New Patient Form

212 N 3rd Street, Marshall, IL 62441
217-686-0302

Date

PERSONAL INFORMATION

Name

Address

City/State/Zip

Home Phone Work Phone Cell Phone

Email

Preferred form of contact

home work cell email

Date of Birth

Marital Status Sex Age

Occupation Referred By

Emergency Contact Name/Phone

CURRENT HEALTH CONDITION

Purpose of this appointment

Today's condition started when?

Please list all medical diagnosis/conditions you are currently being treated for

Other doctors seen for this condition

Type of treatment

Results

Please list medications

Please list vitamins, herbs, and supplements

YOUR LIFESTYLE

- Alcohol
- Tobacco
- Marijuana
- Drugs
- Stress
- Occupational hazards
- Regular exercise
- Type ______ Frequency ______
- Type ______ Frequency ______

FEMALES, PLEASE COMPLETE

- Pregnant
- Planning pregnancy
- Menstrual flow regular/irregular/pain
- Days of flow
- Length of cycle
- First day of your last period
- Pain/Bleeding during or after sex

Number of:

Pregnancies ______

Abortions ______

Miscarriages ______

Live births ______

Bird control method ______

Birth control pill name ______

- Flushing/Menopause

Date of last PAP test ______

- Normal
- Abnormal

Date of last mammogram

- Normal
- Abnormal

HOSPITALIZATIONS

Date ______

Reason ______

Date ______

Reason ______

Date ______

Reason ______

Date ______

Reason ______

- Ringing in ear
- Frequent ear infections
- Dizziness/Fainting
- Failing vision
- Eye infections
- Nose bleeds
- Sinus trouble
- Frequent sore throats
- Hayfever/ Allergies
- Pneumonia
- Bronchitis/Chronic cough
- Asthma/Wheezing
- Chest pain
- High blood pressure
- Heart murmur
- Swollen ankles
- Leg pain (walking)
- Varicose veins/phlebitis
- Loss of appetite
- Difficulty swallowing
- Indigestion/Heartburn
- Persistent nausea/vomiting
- Peptic ulcers
- Chronic abdominal pain
- Gall bladder trouble
- Jaundice/Hepatitis
- Change in bowel habits
- Diarrhea
- Constipation
- Diverticulosis
- Crohn's/Colitis
- Bloody/Tarry stools
- Hemorrhoids
- Hernia
- Frequent urine infections
- Blood in urine
- Urinate overnight more than twice
- Painful urination
- Loss of control of urination
- Decrease in force/flow of urination
- Kidney stones
- Venereal disease
- Chronic fatigue

MEDICAL HISTORY

- Recent weight loss
- Anemia
- Bruise easily
- Cancer
- Diabetes
- Thyroid disease
- Convulsions/Seizures
- Stroke
- Tremor/Hands shaking
- Muscle weakness
- Numbness/Tingling sensations
- Frequent headaches
- Arthritis/Rheumatism
- Osteoporosis
- Recurrent back pain
- Bone fracture/join injury
- Gout
- Foot Pain
- Cold numb feet
- Rashes/Hives
- Psoriasis
- Eczema
- Nervousness
- Depression
- Memory loss
- Excessive moodiness
- Mental illness
- Phobias
- Lactose intolerance
- Prostate disease
- Sexual/Menstrual dysfunction
- Frequent infections
- Diphtheria
- Tetanus
- Chicken pox
- Polo
- Mumps
- Measles
- Rubella
- Rheumatic fever
- Scarlet fever
- Tuberculosis
- Herpes
- Other ______

FAMILY HISTORY (Have any blood relatives had the following illnesses? If so, please indicate the relationship.)

Illness	Family Members
Diabetes	
Cancer	
Blood disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High blood pressure	
Heart disease	
Back Problems	

For FIRST VISIT- Rate severity of symptoms below you have experienced in last 6 MONTHS from 0-10 (10 worst) or circle where

Neuro-hormonal/ Endocrine Pillar #1

Adrenals

- Energy ____ Low/ Variable/ Normal/ High
- Difficulty falling asleep
- Difficulty staying asleep
- Slow to Start in Morning
- Energy Crash ____ am/pm
- Dizzy when stand quickly
- Light Bothers Eyes
- Weak Nails
- Perspire easily or excessively
- Other ____

Pituitary

Sex Drive ☐ Flat ☐ Low ☐ Normal ☐ High

- Menstrual Disorders
- Splitting Headaches
- Other ____

Thyroid

- Tired/ Sluggish throughout day
- Chills, Feel Cold hands, feet, body
- Require Excessive Sleep
- Increase in weight unexplained
- Difficult infrequent bowel movements
- Depression Lack of Motivation
- Hair Loss and Thinning
- Thinning of Outer Third of Eyebrow
- Dryness of Scalp
- Heart Palpitations-Skip/Flutter
- Inward trembling
- Increase pulse at rest
- Insomnia-cannot sleep
- Night Sweats
- Other ____

