pressing matters
Mechano Therapy & Naturopathic Health
150 E Aikens Rd Ste B. Eagle, Idaho 83616 (208) 995-2891

Date:_____

Name:_____ Age:_____ Sex:_____

Date of Birth:_____ Marital Status:_____ SSN:_____

Address:_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ email:_____

Preferred method of contact:_____

Employer:_____ Occupation:_____

Employer's Address:_____City:_____State:_____Zip:_____

How did you hear of us?_____

Is this visit due to a motor vehicle or workplace accident? Yes No (If yes, please provide copy of insurance card)

Name of Insurance Company:_____

Name of Card Holder:_____Policy group number:_____

Policy ID number:_____Employer of cardholder:_____

Card Holder's date of birth:_____
Patient's relationship to cardholder: Self Spouse Child

Please provide us with a copy of a current state photo ID

I attest that the information provided above is true and correct to the best of my knowledge and that I am responsible for payment of all charges and that payment is required at the time of service, unless previous arrangements have already been established. I authorize the release of any medical or other information to process claims on my behalf. I understand that my insurance policy is an agreement between me and my insurance company and reimbursement from my insurance company is their legal obligation to me.

Patient's Signature:_____Date:_____

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At present, what is your chief complaint?_____

_____

_____

Why did you choose come to our office?_____

_____

_____

What do you know of our approach?_____

_____

_____

What **three** expectations do you have from **this visit** to our office?_____

_____

_____

What **Long Term** expectations do you have from working with our office?_____

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?_____

_____

_____

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits?_____

_____

_____

List present/previous diagnosis, treatments, and/or drugs you are taking and what they are for in regards to your present condition:_____

_____

_____

How long have you had these conditions?

Is this condition getting worse?

Have you been on a nutritional program before? Yes____ No____

If so, list nutritional supplements taken and how much:_____

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?_____

_____

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will making?_____

What do you **LOVE** to do?_____

Underline which form of nutritional supplements you prefer: Tablets Capsules Liquid

Underline if you wear: Contacts Glasses Hearing Aid

Surgeries:_____

_____

_____

Allergies:_____

_____

If female, are you pregnant or nursing?

How do you feel presently?

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CONFIDENTIAL HEALTH QUESTIONAIRE

Name:_____ Date:_____

Date of Birth:_____ Age:_____ Sex: M F

Instructions: Circle the number which best describes the intensity of your symptoms. If a question does not apply to you, leave it blank.
1=Mild 2=Moderate 3=Severe

1.	Chills	1 2 3		37.	Rectal Bleeding	1 2 3
2.	Depression	1 2 3		38.	Stomach pain	1 2 3
3.	Dizziness	1 2 3		39.	Vomiting	1 2 3
4.	Fainting	1 2 3		40.	Vomiting Blood	1 2 3
5.	Fever	1 2 3		41.	Chest Pain	1 2 3
6.	Forgetfulness	1 2 3		42.	High Blood Pressure	1 2 3
7.	Headache	1 2 3		43.	Irregular Heart Beat	1 2 3
8.	Loss of Sleep	1 2 3		44.	Low Blood Pressure	1 2 3
9.	Loss of Weight	1 2 3		45.	Poor Circulation	1 2 3
10.	Nervousness	1 2 3		46.	Rapid Heart Beat	1 2 3
11.	Numbness	1 2 3		47.	Swelling of ankles	1 2 3
12.	Sweats	1 2 3		48.	Varicose Veins	1 2 3
13.	Arms: Pain Weakness Numbness	1 2 3		49.	Bleeding Gums	1 2 3
14.	Back: Pain Weakness Numbness	1 2 3		50.	Blurred vision	1 2 3
15.	Feet: Pain Weakness Numbness	1 2 3		51.	Crossed Eyes	1 2 3
16.	Hands: Pain Weakness Numbness	1 2 3		52.	Double Vision	1 2 3
17.	Hips: Pain Weakness Numbness	1 2 3		53.	Difficulty Swallowing	1 2 3
18.	Legs: Pain Weakness Numbness	1 2 3		54.	Earaches	1 2 3
19.	Neck: Pain Weakness Numbness	1 2 3		55.	Ear Discharge	1 2 3
20.	Shoulders: Pain Weakness Numbness	1 2 3		56.	Hay fever	1 2 3
21.	Allergies: Food or Airborne	1 2 3		57.	Hoarseness	1 2 3
22.	Blood in urine	1 2 3		58.	Loss of Hearing	1 2 3
23.	Frequent urination	1 2 3		59.	Nosebleeds	1 2 3
24.	Lack of bladder control	1 2 3		60.	Persistent cough	1 2 3
25.	Painful urination	1 2 3		61.	Ringing in ears	1 2 3
26.	Appetite poor	1 2 3		62.	Sinus problems	1 2 3
27.	Bloating	1 2 3		63.	Visions—flashes	1 2 3
28.	Bowel changes	1 2 3		64.	Vision—Halos	1 2 3
29.	Constipation	1 2 3		65.	Bruise easily	1 2 3
30.	Diarrhea	1 2 3		66.	Hives	1 2 3
31.	Excessive Hunger	1 2 3		67.	Itching	1 2 3
32.	Excessive Thirst	1 2 3		68.	Change in Moles	1 2 3
33.	Gas	1 2 3		69.	Rash	1 2 3
34.	Hemorrhoids	1 2 3		70.	Scars	1 2 3
35.	Indigestion	1 2 3		71.	Sores that won't heal	1 2 3
36.	Nausea	1 2 3				

