LAKESIDE HOLISTIC HEALTH, PLLC

New Patient Intake Packet ~ Adult

The information you provide here helps the provider understand your physical, mental, and emotional condition more completely in order to help you attain your health goals. Please answer all the questions as completely as possible.

Name: _____ Date: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: ___M ___F

Mailing Address: _____ City/State/Zip: _____

Contact Phone Number: _____ May we leave detailed message? (i.e. appointment reminders) ___Y ___N

Occupation: _____ Full / Part Time: _____

Email: _____

May we send you email appointment confirmations? ___Y ___N

Would you like to join our Platinum Wellness Club & receive our monthly newsletter? ___Y ___N

Marital Status:	With Whom do you live?:	How many Children do you have?	Number of Children at home?:
___ Single	___ Alone		
___ Married	___ Spouse		
___ Co-habitating	___ Friends	_____	_____
___ Divorced	___ Relatives		
___ Separated	___ Parents		
___ Widowed	___ Other		

Emergency Contact: _____ Phone: _____

Primary Health Provider: _____ Phone: _____

How did you hear about Lakeside Holistic Health, PLLC?

___ Personal Referral: Please provide their name so we may thank them: _____

___ Business Referral: Please provide their name so we may thank them: _____

___ Website ___Facebook ___Insurance: _____ ___ Print Ad: Which one? _____

PERSONAL HEALTH

Blood Type: _____

What are your current health concerns? Please list in order of importance.

Health Concern	How long have you had this condition?	What other treatment have you sought?	What helps your condition?	What aggravates your condition?

What diagnostic imaging studies have you had?

X-Rays	CT Scan	Bone Density Scan	Mammogram	EKG	MRI

What immunizations have you had? (Place a ? if you do not know)

Diphtheria	Measles/Mumps/ Rubella	Pertusis	Polio	Tetanus	Other
Specify Other:					

Have you had the following childhood illnesses? Mark Y or N

Scarlet Fever	Diphtheria	Rheumatic Fever	Mumps	Measles	German Measles	Other
Specify Other:						

Please indicate if any of the following pertain to you. (Marking Yes does not make you ineligible for acupuncture treatment, however, it may restrict some treatment modalities)

Hepatitis	HIV	HIgh Blood Pressure	Seizures	Pacemaker	Blood Thinning Meds	Pregnancy

Do you have any allergies to food, drugs, or environmental allergens (Cats, mold, dust) ___ Y ___ N

If Yes, Please explain:_____

METABOLIC ASSESSMENT

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always

Category I	0	1	2	3
Feeling that bowels do not empty completely				
Lower Abdominal pain relief by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard, Dry, or small stool				
Coated tongue or "fuzzy" debris on tongue				
Pass large amount of foul smelling gas				
More than 3 bowel movements daily				
Use laxatives frequently				

Category II	0	1	2	3
Increasing frequency of food reactions				
Unpredictable food reactions				
Aches, pains, and swelling throughout the body				
Unpredictable abdominal swelling				
Frequent bloating and distention after eating				

Category III	0	1	2	3
Intolerance to smells				
Intolerance to jewelry				
Intolerance to shampoo, lotion, detergents, etc.				
Multiple smell and chemical sensitivities				
Constant skin outbreaks				

Category IV	0	1	2	3
Excessive belching, burping, or bloating				
Gas immediately following a meal				
Offensive breath				
Difficult bowel movements				
Sense of fullness during and after meals				
Difficulty digesting fruits and vegetables; undigested foods found				

Category V	0	1	2	3
Stomach pain, burning, or aching 1-4 hours after eating				
Use antacids				
Feel hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relief from antacids, food, milk, carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine				

Category VI	0	1	2	3
Difficulty digesting roughage and fiber				
Indigestions and fullness lasts 2-4 hours after eating				
Pain, tenderness, soreness on left side under rib cage				
Excessive passage of gas				
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed				
Frequest loss of appetite				

Category VII	0	1	2	3
Abdominal distention after consumption of fiber, starches, and sugar				
Abdominal distention after certain probiotic or natural supplements				
Decreased gastrointestinal motility, constipation				
Increased gastrointestinal motility, diarrhea				
Alternating constipation and diarrhea				
Suspicion of nutritional malabsorption				
Frequent use of antacid medication				
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/Diverticulitis, or Leaky Gut Syndrome?	YES		NO	

Category VIII	0	1	2	3
Greasy or high-fat foods cause distress				
Lower bowel gas or bloating several hours after eating				
Bitter metallic taste in mouth, especially in the morning				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates from clay colored to normal brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones				
Have you had your gallbladder removed?	YES		NO	

