Today's Date: ______________________

Last Name: _________________________ First Name: ______________________ Middle_________

Main Phone # (________) ___________________ **EMAIL*:**___________________________________

We do NOT give, rent, or sell your information to anyone, EVER.* **We send out special announcements and life hacks to help you stay well.

Street Address: ____ (apt #)________

City: _______________________________ State: __________ Zip:______________________

Date of Birth:______________________ Gender (m) (f) *(optional) Weight:______ Height:______*

Marital Status: □S □M □D □W

I am here for the following services

□ Chiropractic

□ Acupuncture

□ Dry Needling

Other add-ons include: Trigger point and Electrical Therapy as needed.

☑ **Today's fee is $98** for treatment <u>and</u> evaluation. OTHER FEES MAY APPLY)

(We accept cash, check, debit, FSA, HSA, credit card, and Venmo)

We <u>do not</u> accept insurance for payment. You may be able to send in statements for reimbursement.*

☐ -This visit/treatment is related to a motor vehicle or work related injury*. ***(There's more paperwork!)***

Complete health information next…

General health info:

Question	Response
1. Do you have trouble getting to sleep?	□ Always □ Often □Sometimes □Never
2. Do you have trouble sleeping through the night?	□ Always □ Often □Sometimes □Never
3. Do you have trouble getting up in the morning?	□ Always □ Often □Sometimes □Never
4. Are you tired in the day?....................................	□ Always □ Often □Sometimes □Never
5. Do you exercise?...	□ Always □ Often □Sometimes □Never
6. Do you stretch?...	□ Always □ Often □Sometimes □Never
7. Do you meditate?..	□ Always □ Often □Sometimes □Never
8. Do you read (not online)…………………………….….	□ Always □ Often □Sometimes □Never
9. Do you spend time working?..............................	□ Always □ Often □Sometimes □Never
10. Do you get outdoors?...	□ Always □ Often □Sometimes □Never
11. Do you have headaches?....................................	□ Always □ Often □Sometimes □Never
12. Do catch colds/flu easily?..................................	□ Always □ Often □Sometimes □Never
13. Do you have palpitations?..................................	□ Always □ Often □Sometimes □Never
14. Do you have respiratory troubles?.....................	□ Always □ Often □Sometimes □Never
15. Do you get winded/out of breath?......................	□ Always □ Often □Sometimes □Never
16. Do you have constipation?.................................	□ Always □ Often □Sometimes □Never
17. Do you strain at going to the toilet?...................	□ Always □ Often □Sometimes □Never
18. Do you have acid reflux?....................................	□ Always □ Often □Sometimes □Never
19. Do you have abdominal cramps?........................	□ Always □ Often □Sometimes □Never
20. Do you get bloated?...	□ Always □ Often □Sometimes □Never
21. Do you have the feeling you have to urinate?.....	□ Always □ Often □Sometimes □Never
22. Do you have pain when you move your bowels?	□ Always □ Often □Sometimes □Never
23. Do you have urinary leaking?..............................	□ Always □ Often □Sometimes □Never
24. Do you have trouble with greasy foods?.............	□ Always □ Often □Sometimes □Never
25. Do you have trouble digesting meats?................	□ Always □ Often □Sometimes □Never
26. Do you feel tired after eating?............................	□ Always □ Often □Sometimes □Never
27. Are you thirsty often?...	□ Always □ Often □Sometimes □Never
28. Do you feel dizzy?..	□ Always □ Often □Sometimes □Never
29. Do you get allergies?..	□ Always □ Often □Sometimes □Never
30. Do you get frustrated easily?.............................	□ Always □ Often □Sometimes □Never
31. Do you cry easily?..	□ Always □ Often □Sometimes □Never
32. Are you afraid?..	□ Always □ Often □Sometimes □Never
33. Are you worried?..	□ Always □ Often □Sometimes □Never
34. Do you feel sad?..	□ Always □ Often □Sometimes □Never
35. Do you feel depressed ?..................................	□ Always □ Often □Sometimes □Never
36. Do you feel hope?...	□ Always □ Often □Sometimes □Never
37. Do you feel anxious?...	□ Always □ Often □Sometimes □Never
38. Does your mind race?..	□ Always □ Often □Sometimes □Never
39. Do you overthink?..	□ Always □ Often □Sometimes □Never
40. Do you have trouble concentrating?.................	□ Always □ Often □Sometimes □Never
41. Do you have trouble focusing?..........................	□ Always □ Often □Sometimes □Never
42. Do you drink alcohol?.......................................	□ Always □ Often □Sometimes □Never
43. Do you smoke or chew nicotine?......................	□ Always □ Often □Sometimes □Never
44. Do you use CBDs?...	□ Always □ Often □Sometimes □Never
45. Do you crave salt?..	□ Always □ Often □Sometimes □Never
46. Do you crave sugar?...	□ Always □ Often □Sometimes □Never
47. Do you crave stimulants (caffeine, nicotine) …..	□ Always □ Often □Sometimes □Never
48. Do you have pain that wakes you at night?.......	□ Always □ Often □Sometimes □Never
49. Do you have numbness?..................................	□ Always □ Often □Sometimes □Never

