



FIRSTLINE THERAPY INTAKE

*** Please arrive 5 min. prior to scheduled appointment time. Remember to bring Completed Paperwork.**

First Name: _____ MI: _____ Last Name: _____ SS# _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

Sex: M F DOB: ___/___/___ Age: ___ Marital Status: Single Married Divorced Widowed Separated

Employer: _____ Work Address: _____ Zip: _____

Occupation: _____ Work Phone: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Do you give permission for Dr. Davies to update your general medical practitioner with the progress of your condition? Yes No

Name of Medical Doctor: _____ Who may we thank for referring you to us? _____

RESPONSIBLE PARTY INFORMATION

If you are the responsible party mark "self" and move down to "Payment Information".

Person responsible for patient's charges: Self Spouse Parent Other: _____

First Name: _____ MI: _____ Last Name: _____ SS#: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: M F DOB: ___/___/___ Age: ___ Cell: _____ Work Phone: _____

Employer: _____ Occupation: _____

PAYMENT INFORMATION

Please check the following payment methods that apply: Health Insurance Cash

This injury is related to a Work Injury. Date of Injury: ___/___/___.

This injury is related to an auto accident. Date of Accident: ___/___/___.

ASSIGNMENT AND RELEASE

Scheduling an appointment reserves that time especially for you and no one else. Our office requires **24 hours notice to cancel an appointment. If 24 hours is not given, a charge of \$20** will be billed to your account.

I _____ clearly **understand and agree that all services provided will be charged directly to me and that I am personally responsible for payment.** I agree to allow Dr. Mark Davies, DC, CCN, CCSP, RN to bill my insurance company as a courtesy and permit the release of medical records necessary to process my claims. I authorize payments to be made directly to Dr. Mark Davies, DC, CCN, CCSP, RN for treatment rendered. **I understand that co-payments and cash fees are due at the time of service and that I may receive an additional bill for services not covered by my insurance.**

Patient's Signature: _____ **Date:** _____

Parent or Guardian's Signature if under 18

For office use only: Photo Copy Ins Card Intake Complete

HEALTH HISTORY

Name _____ Date _____

Occupation _____ Age _____ Height _____ Sex _____ Number of Children _____

Marital Status: Single Partner Married Separated Divorced Widow(er)

Are you recovering from a cold or flu? _____ Are you pregnant? _____

Reason for office visit: _____ Date began: _____

List current health problems for which you are being treated: _____

What types of therapies have you tried for these problem(s) or to improve your health over-all:

- diet modification fasting vitamins/minerals herbs homeopathy chiropractic acupuncture conventional drugs
 other _____

Do you experience any of these general symptoms EVERY DAY?

- | | | | | |
|--|--|-----------------------------------|---|--|
| <input type="checkbox"/> Debilitating fatigue | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Chronic pain/inflammation |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Nausea | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Bleeding |
| <input type="checkbox"/> Disinterest in sex | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Discharge |
| <input type="checkbox"/> Disinterest in eating | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Low grade fever | <input type="checkbox"/> Itching/rash |

Current medications (prescription or over-the-counter): _____

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

Outcome _____

Major Hospitalizations, Surgeries, Injuries: Please list all procedures, complications (if any) and dates:

Year	Surgery, Illness, Injury	Outcome
_____	_____	_____
_____	_____	_____
_____	_____	_____

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, work, residence or finances, legal problems): _____

Do you consider yourself: underweight overweight just right Your weight today _____

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? _____

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) or health and/or life threatening activities (e.g., fireman, etc.)? _____

