

Please print clearly:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt.# \_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_ ZIP \_\_\_\_\_\_\_\_\_\_\_\_

Main Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_\_ Alternative Phone (\_\_\_\_) \_\_\_\_-\_\_\_\_\_\_\_\_\_

E-mail address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spouse’s Name/ Parent if under 18: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REFERRED BY:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age \_\_\_\_ Sex: M/F Height \_\_\_\_\_ Weight \_\_\_\_\_

Overall health (circle one): Excellent / Good / Fair / Poor / Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chief complaint (reason you are here): (use separate sheet if more room needed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous treatments for this complaint:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications/drugs or Nutritional supplements being taken: (use separate sheet if needed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently under the care of a physician or other healthcare professionals?

(If yes, please give name and date of last visit):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Page 1 of 4

 **NEW PATIENT INFORMATION FORM CONT’D**

HISTORY:

List any major illnesses or surgeries (with approx. dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ List all known allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEALTH CONCERNS: (circle those that apply)

Headaches: Basal/ Temple/Cluster/Crown/Frontal/Migraine/TMJ

Ears: Noise (ring/pound) plugged, pop, ache, itchy, loss, wax

Eyes: burn, tear, ache, red, dry, film, itch, blurry, floaters, twitch, circles, puffy

Sinus: dry, drain, plugged, sneezing, smell loss, taste loss, thirst

Sore throat, hoarseness, coughs (dry/productive), allergies, halitosis, cankers, blisters

Neck stiffness, shoulder tension, dry mouth, sweaty hands or feet

Chest: tension, tight, pressure, heavy, anxiety, congestion, pain

Heart: pain, palpitations, MVP, tachycardia, bradycardia, murmur, arm pain

Shortness of breath: constant, exertion, asthma, wheezes, yawning

Heartburn, indigestion, bloat, gas, belch

Bowels: regular, incomplete, sluggish (every\_\_\_ days) cramps, laxative

Fecal consistency: soft, ribbons, mucous, normal, hard, pebbles, dry, diarrhea, constipation

Hemorrhoids: history, current (swollen, blood, itch)

Prostate: history, current (burn, ache, pain, dribble, restricted)

Vagina: (burn, itch, dry, pain, blood) Discharge (clear, white, yellow, brown, odor)

Menses: regular/ irregular (early, late)

 Flow (heavy, moderate, light, long) Cramps (mild, moderate, severe)

 Breast tenderness

 PMS: (mood swings, irritable, depression)

 Ovulation: pains, cysts, discharge, regular, irregular, fibroids

Menopause: natural, surgical (partial/complete) hormones/ patch/ hot flashes

Urination: nocturnal\_\_\_\_\_/night. Frequency, urgency, burn, pain, odor, spasm, leak, UTI

Sleep: difficulty falling asleep/ insomnia/ interrupted \_\_\_/night. Dreams, nightmares, sweats

Emotions: sad, grief, depression, moodiness, irritable, worrisome, angry, frustrated, anxiety,

 cry, fear, shame

Appetite: low/high, coffee, tea, beer, wine, sodas

Energy: low, variable, high, slow to start (improving/ getting worse)

Exercise: how often \_\_\_week. Length of time \_\_\_ minutes. Type \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Memory: (names, numbers, words). Coordination/ concentration

Sexuality (flat/ low/ normal/ impotent)

Page 2 of 4

**DISCLAIMER/INFORMED CONSENT**

***Please read this entire document prior to signing it.*** *It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.*

**MODALITIES OF TREATMENT:**

* **Nutritional Assessment:** I understand that MFT (Morphogenic Field Technique) testing performed whether in person, via surrogate, or remotely, is a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

**MFT** is not a method for the "diagnosing" or "treating"of any disease including conditions ofcancer**,** AIDS, infections, or other medical conditions and that these are not being tested for or treated. No promise or guarantee has been made regarding the results of MFT or any natural health, nutritional or dietary programs recommended, but rather I understand that MFT is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances so that safe, natural programs can be developed for purpose of bringing about a more optimum state of health.