MEN ONLY					79. Breast lump	1	2	3
72. Breast lump	1	2	3		80. Extreme menstrual pain	1	2	3
73. Erection difficulties	1	2	3		81. Hot flashes	1	2	3
74. Lump in testicles	1	2	3		82. Nipple discharge	1	2	3
75. Penis discharge	1	2	3		83. Painful intercourse	1	2	3
76. Sore(s) on penis	1	2	3		84. Vaginal discharge	1	2	3
WOMEN ONLY					85. Shortness of breath	1	2	3
77. Abnormal pap smear	1	2	3		86. Fibroids or Cysts	1	2	3
78. Bleeding between periods	1	2	3					

Instructions: Mark only those that apply to you and/or your health condition

C=Current P=Past

1. Acid Reflux	32. HIV positive
2. Alcoholism	33. Irritable Bowel Syndrome
3. Anemia	34. Kidney Disease
4. Anorexia	35. Liver Disease
5. Appendicitis	36. Measles
6. Arthritis	37. Migraine Headaches
7. Asthma	38. Miscarriage
8. Auto Immune Disorder	39. Mononucleosis
9. Bleeding Disorder	40. Multiple Sclerosis
10. Breast Lump	41. Mumps
11. Bronchitis	42. Pacemaker
12. Bulimia	43. Pneumonia
13. Cancer	44. Polio
14. Cataracts	45. Prostrate Problem
15. Chemical Dependency	46. Psychiatric Care
16. Chicken Pox	47. Rheumatic Fever
17. Crohn's Disease	48. Scarlet Fever
18. Coffee (2 or more cups per day)	49. Shingles
19. Dental Work (fillings, root canals, etc.)	50. Smoker
20. Diabetes	51. Soft Drinks (1 or more per day)
21. Diverticulitis	52. Diet Soft Drinks (1 or more per day)
22. Emphysema	53. Stroke
23. Epilepsy	54. Suicidal Thoughts
24. Glaucoma	55. Thyroid Problems
25. Goiter	56. Tonsillitis
26. Gout	57. Tuberculosis
27. Heart Disease	58. Typhoid Fever
28. Hepatitis	59. Ulcers
29. Hernia	60. Vaginal Infections
30. Herpes	61. Venereal Disease
31. High Cholesterol	

I have answered the above questions to the best of my knowledge.

Signed:_____

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DECLARATION ON INFORMED CONSENT TO SERVICES

I understand and acknowledge that (i) Dr. Colby Inzer, (ii) Dr. Corrine Inzer, and (iii) all independent contractors of Pressing Matters Massage Therapy & Naturopathic Health (collectively defined as "Pressing Matters") offer no guarantee that the treatments will cure me of any disease or affliction (including cancer). I believe it is within my constitutional rights to seek any form of diagnosis and treatment, whether orthodox or unorthodox (i.e., not recommended by the AMA). It is my choice whether or not to accept such diagnosis and treatment. By my signature, I attest that I have not engaged the service of Pressing Matters for the purposes of filing a malpractice suit or furthering any investigation or prosecution by any government entity or medical association. My sole purpose and intent in seeking the services of Pressing Matters is to get help for my personal health matters.

I understand that Pressing Matters' treatment program includes Naturopathic Medicine, Reflexology, Massage, Acupressure, Applied Kinesiology, Spinal Touch, Nutritional Guidance and Counseling. I also understand that the treatment may be unconventional or experimental. In such case, I agree to hold Pressing Matters harmless if the results of the treatments are not what I hoped for.. I acknowledge that my acceptance of their services binds me to pay the fee and that such fee reflects their knowledge, education and years of experience.

Payments for services are due at the time service is rendered, unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, Discover, or American Express.

I understand that I have the right to choose the doctor of my choice to provide services. I also have the right to discontinue the care and treatments of that doctor at any time, but agree that I will promptly pay to date any outstanding balance due for the services. I also acknowledge that I have not been advised against seeking any other medical examinations or treatments.

I understand that Pressing Matters does the (HLB) DBA/LBA blood research comparison appraisals. This is used to help gather data for future reference and assessment using this type of test. The DBA detects morphological changes which show pathological conditions. However, many of these morphological changes appear similar, particularly in early stages. Therefore, a definitive diagnosis is not possible with the DBA/LBA blood appraisal alone.

If you wish to participate in the blood appraisal comparison program, it will be necessary for you to fill out completely the Confidential Health Questionnaire. An assessment will not be done without the Confidential Health Questionnaire and/or a comparison modality (such as conventional medical reports or lab work). There is an $90.00 fee to analyze the questionnaire and/or conventional medical reports and write a suggested nutritional program for you. We may also give you a prescription to have other conventional tests done if desired or needed to assist with the comparison and assessing of your health condition.

I have read (or have read to me) the Declaration of Informed Consent to Services and agree to be bound by the terms therein. I have not signed this declaration without first reading it or having it read to me and I may ask any questions useful in helping me understand it. I further understand my agreement to the provision of this declaration is an entirely voluntary and informed choice to which my signature attests.

_____ _____

PATIENT SIGNATURE WITNESS SIGNTURE

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Cancellation Policy

Appointments must be cancelled 24 hours in advance. If an appointment is cancelled less than 24 hours in advance, and we are unable to fill your appointment time, or the appointment time is forgotten (patient does not come in or call), there will be no charge the first time. After that, the normal fee will be charged.

_____ _____

Signed Date