What are your current health goals: _____

Medical History

- Arthritis
- Allergies/hay fever
- Asthma
- Alcoholism
- Alzheimer's disease
- Autoimmune disease
- Blood pressure problems
- Bronchitis
- Cancer
- Chronic fatigue syndrome
- Carpal tunnel syndrome
- Cholesterol, elevated
- Circulatory problems
- Colitis
- Dental problems
- Depression
- Diabetes
- Diverticular disease
- Drug addiction
- Eating disorder
- Epilepsy
- Emphysema
- Eyes, ears, nose, throat problems
- Environmental sensitivities
- Fibromyalgia
- Food intolerance
- Gastroesophageal reflux disease
- Genetic disorder
- Glaucoma
- Gout
- Heart disease
- Infection, chronic
- Inflammatory bowel disease
- Irritable bowel syndrome
- Kidney or bladder disease
- Learning disabilities
- Liver or gallbladder disease (stones)
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological problems (Parkinson's, paralysis)
- Sinus problems
- Stroke
- Thyroid trouble
- Obesity
- Osteoporosis
- Pneumonia
- Sexually transmitted disease
- Seasonal affective disorder
- Skin problems
- Tuberculosis
- Ulcer
- Urinary tract infection
- Varicose veins
- Other _____

Medical (Men)

- Benign prostatic hyperplasia
- Prostate cancer

- Decreased sex drive
- Infertility
- Sexually transmitted disease
- Other _____

Medical (Women)

- Menstrual irregularities
- Endometriosis
- Infertility
- Fibrocystic breasts
- Fibroids/ovarian cysts
- Premenstrual syndrome (PMS)
- Breast cancer
- Pelvic inflammatory disease
- Vaginal infections
- Decreased sex drive
- Sexually transmitted disease
- Other _____
- Date of last GYN exam _____
- Mammogram + -
- PAP + -
- Form of birth control _____
- # of children _____
- # of pregnancies _____
- C-section _____
- Age of first period _____
- Date - last menstrual cycle _____
- Length of cycle _____ days
- Interval of time between cycles _____ days
- Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____
- Surgical menopause
- Menopause

Family Health History (Parents and Siblings)

- Arthritis
- Asthma
- Alcoholism
- Alzheimer's disease
- Cancer
- Depression
- Diabetes
- Drug addiction
- Eating disorder
- Genetic disorder
- Glaucoma
- Heart disease
- Infertility
- Learning disabilities
- Mental illness
- Mental retardation
- Migraine headaches
- Neurological disorders (Parkinson's, paralysis)
- Obesity
- Osteoporosis
- Stroke
- Suicide
- Other _____

Health Habits

- Tobacco:
- Cigarettes: #/day _____
- Cigars: #/day _____
- Alcohol:
- Wine: #glasses/d or wk _____
- Liquor: #ounces/d or wk _____
- Beer: #glasses/d or wk _____
- Caffeine:
- Coffee: #6 oz cups/d _____
- Tea: #6 oz cups/d _____
- Soda w/caffeine: #cans/d _____
- Other sources _____
- Water: #glasses/d _____

Exercise

- 5-7 days per week
- 3-4 days per week
- 1-2 days per week
- 45 minutes or more duration per workout
- 30-45 minutes duration per workout
- Less than 30 minutes
- Walk - #days/wk _____
- Run, jog, other aerobic - #days/wk _____

- Weight lift - #days/wk _____
- Stretch - #days/wk _____
- Other _____

Nutrition & Diet

- Mixed food diet (animal and vegetable sources)
- Vegetarian
- Vegan
- Salt restriction
- Fat restriction
- Starch/carbohydrate restriction
- The Zone Diet
- Total calorie restriction
- Specific food restrictions:
- dairy wheat eggs
- soy corn all gluten
- Other _____

Food Frequency

- Number of servings per day: _____
- Fruits (citrus, melons, etc.) _____
- Dark green or deep yellow/orange vegetables _____
- Grains (unprocessed) _____
- Beans, peas, legumes _____
- Dairy, eggs _____
- Meat, poultry, fish _____

Eating Habits

- Skip meals - which ones _____
- One meal/day
- Two meals/day
- Three meals/day
- Graze (small frequent meals)
- Generally eat on the run
- Eat constantly whether hungry or not

