Optimal Health Nutrition Center
Family Chiropractic Clinic

Chiropractic and Nutritional Treatments
Dr. Mark A. Pederson
Chiropractor & Clinical Nutritionist
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Nutrition Intake Form:

Greetings and thank you for contacting our office regarding your health concerns:

Enclosed you will find your intake paper work. Please complete in full and return to our office prior to your appointment if you have been instructed to do so. Otherwise, please bring completed forms with to your appointment. A checklist of necessary items is listed below. **Please see that all are complete prior to your consultation visit.** Thank you.

Checklist of items to be completed for consultation visit:

- ❑ Patient Information Packet
- ❑ Medical Records
    - Please bring copies of all medical records and lab/x-ray/MRI/CT results run within the prior six (6) months.
- ❑ Typed/Written History of Health Concern(s) at end of this packet
    - Please complete the typed/written history of your health concern (s) form enclosed.
- ❑ You Must Bring Shorts and T-Shirt with you to your appointment.
    - You will be asked to change into this for your neurological evaluation.

Note: Prior to receiving this intake packet you should have been scheduled for two (2) appointments.

1. **Your consultation and evaluation appointment.**
2. **Your report of findings and recommendation of care appointment.**

If you were not scheduled for both appointments please contact our office immediately at (218) 745-6655.

Please also note that it is strongly recommended that spouses attend the consultation and evaluation appointment and it is mandatory that spouses attend the report of findings and recommendation of care appointment.

NOTE: If the patient is your child it is mandatory that both parents attend the report of findings and recommendation of care appointment.

PATIENT INFORMATION:

Title: __Dr. __Miss __Mr. __Mrs. __Ms.
First: ________________________
Middle Initial: ____
Last: ________________________
Preferred Name: ____
Sex: __Male __Female
Date of Birth: _________________
Social Security #: _____________________________

Street: ____
City: ________________________
State: ________________________
Zip: _________________________

Marital Status: __Single __Married __Widowed __Separated __Divorced
Spouse Name: ___________________________________
Spouse Birthdate: ________________________
Spouse Occupation: _______________________________
Spouse Employer: _________________________________

PLEASE NOTE**: In order to better serve you we utilize text messaging to remind you of your scheduled appointment.**

Home Phone: ___________________ Work Phone: ___________________
Cell Phone: ____________________ Cell Phone Carrier:___________________________
Does your plan include text messaging? __ Yes __No
Does your plan include email messaging? __ Yes __No

PLEASE NOTE**: In order to better serve you we utilize email messaging to remind you of your scheduled appointment.**

Email: ____

Referred To Our Office By: ____

Emergency contact information:
Name: __________________________________Relationship:_________________________
Phone 1: _______________________ Phone 2: _______________________

Employment:
Your employment status:
__Employed __Employed Part-time __Retired __Part-time student __Full-time student
Employer: ____

- Address: ___________________________________ Phone #:______________
- City: ______________________ State_______ Zip: ______________

Occupation: ____
Type of Work: __Office/Clerical __Light labor __Moderate labor __Heavy labor

INSURANCE INFORMATION:
Has your insurance changed since your last visit? __Yes __No
Please bring your insurance card with you to your appointment.
Insurance Company: ____
Group Number: ________________________________
Who is responsible for this account? ___________________________________
Relationship to patient: ____
Is patient covered by additional insurance? _____Yes _____No
Subscribers name: ____
Birthdate: _________________________
SS #: ____________________________
Relationship to patient: ____
Insurance company: ____
Group #: ____

Assignment and Release: I certify that I, and/or my dependent(s) have insurance coverage with
____
(name of insurance company)
And assign directly to Dr. Mark Pederson all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Mark Pederson may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ Date:______________
Signature of patient, parent, guardian or personal representative

____Date______________
Printed name of patient, parent, guardian or personal representative

PATIENT CONDITION:

Overall health (circle one): Excellent / Good / Fair / Poor / Other: ___________________

Chief complaint (reason you are here):

1. ____

Previous treatment for this complaint ____

____

When did your complaint first begin?____

Have you ever experienced this complaint before? _________________________________

What makes your problem better?____

What makes your problem worse?____

Describe the type of pain/symptom you experience?_______________________________

____

Does your problem travel into any other part of your body? Where? ___________________

Where exactly is the complaint area?____

When do you notice the problem?____

Have you lost control of any body part (arms, legs, bladder, bowel, etc.)?____________________

Rate the severity of your problem on a scale of 1-10, 1 being least severe and 10 being bedridden?