Category IX	0	1	2	3
Acne and unhealthy skin				
Excessive hair loss				
Overall sense of bloating				
Bodily swelling for no reason				
Hormone imbalances				
Weight Gain				
Poor Bowel Function				
Excessively foul-smelling sweat				

Category X	0	1	2	3
Crave Sweets during the day				
Irritable if meals are missed				
Depend on coffee to keep yourself going or started				
Get lightheaded if meals are missed				
Eating relieves fatigue				
Feel shaky, jittery, or have tremors				
Agitated, easily upset, nervous				
Poor memory/forgetful				
Blurred vision				

Category XI	0	1	2	3
Fatigue after meals				
Crave sweets during the day				
Eating sweets does not relieve cravings for sugar				
Must have sweets after meals				
Waist girth is equal or larger than hip girth				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				

METABOLIC ASSESSMENT CONT.

Please mark the appropriate number on all questions below. 0 as the least/never to 3 as the most/always assessment 0

Category XII	0	1	2	3
Cannot stay asleep				
Crave salt				
Slow started in the morning				
Afternoon fatigue				
Dizziness when standing up quickly				
Afternoon headaches				
Headaches with exertion or stress				
Weak nails				

Category XIII	0	1	2	3
Cannot fall asleep				
Perspire easily				
Under high amounts of stress				
Weight gain when under stress				
Wake up tired even after 6 or more hours of sleep				
Excessive perspiration or perspiration with little or no activity				

Category XIV	0	1	2	3
Edema and swelling in ankles and wrists				
Muscle cramping				
Poor muscle endurance				
Frequent urination				
Frequent thirst				
Crave salt				
Abnormal sweating from minimal activity				
Alteration in bowel regularity				
Inability to hold breath for long periods				
Shallow, rapid breathing				

Category XV	0	1	2	3
Tired, Sluggish				
Feel cold - hands, feet, all over				
Require excessive amounts of sleep to function properly				
Increase in weight gain even with low-calorie diet				
Gain weight easily				
Difficult, infrequent bowel movements				
Depression, lack of motivation				
Morning headaches that wear off as the day progresses				
Outer third of eyebrow thins				
Thinning of hair on scalp, face, or genitals or excessive falling hair				
Dryness of skin and/or scalp				
Mental Sluggishness				

Category XVI	0	1	2	3
Heart Palpitations				
Inward trembling				
Increased pulse even at rest				
Nervous and emotional				
Insomnia				
Nightsweats				
Difficulty gaining weight				

Category XVII (Males Only)	0	1	2	3
Urination difficulty or dribbling				
Frequent urination				
Pain inside of legs or heels				
Feeling of incomplete bowel evacuation				
Leg twitching at night				

Category XVIII (Males Only)	0	1	2	3
Decrease in libido				
Decrease in spontaneous morning erections				
Decrease in fullness of erections				
Difficulty in maintaining morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decrease in physical stamina				
Unexplained weight gain				
Increase in fat distribution around chest and hips				
Sweating attacks				
More emotional than in the past				

Category XIX (Menstruating Females Only)	0	1	2	3
Are you perimenopausal	YES		NO	
Alternating menstrual cycle lengths	YES		NO	
Extended menstrual cycle, greater than 32 days	YES		NO	
Shortened menses, less than every 24 days	YES		NO	
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and depressed during menses				
Acne breakouts				
Facial hair growth				
Hair loss/thinning				

Category XX (Menopausal Females Only)	0	1	2	3
How many years have you been menopausal?				
Since menopause, do you ever have uterine bleeding?	YES		NO	
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breasts				
Facial hair growth				
Acne				
Increased vaginal pain, dryness or itching				

HOSPITALIZATIONS OR SURGERIES

Hospitalization / Surgeries	Year

MEDICATIONS

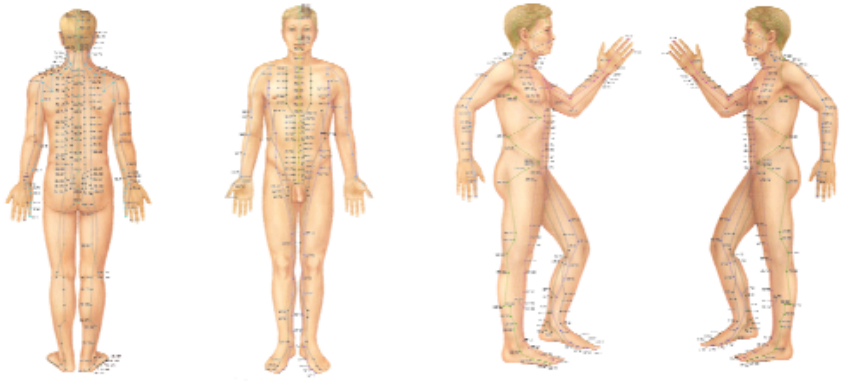
Medication	Reason

VITAMIN & HERBAL SUPPLEMENTS

Supplement	Reason

PAIN PATIENTS

Please indicate on the figures below the areas of the body you experience pain by placing an “X”.