Current Supplements

- Multivitamin/mineral
- Vitamin C
- Vitamin E
- EPA/DHA
- Evening Primrose/GLA
- Calcium, source _____
- Magnesium
- Zinc
- Minerals, describe _____
- Friendly flora (acidophilus)
- Digestive enzymes
- Amino acids
- CoQ10
- Antioxidants (e.g., lutein, resveratrol, etc.)
- Herbs
- Homeopathy
- Protein shakes
- Superfoods (e.g., bee pollen, phytonutrient blends)
- Liquid meals (Ensure)
- Others _____

I Would Like To:

- ENERGY - VITALITY
- Feel more vital
- Have more energy
- Have more endurance
- Be less tired after lunch
- Sleep better
- Be free of pain
- Get less colds and flu
- Get rid of allergies
- Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
- Stop using laxatives and stool softeners
- Improve sex drive
- BODY COMPOSITION
- Loose weight
- Burn more body fat
- Be stronger
- Have better muscle tone
- Be more flexible
- STRESS, MENTAL, EMOTIONAL
- Learn how to reduce stress
- Think more clearly and be more-focused
- Improve memory
- Be less depressed
- Be less moody
- Be less indecisive
- Feel more motivated
- LIFE ENRICHMENT
- Reduce my risk of degenerative disease
- Slow down accelerated aging
- Maintain a healthier life longer
- Change from a "treating-illness" orientation to creating a wellness lifestyle

3 Day Diet Diary

Instructions for Completing the Diet Diary

** Please show typical eating patterns. This helps the practitioners to give you the best results possible.

It is important to keep an accurate record of your usual food and beverage intake as a part of this study. Please complete this 3 Day Diet Diary for three consecutive days with one day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless your doctor advises you to. The purpose of this food record is to analyze your present eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (whole, 2%, or nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages, including water. List them in the “Beverage” category.
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).

FirstLineTherapy® Health Profile

NAME _____

DATE _____

Rate each of the following symptoms based upon your typical health profile for: **Past 30 days** **Past 48 hours**

Point Scale	0	Never or almost never have the symptom	3	Frequently have it, effect is not severe
	1	Occasionally have it, effect is not severe	4	Frequently have it, effect is severe
	2	Occasionally have it, effect is severe		

