WASHINGTON PARK CHIROPRACTIC
heal thrive evolve

1313 S. Clarkson St. Unit 1, Denver, CO 80210 P: 303-744-7100 F: 303-744-7109 washparkchiro.com

Nutrition Client Intake Form

Date_____

Name_____ Date of Birth _____

Gender_____

Address_____ City_____ State_____ Zip_____

Preferred Phone_____ Email Address_____

Best Method of Contact _____Phone _____Email_____Text

Weight_____ Height_____

Who may we thank for referring you to our office?_____

Financial and Insurance Information

Insurance Carrier_____ Do you have a health savings account? ▢YES ▢NO

Insurance ID#_____ Are eligible for Medicare? ▢YES ▢NO

Today's Visit

What is the main reason for your visit?_____

_____

_____

How long have you been experiencing this issue?_____

Have you seen other health care providers?_____

If yes, please list:_____

Have you undergone any treatment? _____

If yes, please explain_____

_____

_____

Medical Information

Please list all medications and doses you are currently taking:_____

_____

Please list all supplement and vitamins you are currently taking_____

_____

Approximate number of bowel movements per day __1 __2 __3 __4 __5 Consistency?_____

What color is your urine typically? _____

Medical History

Have you had any surgeries or procedures that would affect your treatment? Please list:

_____

Please check the boxes that apply to you:

❒ Alcoholism
❒ Alzheimer's Disease
❒ Anemia
❒ Asthma
❒ Autoimmune Disease
❒ Bronchitis
Arthritis
❒ Cancer
If yes to any, list:
_____
_____

❒ Cardiovascular Disease
❒ Celiac Disease
❒ Chronic fatigue
❒ Colitis
❒ Crohn's Disease
❒ Depression
❒ Type 1 Diabetes
If yes to any, list:
_____
_____
_____
_____

❒ Type 2 Diabetes
❒ Eating Disorder
❒ Eczema
❒ Emphysema
❒ Endometriosis
❒ Epilepsy
❒ Fibromyalgia
❒ Genetic Disorders
If yes to any, list:
_____
_____
_____
_____

❒ Glaucoma
❒ Gastric/ Duodenal Ulcer
❒ Head Injuries
❒ Concussion(s)
❒ Hepatitis
❒ High Blood Pressure
❒ High Cholesterol
If yes to any, list:
_____
_____
_____

❒ HIV
❒ AIDS
❒ Intestinal Parasites
❒ Leaky Gut
❒ Mental Illness
❒ Migraine Headaches
❒ Mono
If yes to any, list:
_____
_____
_____

❒ Mono
If so when:_____
❒ Osteoarthritis
❒ Osteoporosis
❒ Pancreatitis
❒ Pneumonia
❒ Psoriasis
❒ Rheumatoid
❒ Skin Conditions
If yes to any, list:
_____
_____
_____

❒ STD
❒ Stroke
❒ Thyroid Condition
❒ Other:
_____
_____
_____
_____
_____
_____
_____

Females

Are you perimenopausal or menopausal?_____ Date of last period_____
Number of pregnancies_____ Number of births_____ Are you currently taking birth control?_____

Are you currently trying to conceive?_____ Do you suffer from PMS?_____
Symptoms_____
_____

Personal Information

Occupation_____ Normal work hours_____

Do you enjoy your job? ___Yes ___Sometimes ___ No How would you rank your stress level from 1-10? _____

How many hours of sleep do you get on average? _____ Normal sleep hours_____

Do you take naps? _____If so, how often?_____ Do you wake feeling refreshed? _____

What do you do to relax? (ex-watch tv, read, get outdoors, etc)_____
_____

Are you physically active? _____ How often? _____ Duration? _____

What physical activities do you enjoy doing?_____
_____

Do you consume alcohol?_____ How many times/week?_____

Do you smoke tobacco?_____ Do you smoke marijuana?_____ Do you use other recreational drugs?_____

How often/describe?_____

Goals

What are your goals for today?_____
_____
Do you see any obstacles in obtaining your goals?_____
_____

Do you have a support system to help you achieve your goals? (ie-friends, family, coworkers, etc)_____

_____

How committed are you to change?_____

_____

Everything I have written and answered in this form is true to the best of my knowledge. I will update Kebbie Stine of any significant changes. I understand and agree that this confidential information of my medical and health history will be maintained by Kebbie Stine and will not be released to any individual except when I have authorized this release in writing or when required by law.

Signature _____ Date _____

Signature of Legal Guardian if Applicable _____ Date _____

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FINANCIAL POLICY

Insurance:

Washington Park Chiropractic is an out-of-network provider with all health insurance companies. It is your responsibility to verify if you have benefits for out-of-network chiropractic before your first appointment. Washington Park Chiropractic can also check your benefits prior to or the day of your visit. All patient responsible payment is due at the time of service.

If you receive services from an out-of-network provider or facility or agency, you may still be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be billed.

If you think you have received a bill for amounts other than your copayments, deductible, and/or coinsurance please contact the billing department.

No-Show/Cancellation:

To better serve our patients and assure that they have a fair opportunity to have an appointment as promptly as possible, please observe our cancellation policy for chiropractic, nutrition, massage, and acupuncture appointments.

We require a minimum 24-hour notice to cancel or reschedule massage, acupuncture, nutrition, and new patient chiropractic appointments. We also require at least 2 hours notice for regular chiropractic appointments.

Fees:

Chiropractic: no-shows/late cancels will be billed $25 for the first missed appointment and full price for subsequent missed appointments.

Massage/Acupuncture/Nutrition: no-shows/late cancels will be billed for half of the price of the appointment for the first miss and full price for any subsequent missed appointments.

Please arrive on time for your appointment. If you know you will be late, please call to verify that the doctor will be able to devote your full scheduled time to you. If it is best, we will reschedule your appointment.

Packages:

All packages/ pre-payments expire after 3 years. They are non-refundable. Packages may be shared between family members.

Please check the box if you agree to share your packages with family members:
▢ YES ▢ NO

_____ _____
Patient's Signature Date

_____
Patient's Name (print)