 NAME: ______________________

Question	Response
50. Do you have tingling in arms or legs?.................	□ Always □ Often □Sometimes □Never
51. Do you get muscle spasms?................................	□ Always □ Often □Sometimes □Never
52. Do you have lower back pain?	□ Always □ Often □Sometimes □Never
53. Do you have tension between your shoulders?	□ Always □ Often □Sometimes □Never
54. Do you have neck pain?	□ Always □ Often □Sometimes □Never
55. Do you have Shoulder pain?	□ Always □ Often □Sometimes □Never
56. Do you have elbow pain?	□ Always □ Often □Sometimes □Never
57. Do you have wrist pain?	□ Always □ Often □Sometimes □Never
58. Do you have hip pain?	□ Always □ Often □Sometimes □Never
59. Do you have knee pain?	□ Always □ Often □Sometimes □Never
60. Do you have ankle pain?	□ Always □ Often □Sometimes □Never
61. Do you have foot or heel pain?	□ Always □ Often □Sometimes □Never
62. Do you have jaw pain?	□ Always □ Often □Sometimes □Never
63. Do you have muscle soreness?	□ Always □ Often □Sometimes □Never
64. Do you get sore when the weather changes?	□ Always □ Often □Sometimes □Never
65. Do you sit at a desk at work?	□ Always □ Often □Sometimes □Never
66. Do you drive more than ½ hour at a time?	□ Always □ Often □Sometimes □Never
67. Do you have high blood pressure?	□ Yes □No
68. Do you have LOW blood pressure?	□ Yes □No
69. Do you take any over the counter medications daily? Aspirin, Tylenol, etc.	□ Yes □No
70. Do you take any prescription medications?	□ Yes □No
71. Do you have cholesterol problems?	□ Yes □No
72. Unexpected weight changes in last 6 months:	□ Yes □No
73. Do you have other digestive issues: Indigestion, Crohn's, Ulcerative Colitis, IBS, etc.	□ Yes □No
74. Do you have a nervous stomach? Including ulcers, GERD, reflux, etc.	□ Yes □No
75. Do you have diabetes?	□ Yes □No
76. Have you been diagnosed with cancer? (Ever?)	□ Yes □No
77. Have you (in the past three years) or are you currently treated with chemotherapy or radiation?	□ Yes □No
78. Do you have a disc injury, □ Cervical (Neck), □ Lumbar (lower back)	□ Yes □No
79. Do you have osteoarthritis, rheumatoid arthritis, SLE, or other joint disease?	□ Yes □No
80. Did you have Covid?	□ Yes □No
81. Did or do you experience symptoms?	□ Yes □No
82. Did you get vaccinated?	□ Yes □No
83. Did you have any reaction?	□ Yes □No
84. Do you have Fibromyalgia?	□ Yes □No

Where do you hurt now? (The most, or area you would like to focus on)