* **Emotional Assessment:** Energy Healing promotes harmony and balance within, relieving stress and supporting the body's natural ability to heal. Energy Healing is widely recognized as a valuable and effective complement to conventional medical care. It is my understanding that releasing trapped emotions using the Body Code, Emotion Code, or any other type of Energy Healing practiced by Dr. Elmore whether in person or remotely, is not a substitute for medical care. This information is not intended as medical advice and should not be used for medical diagnosis or treatment. Information given to you by Dr. Elmore is not intended to be a replacement for consultation with a healthcare professional. If you have questions or concerns about your health, please contact your healthcare provider. Healing sessions are strictly confidential. Your personal information will never be shared with anyone. Dr Elmore makes no claims as to healing or recovery from any illness. This information is offered as a service and is not meant to replace medical treatment. No guarantee is made towards validity. Use this information at your own risk. Following evaluation, if deemed necessary, a higher level of care may be recommended.
* **Chiropractic/Structural Assessment:** If determined necessary as part of your treatment, chiropractic or soft tissue manipulation may be used. Dr. Elmore may use his hands or mechanical instrumentS on your body in a way as to move your joints that may cause an audible “pop” or “click.” As with any healthcare procedure, there are inherent risks or complications that may arise. This may include:
* Stiffness/Soreness
* Pain
* Inflammation

Dr. Elmore will make every reasonable effort during examination to screen for contraindications to care; it is your responsibility to inform me as the doctor of any major health conditions.

The availability of other treatment options may include:

* Medical care, including prescription drugs
* Psychological care
* Self-administered, over-the-counter analgesics and rest

\_\_\_\_\_\_\_\_ *Patient Initials or Guardian if Under 18 years of age \_\_\_\_\_\_\_\_ Today’s Date*

Page 3 of 4

**Scheduling and Office Policies**

 **We do not accept insurance as payment for services**. We do not provide any billing coding for insurance in receipt of service. All appointments must be paid in full at the time of service*. Note:* You must notify the office of any *Cancellations* or *Scheduling Changes* within 24 hours of the scheduled appointment in order to avoid a $35.00 cancellation fee. **Appointments cannot be switched between other patients or family members without a 24 hour notification and confirmation from our staff.**

 Our office has a high volume of New Patients, and to allow each patient adequate care*,* ***WE RESERVE THE RIGHT*** to reschedule any patient that is more than ***ten minutes*** late from their scheduled appointment time. We understand that this is different from many other offices. However, we are unique in the care that we offer and the need for Dr. Elmore’s expertise. Please make any considerations for traffic, travel time or any other circumstances that may occur.

 Due to other Therapists who contract in our office and for you as the patient to receive the best care during your appointment, we ask that all children be left at home or in care unless they have a scheduled appointment. If children without an appointment are brought along, you will be asked to reschedule.

 Patients who have not been seen in over a year, **will** be archived and you will be asked to fill out new patient paperwork when you schedule back in. Dr. Elmore **WILL REQUIRE** more time with you so that he can re-evaluate your health concerns. As a result this process, *you will be charged the Archived Patient Fee along with a scheduling deposit.*

**WE RESERVE THE RIGHT** to terminate patient care if deemed necessary, and in the highest good for both the patient and the practice.

\_\_\_\_\_\_\_\_ *Patient Initials or Guardian if Under 18 years of age* \_\_\_\_\_\_\_\_ *Today’s Date*

 **NOTICE OF PRIVACY PRACTICES**

 I understand that the information obtained concerning me or my minor child will be kept private. I understand that written notice is required by Sugarhouse Health and Wellness in order for any information to be released to any third party other than release for work/school.

\_\_\_\_\_\_\_\_ *Patient Initials or Guardian if Under 18 years of age* \_\_\_\_\_\_\_\_ *Today’s Date*

Page 4 of 4