____

Other complaints or problems:

1. ____
2. ____
3. ____
4. ____

Current medications/drugs being taken:

1. __________________________ __________________________
2. __________________________ __________________________
3. __________________________ __________________________
4. __________________________ __________________________
5. __________________________ __________________________
6. __________________________ __________________________

Medical doctors or other health care professionals you have consulted with in the last 12 months?

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

Nutritional supplements you are taking:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

Do you smoke, drink coffee or alcohol? (If yes indicate how much)

Cigarettes ________________ Coffee __________________ Alcohol _________________

Please check off the following that apply to you:

Digestive Track:
- ❑ Nausea and vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Bloated feeling
- ❑ Stomach pains/cramps
- ❑ Heart burn
- ❑ Blood/mucous in stools

Ears:
- ❑ Itchy ears
- ❑ Ear aches/ear infections
- ❑ Drainage from ears
- ❑ Ringing in the ears
- ❑ Hearing loss
- ❑ Reddening of ears

Emotions:
- ❑ Mood swings
- ❑ Anxiety/fear/nervousness
- ❑ Argumentative
- ❑ Frustrated/cries easily
- ❑ Depression

Eyes:
- ❑ Watery/itchy eyes
- ❑ Red/swollen/eyelids
- ❑ Bags/dark circles under eyes
- ❑ Blurred or tunnel vision

Head:
- ❑ Headaches
- ❑ Faintness
- ❑ Dizziness
- ❑ Insomnia/sleep disorder
- ❑ Facial flushing

Heart:
- ❑ Irregular/skipped heartbeat
- ❑ Rapid/pounding heartbeat
- ❑ Chest pain

Joints:
- ❑ Pain/ache in joints
- ❑ Arthritis/osteoarthritis
- ❑ Stiffness/limited movement
- ❑ Pain/aches in muscles
- ❑ Feeling weak/tired
- ❑ Swollen/tender joints
- ❑ Growing pains in joints
- ❑ Psoriatic/gouty arthritis
- ❑ Rheumatoid arthritis

Lungs:
- ❑ Chest congestion
- ❑ Asthma/bronchitis
- ❑ Shortness of breath
- ❑ Difficulty breathing
- ❑ Persistent cough
- ❑ Wheezing

Mind:
- ❑ Poor memory
- ❑ Difficulty completing projects
- ❑ Difficulty with mathematics
- ❑ Underachiever
- ❑ Poor/short attention span
- ❑ Confusion
- ❑ Easily distracted
- ❑ Difficulty making decisions
- ❑ Learning disabilities

Mouth and Throat:
- ❑ Chronic coughing
- ❑ Gagging/clearing throat
- ❑ Sore throat/hoarse voice
- ❑ Swollen/discolored tongue
- ❑ Canker sores recurrent
- ❑ Itching on roof of mouth

Nose:
- ❑ Stuffy nose
- ❑ Chronically red/inflamed nose
- ❑ Sinus problems
- ❑ Hay fever
- ❑ Sneezing attacks
- ❑ Excessive mucous formation

Skin:
- ❑ Acne
- ❑ Itching
- ❑ Hives/rash/dry skin
- ❑ Hair loss
- ❑ Flushing/hot flashes

Weight:
- ❑ Binge eating/drinking
- ❑ Craving certain foods
- ❑ Excessive weight
- ❑ Compulsive eating
- ❑ Water retention

Genitourinary:
- ❑ Frequent illness
- ❑ Frequent/urgent urination
- ❑ Genital itch/discharge
- ❑ Anal itching
- ❑ Kidney problems
- ❑ Urinary tract infections
- ❑ Bladder problems
- ❑ Yeast infections

Other Conditions:
- ❑ Autism
- ❑ ADD
- ❑ ADHD
- ❑ Psoriasis
- ❑ Eczema
- ❑ Auto immune disorder
- ❑ Chronic fatigue
- ❑ Multiple chemical sensitivities
- ❑ Asthma
- ❑ Congestive heart failure
- ❑ Severe diabetic
- ❑ Severe depression
- ❑ Obsessive compulsive disorder

