

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**

- | | | | |
|---------------------------------------------|------------------------------------------|------------------------------------------|-------------------------------------|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV / Aids |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Shingles/herpes | <input type="checkbox"/> Seizures | |
| <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Heart Disease | |

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)

- | | |
|----------------------------------|------------------------------------------------|
| <input type="checkbox"/> Tobacco | <input type="checkbox"/> Recreational drugs |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Caffeinated beverages |

Musculoskeletal

<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Spinal pain	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain/ Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Limited range of motion	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel
<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Vertebral disc degeneration	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis

Psychological

<input type="checkbox"/>	<input type="checkbox"/>	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Easily stressed
<input type="checkbox"/>	<input type="checkbox"/>	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal mood disorder	<input type="checkbox"/>	<input type="checkbox"/>	Tics
<input type="checkbox"/>	<input type="checkbox"/>	Recent divorce	<input type="checkbox"/>	<input type="checkbox"/>	Currently in psychotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Job stress
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Death of someone close	<input type="checkbox"/>	<input type="checkbox"/>	Financial setback

Skin / hair

<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Dry skin	<input type="checkbox"/>	<input type="checkbox"/>	Rashes / hives / ac <input type="text" value="OVER →"/>
<input type="checkbox"/>	<input type="checkbox"/>	Fungal infections	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Dandruff
<input type="checkbox"/>	<input type="checkbox"/>	Hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Brittle nails	<input type="checkbox"/>	<input type="checkbox"/>	Ridged nails

Genito-urinary

<input type="checkbox"/>	<input type="checkbox"/>	Dribbling when laughing or sneezing	<input type="checkbox"/>	<input type="checkbox"/>	Incomplete urination / retention	<input type="checkbox"/>	<input type="checkbox"/>	Decreased libido / sexual desire
<input type="checkbox"/>	<input type="checkbox"/>	Burning urination	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Bedwetting	<input type="checkbox"/>	<input type="checkbox"/>	Wake frequently to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Infertility	<input type="checkbox"/>	<input type="checkbox"/>	

Men only

<input type="checkbox"/>	<input type="checkbox"/>	Impotency	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems	<input type="checkbox"/>	<input type="checkbox"/>	Erectile dysfunction
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Women only

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

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.

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.

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.

(Signature)

(Date)