How would you characterize your pain:

___ dull/achy

___ sharp/stabbing

___ tingling

___ electrical

___ burning

___ numbness

DIET

Meal	List the types of foods you typically consume.
Breakfast	
Lunch	
Dinner	
Snacks	
Beverages	
What do you crave?	
Any food intolerances?	
Do you eat three meals per day?	

HABITS

What are you main interests & hobbies? _____

Do you Exercise? ___Y ___ N Explain: _____

Do you smoke or chew tobacco? ___ Y ___ N If not currently, have you in the past? _____

Do you use recreational drugs? ___ Y ___ N Explain: _____

Have you been treated for drug dependence? ___ Y ___ N Explain: _____

FAMILY HISTORY

Please mark if you or your family have experienced:

Illness	Self	Father	Mother	Sister	Brother	Other
Anemia						
Arthritis						
Asthma						
Cancer						
Diabetes						
Epilepsy						
Gallbladder Disease						
Glaucoma						
Goiter						
Hay Fever, Hives						
Heart Disease						
Heart Murmur						
High Blood Pressure						
Kidney Disease						
Liver Disease						
Mental Illness						
Stroke						
Tuberculosis						
Ulcer						
Other						

CONSENT & RECORD OF DISCLOSURES

By signing below you acknowledge that you have read, fully understand and agree to all the information in the Introductory Patient Information packet. My sole purpose and intent in seeking the services of Lakeside Holistic Health, PLLC is to obtain help for my personal health. My signature is entirely voluntary and based upon informed choice. I also acknowledge this as a Notice of Information Practices. As a patient you have the right to see, copy and supplement your medical records. Medical records obtained in this office may only be used for health care related functions and Lakeside Holistic Health, PLLC will not share or release records without patient authorization.

I acknowledge that I am 18 years of age or older.

I understand that Lakeside Holistic Health, PLLC does not provide after hours services, and that in case of emergency I should contact the appropriate licensed health care provider.

I am aware of Dr. Langenderfer's professional training as a Naturopathic Physician and Licensed Acupuncturist and have been informed to my satisfaction.

I am aware of Dr. Bailey's professional training as a Chiropractic Physician and a Certified Acupuncturist and have been informed to my satisfaction.

I understand that I am financially responsible for all products and services that I receive from Lakeside Holistic Health, PLLC.

I understand that payment is due at the time of service for treatments and services not covered by my insurance plan.

Consent to Bill Third-Party Payer (Commercial Insurance)
I understand that some third party payers may require that my medical information, including copies of treatment notes, be submitted along with requests for payment. I hereby authorize Lakeside Holistic Health, PLLC to release all medical information necessary to secure payment of benefits from my insurance carrier.

FINANCIAL CONSENT & AGREEMENT

For your convenience we are Preferred Providers with most commercial insurance carriers. We are happy to complete and submit insurance claims when coverage is available for you. If we are not contracted with your insurance carrier we may be able to submit a courtesy claim on your behalf.

We do not accept Medicare, Medicaid, United Healthcare, or any Medicare or Medicaid supplemental insurance.
We hereby notify you that Lakeside Holistic Health, PLLC and all our Providers have opted out of Medicare and Medicaid. When a physician or practitioner opts out of Medicare and Medicaid, no services provided by that provider are covered by Medicare and no Medicare/Medicaid payment can be made to that provider directly or on a capitated basis. Additionally, no payment may be made to a beneficiary for items or services provided directly by a provider who has opted out of the program(s). Under the statute, the provider cannot choose to opt out of Medicare for some Medicare/Medicaid beneficiaries but not others; or for some services but not others.

By signing this agreement you;

1. Agree not to submit a claim for payment under Medicare/Medicaid, even if such items and services would otherwise by covered by Medicare/Medicaid;
2. Agrees to be responsible for payment of such items and services;
3. Acknowledges that no reimbursement will be provided by Medicare/Medicaid for such items and services;
4. Acknowledges that the provider is not limited in the amount that he or she may charge the beneficiary for the items and services furnished;
5. Acknowledges that quoted benefits from my insurance plan is not a guarantee of coverage and I am responsible for all charges.
6. Acknowledges that it is my own responsibility to know my insurance benefit information.

Patient Printed Name		Date	
Patient Signature			