Providing Steps to Wholeness

Welcome to our clinic, we are here to serve you.

Our goal is to provide you with a totally natural approach to feeling your very best again.

Natural Medicine

• Chiropractic Treatment • Acupuncture • Detoxification • Lab & Food Sensitivity Testing • Nutritional Counseling • Laser • Personalized Health Coaching • Nutritional/Herbal Therapy • Hormone Testing/Treatment

Dr. Joseph H. Sevlie, D.C., FASA
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PATIENT INFORMATION

Name:____ Date: ______________

Address: ______________________________________ Home Phone: ________________

City: ____________________ State: _______ Zip: __________ Cell Phone: ________________

Birthdate: __________ Age: _____ Sex: M - F Place of Employment: ____________________

Email:____

Number of Children: __________ Circle: Married - Single - Widowed - Divorced - Separated

Emergency Contact: ______________________________ Phone: ________________

Referred by: ___________________________________

HEALTH INSURANCE

Who is responsible for your bill: (Circle one) SELF - SPOUSE - PARENT

Type of Insurance: (Circle one) HEALTH INSURANCE - AUTO - MEDICARE - OTHER

Insurance ID#: ________________________

If your health insurance is being provided by your spouse/parent, please provide the following information:

Insured's Name:_________________________________ Insured's Birthdate: ________________

I authorize payment of medical benefits to Center for Natural HealthCare, PLLC for services. I authorize the release of any medical or other information necessary to process my insurance claims. I also request payment of government benefits either to myself or to the above named party who accepts assignment.

Patient's Signature: ___________________________________ Date: __________

CURRENT HEALTH CONDITION

What do you want us to do for you? ____

____

Other doctors you have seen for this condition: ________________________________

____

Date Condition Started: ___________ (Circle one) Job Related - Auto Related - Other

If disabled from work, give dates: ____

Drugs you take: (Circle) Nerve Pills - Pain Killers/Muscle Relaxers - Insulin - Blood Pressure Medication

Other: ____

PATIENT HEALTH HISTORY

Major Surgery/Operations: (Circle) Appendectomy - Tonsillectomy - Gall Bladder - Hernia - Broken Bones

Other: ____

Other Hospitalizations: ____

Major Accidents/Falls: ____

____

Treatment For Any Health Conditions This Last Year: ____________________________

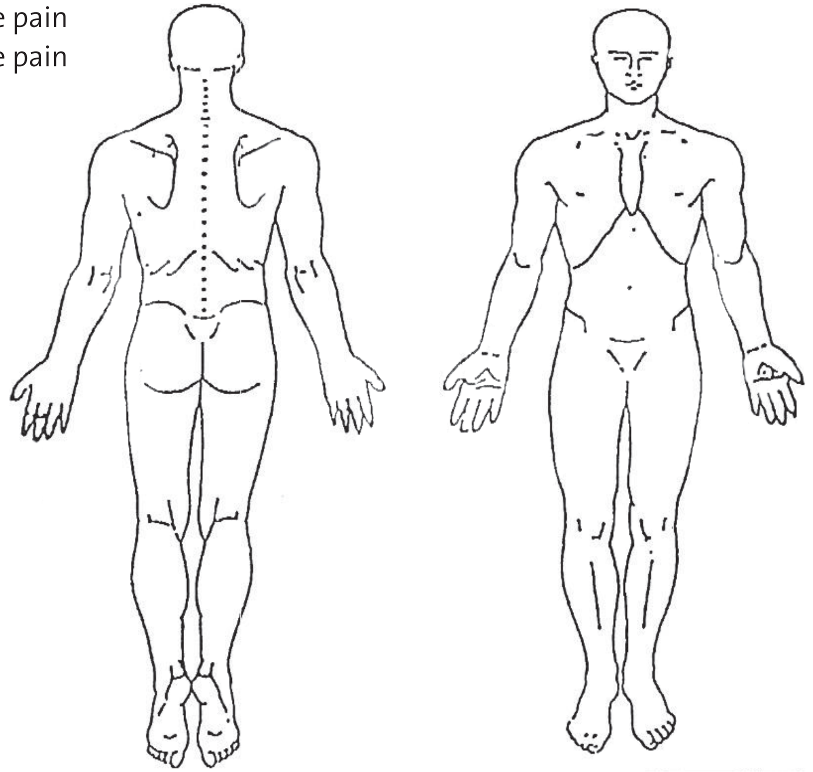
____

Previous Chiropractic Care (Doctor's Name and Date of Last Visit): ______________________

