Body Injury Sheet [PLEASE LABEL AND WRITE CLEARLY]

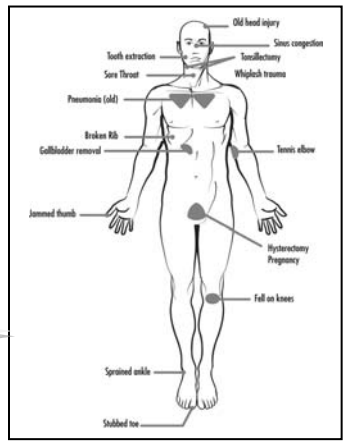
Name: _____ Date:_____

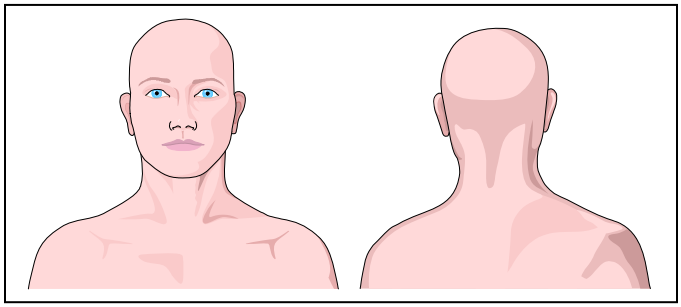
LABEL AREAS of <u>old injuries</u> and <u>location in body of past infection</u>.

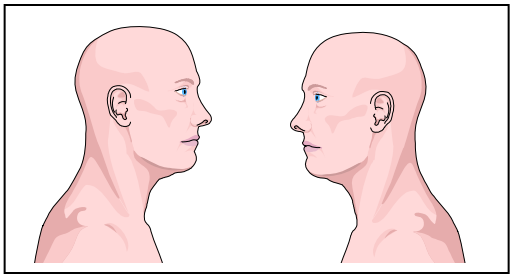
Examples: scars, whiplash from auto accident injuring neck or chin hitting dashboard, head injury, blows to the body from falls or hits (ex. falling on your tail bone, hit in the nose or on the head), surgeries, broken bones (ex. broke rib, toe, arm), muscle, tendon or ligament tears, organs removed, etc. *Examples:* sore throat, tonsils swollen, ear infections, lung infection, brochial infections, bladder infections, sinus infection, appendix, etc.

