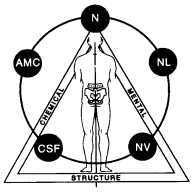


# Holistic Health & Chiropractic of Frankfort

Jon K. Heyer, D.C., Licensed Nutritionist, Acupuncturist

## Functional Medicine New Patient Registration and Case History

**Patient Information**

Today's Date_____

Name_____Birth date_____

Address_____City_____State_____Zip_____

Home Phone_____Cell_____Work_____

Age_____Email_____

Occupation_____Employer_____

Employer Address_____City_____State_____Zip_____

Sex: [ ] Male [ ] Female # of Children_____Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widow

Spouses Name_____Who may we thank for referring you?_____

In case of emergency notify: _____

Phone #_____Alternate Phone #_____

Have you ever seen a Nutritionist/Functional Medicine Dr? [ ] Yes [ ] No

If yes, when and why? _____

If yes, what were your results?_____

Main Reason for consulting our office today_____

**Please fill out the remaining to the best of your ability, we understand dates may not be exact.**

**For women only:**

[ ] Cramps/backaches-625.3 [ ] Excessive flow-626.2 [ ] Hot flashes-627.2 [ ] Miscarriage-634.9

[ ] Irregular cycle-626.4 [ ] Painful periods- 625.3 [ ] Vaginal discharge-623.5

Are you pregnant now? [ ] Yes [ ] No Last Pap Date :_____By whom_____

**Family History**

| | | | |
|---|---|---|---|
| [ ] Heart Attack | [ ] Headache | [ ] Arthritis | [ ] Alcohol/drug abuse |
| [ ] Dizziness/Vertigo | [ ] Emphysema | [ ] Fainting/drop attacks | [ ] Seizures/Epilepsy |
| [ ] Diabetes | [ ] Stroke | [ ] Cancer | [ ] Depression/Anxiety |
| [ ] Osteoporosis | [ ] Anemia | [ ] Digestion difficulties | [ ] Ulcer |
| [ ] Gout | [ ] Unusual Bleeding | | |

Operations and Procedures: (Please check all that apply and add date)

[ ] Vaccinations_____ [ ] Tonsillectomy_____ [ ] Gall Bladder_____ [ ] Back operation_____

[ ] Tubes in ears_____ [ ] Appendectomy_____ [ ] Female organs_____ [ ] Rectal surgery_____

[ ] Sinus_____ [ ] Hernia_____ [ ] Thyroid_____ [ ] Stomach_____

Please list any operations or procedures not indicated above:_____

Were you ever knocked unconscious? [ ] Yes [ ] No Have you ever had lapse of memory? [ ] Yes [ ] No

**History Continued**

What other factors of your health, have you not revealed, if any?_____

Please list any medications you are presently taking (include prescription and over the counter)

_____

Please list any supplements you are presently taking

_____

I understand that the Doctor and his staff will rely on my answers to this Intake Form and affirm that my answers are true and complete. I agree to hold the Doctor and his staff harmless for any injury, which I may suffer as a result of my failure to fully complete the Intake From truthfully and accurately. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctors office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctors Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Nutritional Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid will be out of pocket and not covered by insurance. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

**Patient/Guardian Signature**_____ **Date**_____