Uterus (women only)

Last Menstrual Period ____

Length of Menses ____

- Regular cycle
- Irregular cycle
- Early (less than 28 days)
- Late (more than 28 days)
- Skip cycle
- Flow ____ (heavy/ moderate/ light)
- Cramps ____ (mild/ mod/ severe)
- Clotting/ Spotting
- Headache side of head
- Other ____

Ovaries (women only)

Sex Drive ☐ Flat ☐ Low ☐ Normal ☐ High

- Low Abdominal Puffiness

Fluid Retention ☐ Face ☐ Hands ☐ Feet

Mood swings ☐ irritable ☐ depression

- Tired during cycle
- Ovarian pain
- Breast Tender around cycle
- Acne around cycle (pre/mid/post)

Birth Control ☐ Pill ☐ Patch

Menopausal ☐ Natural ☐ Surgical

- Hot Flashes
- Facial Hair growth
- Dark Nipple Hair
- Hair growing up towards belly button
- Skin Crawling
- Breast discharge
- Breasts shrinking
- Breast Feeding
- Breast Surgery
- Other ____

Vagina (women only)

- Burn
- Itch
- Dry

Discharge ☐ clear ☐ white ☐ yellow ☐ green ☐ brown

- Pain with Intercourse
- Other ____

Testes (men only)

Sex Drive ☐ Flat ☐ Low ☐ Normal ☐ High

- Decreased morning erections
- Decreased fullness erections
- Inability to concentrate
- Episodes of depression
- Decreased physical stamina
- Sweating Attacks
- More emotional than past
- Unexplained weight gain
- Other ____

Sleep

Quality ☐ poor ☐ fair ☐ good ☐ great

- Hours in bed
- Hours asleep
- Interrupted ____ per night
- Awaken Suddenly (Jolt)
- Other ____

Emotions

- Stress
- Sad
- Grief
- Depression
- Moodiness
- Frustrated
- Irritable
- Angry
- Worrisome
- Nervous
- Anxiety
- Panic
- Cry
- Fear
- Shame
- Guilt
- Other ____

Brain

- Forget Names
- Forget Numbers
- Forget Words
- Forget Actions
- Difficulty Focus/ Concentrating
- Other ____

Exercise

Cardiovascular ____ times/ week

Weight Train ____ times/per week

Other ____

Glycemic Management Pillar #2

Pancreas

- Crave Sweets
- Irritable when skip meals
- Light headed skip meals
- Eating relieves fatigue
- Bouts of blurred vision
- Fatigue after meals
- Frequent Urination
- Increased Thirst
- Difficulty losing weight

Other ____

Appetite / Diet

Appetite ☐ Low ☐ Norm ☐ High

- Eat Animal Protein ____ /per day

Eat Starch ☐ pasta ☐ bread ☐ potatoes ☐ rice

- Eat Sweets ☐ cakes ☐ cookies ☐ candy
- Eat Chocolate ____ /per week
- Eat Spicy Foods ____ /per week
- Eat Ice Cream ____ /per week
- Coffee ____ cups/ week
- Caffeinated Tea ____ cups/week
- Juice ____ per week
- Soda ____ per week
- Beer ____ per week
- Wine ____ per week
- Liquor ____ per week
- Artificial Sweeteners
- Trans Fats
- Food Allergens
- Special Diet? ____

Bioterrain/ Mineral Pillar #3

- Twitching around eyes
- Difficulty falling asleep
- Restlessness
- Don't Remember Dreams
- Nails spots or weakness
- Air Hunger/ frequent sighs
- Cramps ☐ legs ☐ feet ☐ arms ☐ hands
- Aches s ☐ legs ☐ feet ☐ arms ☐ hands
- Restless ☐ legs ☐ feet ☐ arms ☐ hands
- Frequent Thirst
- Shallow rapid breathing
- Poor muscle endurance
- Swelling in ankles and wrists
- Uterine cramps women
- Urination leakage
- Other ____

Inflammatory / Immune Pillar #4

Eyes

- Burn ☐ Red ☐ Dry
- Tears
- Eye Film/ Crust in morning
- Floaters
- Stye
- Itchy eyes
- Eye ache
- Vision blurry
- Tired
- Spots
- Puffy
- Dark Circles
- Other ____

Ears

Ear Noise ☐ Ring ☐ Hiss ☐ Pound

- Ear Plugged
- Ear Popping
- Ear Ache / Infections
- Ears Itch internally
- Ear Drainage
- Hearing Loss
- Excessive Ear Wax
- Dizziness/ Vertigo
- Other ____

Sinus

- Frontal headache
- Sinus dry
- Sinus drain
- Sinus stuffy or pressure
- Sneeze frequent
- Smell / Taste loss
- Post nasal drip

mucous ☐ clear ☐ white ☐ yellow ☐ green ☐ brown

Other ____

Lungs

- Chest congestion
- Pain on breastbone
- Shortness of breath upon exertion
- Frequent sighs
- Wheezing
- Asthma
- Emphysema
- Bronchitis
- Other