Health Goals: **Please list goals YOU would like to accomplish after beginning care at our office:**

6 Month Goals:

____

____

____

12 Month Goals:

____

____

____

History:

List any major illnesses:

1. ____
2. ____
3. ____
4. ____

List any surgery or operations with approximate date:

1. ____
2. ____
3. ____
4. ____

Past Accidents or injuries: ____

____

Marital Status: S M D W Describe health of spouse: ______________________________

Number of children if any __________Are you currently pregnant? Yes/No

Name of Child	Age	Sex	Any physical conditions or concerns?
______________________	_____	M/F	______________________________________
______________________	_____	M/F	______________________________________
______________________	_____	M/F	______________________________________

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes /Heart /

Other? ____

Any household pets or other animals you or family members are in close contact with?

____

Dietary Intake: Please list your dietary intake for the past two days.

Date: _______________

Breakfast ____

Morning snacks ____

Lunch ____

Afternoon snacks ____

Dinner ____

Evening snacks ____

Water intake for the day in ounces____

Date: _______________

Breakfast ____

Morning snacks ____

Lunch ____

Afternoon snacks ____

Dinner ____

Evening snacks ____

Water intake for the day in ounces____

Patient Qualification:

Please take several minutes to answer these questions so Dr. Pederson can help you get better faster. (Please circle as many that apply)

1. How have you taken care of your health in the past?

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic
i. Other (please specify): ___________________

2. How did the previous method(s) work out for you?

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

3. How have others been affected by your health condition?

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

4. What are you afraid this might be (or beginning) to affect (or will affect)?

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

5. Are there health conditions you are afraid this might turn into?

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic Fatigue
i. Need surgery

How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

____

____

What has that cost you ? (time, money, happiness, freedom, sleep, promotion, etc.) Give 3 examples

____

____

What are you most concerned with regarding your problem?

____

____

Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

____

____

What would be different/better without this problem? Please be specific.

____

____

What do you desire most to get from working with us?

____

____

Is there anything that would hold you back from beginning care?

____

____

If I accept you for care and you needed to be here 1-2 times per week, would that be a present problem?
Yes_____ No_____

If I accept you for care and required to make certain lifestyle changes (i.e. diet), would that be a problem?
Yes_____ No_____

The specialized care we perform requires out of pocket expenses, would that be a problem for you?
Yes_____ No_____

Typed or Written History of Health Concern

(Please complete a typed or written history of your health concern(s) below)

Family Chiropractic
Informed Consent for Chiropractic

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition of your health and the recommended care and treatment to be provided so that you may make the decision whether or not to undergo chiropractic care after being advised of the known benefits, risks and alternatives.

Chiropractic is a science and art, which concerns itself with the relationship between structure (primarily the spine) and function (primarily the nervous system) as that relationship may affect the restoration and preservation of health. **Health is a state of optimal physical, mental and social well-being, not merely the absence of disease or infirmity.**

One disturbance to the nervous system is call a **vertebral subluxation**. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes alteration of nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by an adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustment of the spine. Adjustments are usually done by hand but may be performed by handheld instruments. In addition, ancillary procedures such as physiotherapy and/or rehabilitative procedures may be included.

We do not offer to diagnose or treat any disease or condition other than vertebral subluxation. However, if during the course of care we encounter non-chiropractic or unusual findings, we will advise you of those findings and recommend that you seek the services of another health care provider.

All questions regarding doctor's objective pertaining to my care in this office have been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

______________________________ ______________________________ ______________________

Print Name Signature Date

____

Doctor's Signature

Minors:

I, ______________________________ being the parent or legal guardian of ______________________________ have read and fully understand the above Informed Consent and hereby grant permission for my child to receive chiropractic care.

Females:

Pregnancy Release:

This is to certify that to the best of my knowledge I am not pregnant and the above doctor and his/her associates have my permission to perform an x-ray evaluation. I have been advised that x-ray can be hazardous to an unborn child. Date of last menstrual cycle: ________________

____ ________________________

Signature Date

Revised 11/2016