PRESENTING PAIN SYMPTOMS

Please mark the areas of pain you are experiencing today on the diagram below. Use the symbols shown to the left of the diagram. Label the worst area of pain #1 on the diagram, #2 on the next most intense are of pain, etc. Mark the intensity by placing a mark somewhere between the "no pain" and the "intense pain" end of the dotted line areas 1, 2 and 3.

AREA #1: No pain ⮜------------------------------------⮞ Intense pain
AREA #2: No pain ⮜------------------------------------⮞ Intense pain
AREA #3: No pain ⮜------------------------------------⮞ Intense pain



SHARP	x x
BURNING	+ +
DULL PAIN	✓✓
NUMB	○ ○
NEEDLES	• •

Are you pregnant? Yes - No - Maybe

TREATMENT OPTIONS

Why Chiropractic? People go to Chiropractors for a variety of reasons. Some go for symptomatic relief of pain or discomfort ***(Initial Intensive)***. Others are interested in having the cause of the problem, as well as the symptoms, corrected and relieved ***(Rehabilitative)***. Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible with Chiropractic care ***(Comprehensive)***. Your doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of treatment desired so that we may be guided by your wishes whenever possible.

☐ **Initial Intensive** ☐ **Rehabilitative** ☐ **Comprehensive**

☐ **Check here if you want doctor to select the type of care appropriate for your condition.**

MEDICATION/SUPPLEMENTS SUMMARY

Over the Counter and Prescription Drugs, Vitamins, Minerals, Etc.

Date:	Drugs/Supplements Currently Using with Dosage and Purpose of Each

Note: Please bring in a copy of side effects of each drug - if you didn't receive one with your prescription, contact your pharmacist for a copy.

FAMILY HEALTH HISTORY

Please review the below listed diseases and conditions and indicate those that are current/past health problems of a family member.
Mark the space with the letter **"C"** for a **Current Problem**; use the letter **"P"** for a **Past Problem**. Leave spaces blank if they don't apply.

CONDITION	Father: Age___	Mother: Age___	Brother(s): Age___ Age___	Sister(s): Age___Age___	Children: Age___Age___ Age___ Age___
Allergies					
Anemia					
Arthritis					
Asthma-Hay Fever					
Autoimmune Disease					
Back Problems					
Cancer					
Chronic Fatigue					
Constipation					
COPD					
Diabetes					
Disc Problems					
Emotional Problems					
Emphysema					
Epilepsy					
Headaches					
Heart Problems					
High Blood Pressure					
Insomnia					
Kidney Problems					
Liver Problems					
Lung Problems					
Migraine					
Nervousness/Anxiety Attacks					
Scoliosis					
Sinus Problems					
Stomach Problems					
Stroke					
Thyroid Problems/Goiter					
Other:					

PAYMENT OPTIONS

Dear Patient,

We are a cash practice which means payment is due on the day of service. You have three options of payment at our office for services rendered. If you have insurance, your insurance forms will be electronically submitted, and reimbursement will come directly to you.
<u>All laboratory testing is done on a cash basis only, so no insurance is submitted for lab work done.</u>

<u>Payment Options:</u>

- Pre-payment plan: Pre-pay for 8 visits and receive the 9th visit at no charge.
- Cash or check payment
- Credit card payment. We accept Visa, Mastercard, American Express & Discover.

<u>Informed Consent</u>: I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment by cash, check or credit card. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: ______________________________ **Date:** ____________

PERMISSION TO TREAT A MINOR

Parent or Guardian's Signature Authorizing Care: ______________________________ **Date:** ____________