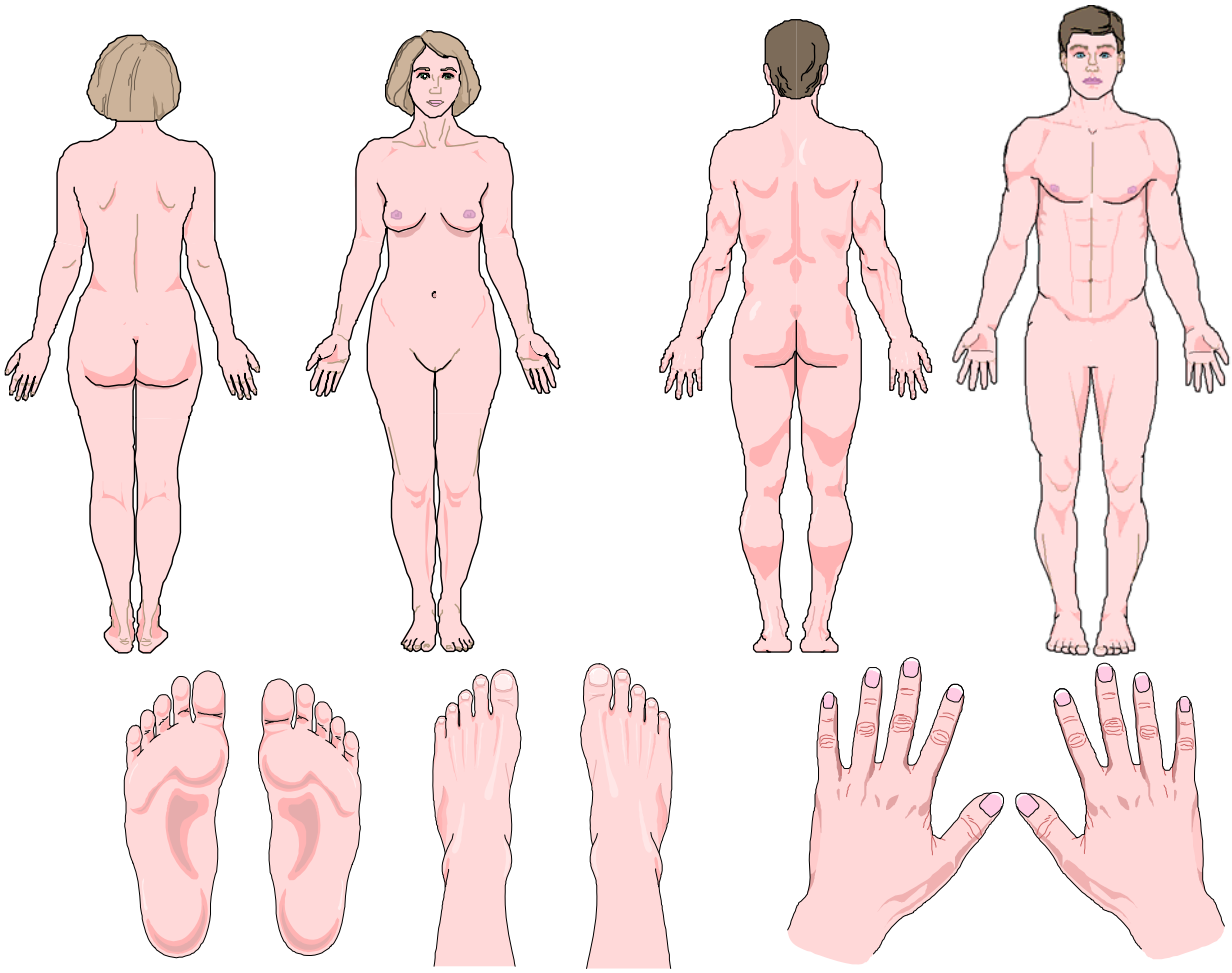
SEE EXAMPLE TO THE RIGHT →

Example:









Practitioner Signature: _____

Designed Clinical Nutrition: Client Case Record

Name: _____ Date: _____ Client ID#: _____
Home phone: _____ Work phone: _____
Address: _____
City: _____State: _____ Zip: _____
Age: _____ Birth date: _____ Sex: [ ]Female [ ]Male
Occupation: _____ Email: _____
How did you find out about us or who referred you? _____

Please list the five main important complaints in order of importance:

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

Current Medications taking (patient fills out):

_____
_____
_____

Practitioner Notes: _____
_____
_____
_____
_____
_____
_____

Practitioner Signature: _____ _____

History of medical illnesses, surgeries, removed organs and treatments:

____
____
____
____
____

Family / Social History: (leave blank if doesn't apply or do not understand)

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 refined grains? [ ]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:

____
____
____

Current Physician Name / #:

____
____

Patient fills above this line

- -

Blood Pressure:

Lying down: __________Pulse:_____
Standing: ____________ Pulse:_____

Weight: ________ Height: _______

Practitioners Notes:
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 Management program, eating plan: _______________________________________
- ☐ Exercise program

Practitioner Signature: ____________________________________

Designed Clinical Nutrition
Informed Consent for Care

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, 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.

_____
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.

_____
Initials

6. OFFICE FEES:
I understand that the following Center office visit fees apply:

Initial Consult – No Charge
Comprehensive Initial Exam $95.00
(Comprehensive consult and full testing**.** 24 hour cancellation or reschedule call is needed or fee is forfeited)
Office visits $90.00/visit
(Discounted, no-refund pre-payment programs are variable in rates.)
Chiropractic Adjustment - $40.00/visit
Chiropractic Adjustment done in conjunction with an acupressure visit - $25.00/visit
Body Composition Testing (Body Fat Testing) - $50.00/test
Urine Testing - $25/test
Autonomic Nervous System Test - $50/test
(This is for educational purposes and assists in monitoring exercise programs.)
Exercise Recovery Testing - $150/test
(This test allows the practitioner to evaluate the body's recovery time after exercise.)
Consultation upon request by client - $50 per 15 min.
Missed Appointment Charge (with no 24 hour advance notice) - $25.00
Bounced Check Fee per incident (Two max. then cash only) - $35.00
Records Copy Fee - $20.00/request (issued to client only, not sent to 3rd party)
Nutrient Analysis - $20.00/analysis

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 by the cashier.

_____
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 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. I understand that I am free to pay in full, visit by visit and that any prepaid package program is only an incentive to move through my program to achieve my goals.

_____
Initials

9. I understand that our office is paid in cash 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. I have read and agree to the Center's above terms.
Guardian Signature_____ Date _____

Staff Member _____ Date _____

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**

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**
- ☐ **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**

NOTES:

_____

Practitioner Signature