____

When did it begin? ____

What makes it better? ______________________________________

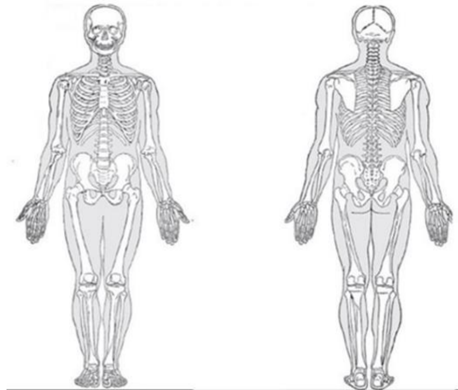
What makes it worse? ______________________________________

How do you describe the pain? ______________________________

Does the pain travel? _______________________________________

On a scale of 1 – 10, ten being the worst pain imaginable, what is your pain NOW?_______
What is your pain at night?_____ What is your pain when you wake up?_____

How often do you have pain? (Circle One) Occasionally, Frequently, Often, Constantly
Feel free to mark where you have pain on the diagram below.



Do you have any?
□ Missing parts (surgeries where something was removed) Please mark where-
□ Extra parts (surgeries with implants) Please mark where-
□ Nuts and bolts or metal plates **please mark where they are.**

A SINGLE VISIT IS NOT INTENDED TO CHANGE YOUR CONDITION DRAMATICALLY. THERE ARE NO MAGIC ADJUSTMENTS OR TECHNIQUES.

Acknowledgement and Acceptance of Treatment (the fine print…)

I understand and I am informed that, as is with all healthcare treatments, results are not guaranteed and there is no promise to cure. In the therapies practiced at Natural BodyWorks there are some risks to treatment, including, but not limited to, muscle soreness or spasms for short periods of time, dizziness, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, and on extremely rare occasions; sprains, fractures, disc injuries, strokes, dislocations, bruising, hematomas, and the possibility of a small amount of bleeding (acupuncture or dry needling only).

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I will rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, and is in my best interests. I understand and have been informed that I have the right to and are encouraged to get a second opinion if I have concerns as to the nature of my symptoms and treatment options. I understand that some procedures used may be considered 'unproven'. Please contact us immediately with any increase or change in your condition after treatments.

I understand that my information is strictly private and protected here under the Health Insurance Portability and Accountability Act or HIPAA. It may only be released by this signature or under subpoena. *Details are available upon request. I also verify ALL information as true and complete as remembered or understand as complete. Any information* *<u>not provided</u>* *cannot be used to render an effective treatment plan and may delay recovery, referral, and relief or may render any treatment ineffective. By signing below you are also allowing us to use your contact information for advertising, emails, tweets, texts and other forms of contact. No information is ever provided to any other party without a verified legal subpoena or YOUR authorization.*

1. Services provided in this office are payable the day services are rendered. Patients are personally responsible for all charges. There are no refunds**.**

2. There will be a $25.00 charge for returned checks due to nonsufficient funds (NSF). After two NSFs, checks can no longer be accepted as a method of payment.

3. Any balance remaining after 60 days with no action on the account will be charged an 18% per annual service charge.

4. *I hereby assign directly to Dr. Sean H. Thompson and or Natural BodyWorks LLC (Parker) all insurance benefits, if any, otherwise payable to me for services. I understand that I am financially responsible for ALL charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions and understand that health information may need to be disclosed to the above insurance company and their respective agents for the purpose of payment for related services. This consent will end when my treatment is completed or 5 years from the date signed.*

5. We charge for copies of records $18.53 for up to 10 pages, 85 cents for each additional page.
6. We charge for ANY reports, opinions, or other statements other than billing receipts. $325.00 minimum.
7. We do not work on contingency, you may prepay and a receipt will be printed for you to get reimbursement.
8. *Med-pay on Auto insurance **is** accepted. <u>You are responsible for any</u> unpaid balance by your insurance or legal case, we do not work on Lien, unless prior agreement is made.

Signed: ____ Date_________________________

We are not able to evaluate or treat you until this entire documentation is complete and signed.

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