NUTRITION FORM

HUDSON VALLEY CHIROPRACTIC & NUTRITION OFFICE
PATIENT INTAKE FORM

475 Tuckahoe Road Suite 200
Yonkers, NY 10710
914-793-1824

Disclaimer: Thank you for your interest in being a patient of our office. Information collected about new patients is confidential and will be treated accordingly.

Patient Name: _____
Date of Birth: _____
SSN: _____ **Sex**: Male Female Other: _____
Street Address: _____
City: _____ **State**: _____ **ZIP Code**: _____
Home Phone: _____ **Mobile Phone**: _____
Work Phone: _____ **E-Mail**: _____
# of Children: _____ **Marital Status**: Single Married Divorced Widowed
Employer (if any): _____ **Job Title**: _____
Primary Physician: _____ **Phone**: _____
Have you been to a chiropractor before? Yes No

- If so, how long ago? _____ Where? _____

Emergency Contact Information

Emergency Contact: _____ **Phone**: _____
Relationship to Patient: _____

Purpose of this appointment:

_____

_____

Other doctors seen for this condition:

_____

_____

Describe your symptoms in order of severity, beginning with the worst symptom:

_____

_____

How long ago did your symptoms begin? _____

How often do your symptoms occur?

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

What makes your symptoms better? _____

What makes your symptoms worse? _____

Other doctors seen for this condition? _____

Are you taking:

Nerve Pills

Do you drink alcohol? Yes No

- If yes, how many drinks per week? _____

Do you smoke cigarettes? Yes No

- If yes, how many cigarettes per day? _____

Do you chew tobacco? Yes No

- If yes, how often? Frequently Occasionally Rarely

Do you drink caffeine? Yes No

- If yes, how many cups per day? _____

How often do you exercise? Frequently Occasionally Rarely Never

Metabolic Screen Questionaire

Rate the symptoms below based on your typical health profile for the specified duration:

Point Scale: 0- almost never have the symptom 1-Occasionally have it, effect is not severe
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 _____	**Digestive Tract** ___Nausea/Vomitting ___Diarrhea ___Constipation ___Bloated Feeling ___Belching, passing gas ___Intestinal/stomach pain ___Heartburn Total _____
Eyes ___Watery or itchy eyes ___Swolllen, reddened, sticky eyelids ___Bags or Dark Circles ___Blurred/Tunnel Vission Total _____	**Joints/Muscles** ___Pains or aches in joints ___Stiffness or limitation of movement ___Feelings of weakness or tiredness ___Pains or aches in muscles ___Arthritis Total _____
Ears ___Itchy Ears ___Earaches/Ear infections ___Drainage from ear ___Ringing in ears/hearing loss Total _____	**Energy/Activity** ___Fattigue/sluggishness ___Apathy/lethargy ___Hyperactivity ___Restlessness Total _____
Nose ___Stuffy Nose ___Sinus Problems ___Excessive mucous formation ___Sneezing atacks	**Weight** ___Binge eating/drinking ___Craving certain foods ___Compulsive eating ___Excessive weight ___Water retention

___Hay Fever Total _____	___Underweight Total _____
Mouth/Throat ___Chronic coughing ___Gagging, frequent need to clear throat ___Sore throat, hoarseness, loss of voice ___Swollen or discolored tongue/gum/lips ___Canker Sores Total _____	**Mind** ___Poor Memory ___Confusion, poor comprehension ___Difficulty in making decisions ___Stuttering or stammering ___Slurred speech ___Poor concentration ___Poor physical coordination ___Learning disabilities Total _____
Skin ___Acne ___Hives, rashes, dry skin ___Flushing, hot flashes ___Excessive sweating ___Hair Loss Total _____	**Emotions** ___Mood Swings ___Anxiety, fear, nervousness ___Anger, irritability, aggresiveness ___Depression Total _____
Heart ___Chest Pain ___Irregular or skipped heartbeat ___Rapid/pounding heartbeat Total _____	**Other** ___Frequent Illness ___Frequent or urgent urination ___Genital itch/discharge Total _____
Lungs ___Chest Congestion ___Asthma/Bronchitis ___Shortness of Breath ___Difficulty Breathing Total _____	**Grand Total** _____

Nutritional Response Testing

I authorize the natural health practitioners at Hudson Valley Chiropractic and Nutrition Office to perform a Nutritional Response Testing health analysis using the body's natural reflexes, along with live cell microscopy and Heart Rate Variability Test. Results will be used to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutrition or dietary programs recommended.

Nutritional Response Testing is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas can cause or contribute to various health problems. This program does not diagnose and is not for the treatment or "cure" of any disease.

Initials _____

Ion Cleanse Detoxification

The "Ion Cleanse" has shown in clinical trials using electro dermal scanning to improve and balance the body's energy channels or meridians. These meridians begin or end on the feet or hands and provide a pathway for energy to flow to or from a particular organ (i.e. liver, kidney, etc.). A person's current state of health is determined by how well energy flows through these meridians or energy channels. The "Ion Cleanse" has also shown in clinical trials to change and balance the body's pH. Balancing the body's pH is critical in assisting the body in every aspect, from its ability to detox to its ability to digest.

This detoxification occurs through the skin, which is the second largest detoxifying system in the body after the lungs.An energized and balanced body will naturally be able to detoxify at a higher rate, thereby protecting itself from further toxins, pollutants and viruses.

It is important to have something to eat just before or during the treatment. It is also important to drink at least 3 or 4 glasses of water following the treatment.

I understand that this is a non-invasive, safe method of aiding the body's cleansing process and balancing the body's organ system. I further understand that this is a general health treatment and that I am not being treated for any specific disease or infirmity.

Initials _____

Acknowledgement

By signing below, I hereby acknowledge, agree, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I understand that the healthcare facility maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

d) **Consent for Treatment**. I grant the healthcare facility, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the healthcare facility regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or other channels.

f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize the healthcare facility to retrieve and review my medical history and authorize the healthcare facility to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient Signature: _____ **Date**: _____

Print Name: _____

Parent or Guardian Signature: _____ **Date**: _____

Print Name: _____