Mouth/ Throat/ Immune

- Blisters
- Canker Sore
- Bad Breath
- Dry Mouth
- Bleeding gums
- Receding gums
- Teeth Health Problems
- Swelling of Glands
- Cough dry productive
- Sore Throat
- Hoarseness
- Fever
- Frequent Colds/ Flu
- Environmental Allergies
- Nail fungus mild mod severe
- Nightmares
- Other

Bladder

Urinate times per day-awake

Awake from sleep to urinate times

- Urination urgency
- Burning /Pain urination
- Cloudy urine
- Odor urine
- Spasm urinate
- Urinary Tract Infection
- Kidney Pain or Infections
- Other

Skin

- Skin Rash
- Acne
- Itchy Skin
- Cellulite
- Other

Breasts (women only)

- Breast fibrosis
- Breast Lumps
- Other

Prostate (Men only)

- Urination difficulty
- Frequent urination
- Urination Burn Achiness Pain
- Urination Dribbling Emission Swelling
- Pain inside of legs or heels
- Headache side of head
- Other

Cardiovascular Pillar #5

- Chest Tension/ Tight/ Pressure
- Chest Heaviness
- Chest Heart Pain
- Heart Palpitations-Skip/Flutter
- Heart Racing
- Heart Slowing down
- Constant Shortness of Breath
- Sleep Apnea
- Mitral Valve Prolapse
- Murmur
- Bruise easily
- Other

Digestion Pillar #6

Stomach

- Heartburn
- Indigestion
- Stomach Aches
- Stomach Cramps
- Nausea/ Queasy
- Bloat after Eat
- Gas/ Flatulence
- Belching
- Ulcer
- Hiatal Hernia
- Other

Liver/ Gallbladder

- Headaches at base of skull
- Greasy high fat foods cause distress
- Difficulty losing weight
- Dry or Itchy Skin
- Patches skin look different
- Yellow cast to eyes
- Stool color clay colored
- History of gallbladder attacks
- Excessively foul smelling sweat
- Hormonal imbalances
- Difficulty Swallowing
- Wake up between 11pm - 3am
- Other

Hemorrhoids

- Swollen/ Distended / Bloody Anus
- Burning Anus
- Itchy/ Stingy Anus
- Achy Anus
- Other

List Your Primary Concerns in order of importance to you:

1)
2)
3)
4)
5)

Bowels

- Bowel Movements Per day
- Regular
- Incomplete
- Skip days per (week/month)
- Sluggish bowels every days
- Cramps in Abdomen
- Taking Laxatives
- Using Suppositories
- Enemas
- Colonics
- Pain with Bowel Movements
- Irritable Bowel Syndrome
- Chrons
- Colitis
- Other

Fecal Consistency

- Color feces (light or dark)
- Normal
- Soft
- Hard
- Pebbles
- Dry
- Ribbon-like
- Bulky
- Mucous
- Diarrhea
- Constipation
- Other

Cellular Vitality Pillar #7

- Fatigue constant
- Dehydrated
- Slow to Heal
- Low Stamina
- Sluggish Memory
- Inability to achieve lean body
- Other

PAIN/ STIFFNESS/ SWELLING/ACHE/ NUMBNESS/ TINGLING (circle all that apply)

- Head
- Facial
- Neck
- Trapezius
- Upper Back
- Shoulders
- Arms
- Elbows
- Wrist
- Hand
- Mid Back
- Low Back
- Sacral Iliac
- Hips
- Buttocks
- Legs
- Knees
- Ankles
- Feet
- Other

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form.

CONSENT TO PAYMENT

I understand that all services are rendered on a cash, check, or credit/debit card basis. I agree to pay for each appointment at the time of the appointment. I understand that I am responsible for any debts incurred at this office.

PATIENT NAME

PATIENT SIGNATURE ____________________ DATE

CONSENT TO EXAMINATION AND TREATMENT

Carie Jansen utilizes Neurolinking testing as part of his evaluation process. NIS does not diagnose pathological medical conditions or disease processes. NIS does evaluate for and diagnose functional health conditions.

Carie combines the information he obtains from any medical testing that might be indicated with NIS testing, a medical history and systems survey to arrive at a clinical diagnosis and treatment plan.

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and treatment of my condition. I have read and agree with the above statements.

PATIENT NAME

PATIENT SIGNATURE ____________________ DATE

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities.

Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. This provision does not apply to the transfer of medical records for treatment. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

We maintain a history of protected health information disclosures that is accessible to you. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

In the future we may contact you by mail, email, or telephone for appointment reminders or announcements. Our practice is required to abide by this notice. We have the right to change this notice in the future.

PATIENT NAME

PATIENT SIGNATURE ____________________ DATE