Richell Nordhaus BCFWP, LEHP, ACNC

North River CHIROPRACTIC

NRC PATIENT INTAKE FORM

Please fill out this form as honestly,as possible and bring with you to your scheduled appointment.

NAME

ADDRESS

CITY ZIP

PHONE DOB

How long have you been seeing Dr. Johns?

If you could have assistance with your biggest health concern - what would it be?

Energy & Blood Sugar

- □ **Energy is generally good**
- □ **Tired when I wake up**
- □ **Afternoon energy crash**
- □ **Energy is up and down throughout the day**
- □ **I get shaky, irritable, weak, or "hangry" if I don't eat**
- □ **I crave sugar/carbs**
- □ **I often skip meals**
- □ **I drink coffee/caffeine before eating**
- □ **I struggle with weight gain or difficulty losing weight**

Sleep & Stress

- **Average hours of sleep nightly: _____**
- □ **Trouble falling asleep**
- □ **Wake during the night**
- □ **Wake around 2–4 AM**
- □ **Wake tired/unrefreshed**
- □ **Snore/use CPAP**
- □ **Feel "wired but tired"**
- □ **High stress**
- □ **Anxiety/worry**
- □ **Feel overwhelmed easily**
- □ **Difficulty relaxing or shutting my brain off**

Digestion

- **Bowel movements: □ Daily □ Every other day □ Less often □ Multiple/day**
- **□ Constipation**
- **□ Loose stools/diarrhea**
- **□ Bloating**
- **□ Gas**
- **□ Heartburn/reflux**
- **□ Abdominal discomfort**
- **□ Food sensitivities**
- **□ Nausea**
- **□ Gallbladder removed**
- **□ History of IBS/other digestive concerns**

  _____

Nutrition & Hydration

- **Do you regularly eat breakfast? □ Yes □ No**
- **Do you intentionally include protein with meals? □ Yes □ Sometimes □ Rarely**
- **Approximate daily water intake : _____**
- **□ Use electrolytes/minerals**
- **□ Eat fruits/vegetables daily**
- **□ Frequent sweets/sugary drinks**
- **□ Frequent fast food/processed foods**
- **□ Alcohol regularly**
- **□ Diet is fairly balanced**
- **□ I know my nutrition needs improvement**

Other Symptoms — Check Any That Apply

- **□ Headaches/migraines**
- **□ Joint or muscle pain**
- **□ Chronic inflammation/puffiness**
- **□ Brain fog / Poor concentration**
- **□ Dizziness/lightheadedness**
- **□ Hormonal concerns**
- **□ Irregular/painful cycles**
- **□ Hair thinning/loss**
- **□ Skin issues/rashes**
- **□ Frequent illness**
- **□ Allergies/sinus issues**
- **□ Autoimmune concerns**
- **□ Thyroid concerns**
- **□ Blood sugar/diabetes concerns**
- **□ High blood pressure**
- **□ Other: _____**

Quick Health History

- **Current medications: _____**
  (can list on back if necessary)
- **Current vitamins/supplements: _____**
  (can list on back if necessary)
- **Major diagnoses/health conditions:**
  _____
- **Major surgeries:**
  _____
- **Recent labs? □ Yes □ No**
- **If yes, approximately when? _____**

- **What do you feel is your biggest obstacle to being the best you right now?**
  - **□ Time**
  - **□ Stress**
  - **□ Energy**
  - **□ Nutrition**
  - **□ Sleep**
  - **□ Motivation/consistency**
  - **□ Cost**
  - **□ I simply don't know where to start**
  - **□ Other: _____**

- **On a scale of 1–10, how ready are you to make changes to improve your health?**
  _____

ACKNOWLEDGEMENT & INFORMED CONSENT

I, _____, understand that my wellness recommendations may include nutrition, lifestyle, and supplementation intended to support my overall health and well-being. I understand that meaningful, sustainable changes may take time and that individual results will vary.

I understand that Richell's services are educational and wellness-based and are not intended to diagnose, treat, cure, or prescribe for any disease or medical condition. Dr. Johns provides medical/chiropractic oversight as part of my care at North River Chiropractic in your treatment plan, and relevant wellness information may be shared with Dr. Johns to support coordinated care.

I agree to disclose relevant health conditions, medications, and concerns that could affect recommendations and to ask questions about anything I do not understand. I understand that I should never discontinue or change a prescribed medication without direction from the prescribing medical provider.

I understand that my health outcomes depend on many factors and that no specific results are guaranteed.

Name (print) : _____ Date: _____

Signature (guardian if under 18): _____

Name (guardian if under 18): _____
(please print)