HEAD

_____ Headaches

_____ Faintness

_____ Dizziness

_____ Insomnia

_____ **TOTAL**

EYES

_____ Watery or itchy eyes

_____ Swollen, reddened or sticky eyelids

_____ Bags or dark circles under eyes

_____ Blurred or tunnel vision (does not include near- or far-sightedness)

_____ **TOTAL**

EARS

_____ Itchy ears

_____ Earaches, ear infections

_____ Drainage from ear

_____ Ringing in ears, hearing loss

_____ **TOTAL**

NOSE

_____ Stuffy nose

_____ Sinus problems

_____ Hay fever

_____ Sneezing attacks

_____ Excessive mucus formation

_____ **TOTAL**

MOUTH/ THROAT

_____ Chronic coughing

_____ Gagging, frequent need to clear throat

_____ Sore throat, hoarseness, loss of voice

_____ Swollen or discolored tongue, gums or lips

_____ Canker sores

_____ **TOTAL**

SKIN

_____ Acne

_____ Hives, rashes, dry skin

_____ Hair loss

_____ Flushing, hot flashes

_____ Excessive sweating

_____ **TOTAL**

HEART

_____ Irregular or skipped heartbeat

_____ Rapid or pounding heartbeat

_____ Chest pain

_____ **TOTAL**

LUNGS

_____ Chest congestion

_____ Asthma, bronchitis

_____ Shortness of breath

_____ Difficulty breathing

_____ **TOTAL**

DIGESTIVE TRACT

_____ Nausea, vomiting

_____ Diarrhea

_____ Constipation

_____ Bloating feeling

_____ Belching, passing gas

_____ Heartburn

_____ Intestinal/stomach pain

_____ **TOTAL**

JOINTS/ MUSCLE

_____ Pain or aches in joints

_____ Arthritis

_____ Stiffness or limitation of movement

_____ Pain or aches in muscles

_____ Feeling of weakness or tiredness

_____ **TOTAL**

WEIGHT

_____ Binge eating/drinking

_____ Craving certain foods

_____ Excessive weight

_____ Compulsive eating

_____ Water retention

_____ Underweight

_____ **TOTAL**

ENERGY/ ACTIVITY

_____ Fatigue, sluggishness

_____ Apathy, lethargy

_____ Hyperactivity

_____ Restlessness

_____ **TOTAL**

MIND

_____ Poor memory

_____ Confusion, poor comprehension

_____ Poor concentration

_____ Poor physical coordination

_____ Difficulty in making decisions

_____ Stuttering or stammering

_____ Slurred speech

_____ Learning disabilities

_____ **TOTAL**

EMOTIONS

_____ Mood swings

_____ Anxiety, fear, nervousness

_____ Anger, irritability, aggressiveness

_____ Depression

_____ **TOTAL**

OTHER

_____ Frequent illness

_____ Frequent or urgent urination

_____ Genital itch or discharge

_____ **TOTAL**

GRAND TOTAL _____

MUTUAL UNDERSTANDING & CONSENT

(Nutrition & Therapeutic Lifestyle Counseling Services)

Name: _____

Date: _____

The following information is provided to enable our sharing of common understanding of our rights and roles in this professional relationship. Please read this agreement and sign at the end indicating that you have understood and agree to the following. Please ask any questions if you would like clarification or additional information.

- Information revealed during nutrition & therapeutic lifestyle counseling sessions is confidential. Exceptions to this confidentiality include disclosure by you regarding intention to harm yourself or others. Your record and the information contained within it will not be disclosed to others unless you direct us to do so or unless the law authorizes or compels us to do so.
- Nutrition & therapeutic lifestyle counseling is intended to help achieve better state of health. However, nutrition & therapeutic lifestyle counseling carries with it both risk and benefits. Risks include but are not limited to adverse reaction to nutritional supplementation or foods and worsening of symptoms.
- The general benefits of nutrition & therapeutic lifestyle counseling have been explained to me or have been presented to me. Nutrition & therapeutic lifestyle counseling is not a substitute for care by a physician. It is recommended you concurrently continue to work with your doctor. Nutritional counselors are not trained to diagnose illness or disease and do not prescribe medication.
- There may be additional or alternative treatments available. You are encouraged to ask questions if you would like additional information. Although your plan will be thoroughly researched and will be customized to your unique health assessment and your personal goals, no guarantees can be assured regarding the outcomes of counseling session(s) or effects from supplementation.
- Fees are charged for professional services, and full payment with cash, check, or credit card is due at the time these services are rendered.
- Treatments with other physicians or healthcare providers are not necessarily to be discontinued. Consult your prescribing doctor before discontinuing medications. It is your responsibility to disclose changes in your condition, symptoms, contact information, or treatments by other providers between visits.
- You are encouraged to ask questions on any health-related topic and to take an active role in your health care. Ours is a team approach, and natural treatments may involve encouraging you to make changes in your diet and lifestyles that can help you attain your highest level of health.

My signature below assures that the contact information, health history, and other information that I provide on my intake forms are current, complete and accurate. I understand and agree to all the information on this page. My questions, if any, were answered to my satisfaction. I will not hold or attempt to hold Falling Waters Natural Health & Fitness LLC, or any of its employees or independent contractors liable for any negative or ill effects of nutritional & therapeutic lifestyle counseling interventions.

Signature of Patient: _____ Date: _____

Parent or Guardian: _____ Date: _____

(If patient is under 18)