STD history (chlamydia, PID, etc)			Breast cancer			Acne associated with period
		Pain at ovulation			Cramps / low back pain			_____ days between periods
		Constipation or diarrhea associated with period			Emotional irritability or depression associated w period			Bleeding outside of regular menstrual cycle
		No period / skipped cycles			Irregular cycle			Period lasts _____ days
		Headache o before menstrual cycle o during cycle o after cycle						

Anything else?

_____

_____

_____

_____

ALL patients please note:

I understand that any billing of my insurance company is a courtesy provided by my doctor and that **I am ultimately responsible for 100% of my bill, even if it was thought that insurance would cover the cost.** Should I fail to pay in full, I will be responsible for collection costs and interest charges. **Cancellation Made With Less Than 24 hour** notice will be charged $25.00 for the first occurrence, and the full cost of the visit for additional occurrences.

_____ _____ _____

Signature Print Name: Date

Terms of Acceptance of Care and Consent for Treatment

In the course of care, it is essential for the practitioner and client to work towards the same objectives. Here is a brief explanation of goals and methods of treatment that will be used, and risks of treatment.

Health:

A state of optimal physical, mental, emotional and social well being, not just the absence of disease or infirmity.

Chiropractic Adjustment:

The chiropractic method of correction is by specific adjustments of the spine, extremities, and/or cranium. An adjustment is the specific application of forces to facilitate the body's correction of vertebral subluxation, *a misalignment or fixation of one or more of the vertebra in the spinal column (which causes alteration of nerve function and interference to the transmission of nerve impulses), which can impair the body's ability of achieve maximum health potential.*

As in the practice of medicine and all health care, the practice of chiropractic carries some risks to treatment, including, but not limited to, fractures, disc injuries, and strokes (CVA), dislocations, and sprains. Chiropractic treatments rank among the safest and most effective form of health care, and chiropractors' malpractice insurance rates remain among the lowest in the health professions.

Functional holistic treatment:

Functional holistic treatment endeavors to correct those things that are actually found to be dysfunctional, not a disease label. As such, I do not offer treatment based on diagnosis or treat any specific disease or condition. (Disease is defined here as a collection of symptoms and other findings that are labeled with a name – arthritis or pneumonia for example.) If during the course of examination and treatment I encounter findings that suggest a pathology or that I feel are beyond my area of expertise or that I cannot treat, I will advise you.

If you desire further advice, diagnosis, or treatment for those findings, I recommend that you seek the services of a health care provider who specializes in diagnosis and treatment based on diagnosis.

The therapeutic objective is to eliminate chemical, structural, neurological or other interference to the expression of the body's innate healing ability. The elimination of interference leads to improved health. My methods are: adjusting to correct vertebral subluxations, specific muscle work, acupuncture or laser or electro-acupuncture, techniques to support self-awareness and nutritional supplementation, all provided as needed.

Feel free to ask whatever questions you need to fulfill your understanding. You may at any time refuse or decline a specific treatment or test that you feel uncomfortable with.

Because the treatment provided relaxes compensations that may be keeping symptoms at bay, temporary aggravation of symptoms, or new symptoms may be experienced. Should this occur, it is important that you call me if the symptoms feel intense or you are concerned.

I treat all patients equally, regardless of age, sex, race, nationality or sexual orientation.

Payment

Unless previous arrangements are made, payment in full is due at the time of the visit, as check, cash, or Credit Card. Despite efforts to be assured of insurance coverage before treatment, at times the insurance will not cover some or all of the examinations and treatment. A promise of payment by your insurance does not eliminate your personal responsibility for payment. **Missed appointments not canceled at least 24 hours prior to the visit will be charged full price**.

Privacy Notice

This Practice is committed to maintaining the privacy of your protected health information. A Privacy Notice (posted online at www.NeurOntogenics.com/forms.html) that provides a more complete description of information uses and disclosures is available online, and you may request a hard copy at any time. You have the right to review the notice prior to signing this consent. I understand that I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance thereon.

Sincerely,

Robert Weissfeld D.C., C.N.T.

I, (Print name)_____ have read and understand the above statements.

I understand that all questions regarding the doctor's objectives pertaining to my care in this office will be answered to my satisfaction. I do not expect that physician to be able to anticipate and explain all risks and complications. I wish to rely on the physician to exercise judgment during the course of the procedure which the physician feels are in my best interests, at the time, based upon the facts then known. I therefore accept and authorize care on this basis.

_____ _____

(Signature) (Date)