NEW PATIENT FORM

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):

_____

_____

Previous treatments for this complaint:

_____

Diagnostic test you have received for this condition: X-Ray / MRI / CT Scan / EMG / EEG / Blood Tests (type) _____ / Other _____

Current medications / Drugs or Nutritional supplements being taken:

_____

Are you currently under the care of a physician or other healthcare professionals? Yes / No
(If yes, please give name and date of last visit):

_____

NEW PATIENT INFORMATION FORM CONTINUED

HISTORY:
List any major illnesses or surgeries (with approx. dates): _____
_____
List all known allergies: _____
_____

HEALTH CONCERNS: (circle those that apply)
Headaches: Where: Basal / Temple / Crown / Frontal
Type: Cluster / Migraine / Tension / TMJ
Ears: Noise (ring/pound) / Plugged / Pop / Ache / Itchy / Loss / Wax
Eyes: Burn / Teary / 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
Gastro-intestinal: Heartburn / Indigestion / Bloating / Gas / Belching
Bowels: Regular / Incomplete / Sluggish (every___ days) / Cramps / Laxative
Fecal Consistency: Soft / Ribbons / Mucous / Normal / Hard / Pebbles / Dry / Diarrhea / Constipation
Hemorrhoid: 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** / Crying / 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)

DISCLAIMER/INFORMED CONSENT

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

Emotional Assessment: Energy Healing promotes harmony and balance within. Through this medium we can support 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. Patterson 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. Patterson is not intended to be a replacement for consultation with a healthcare professional.

If you have questions or concerns about you health, please contact your healthcare provider. Healing sessions are strictly confidential. Your personal information will never be shared with anyone. Dr. Patterson makes no claims towards 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.

MFT (Morphogenic Field Technique) is not a method for the "diagnosing" or "treating" of any disease including conditions of cancer, 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 the purpose of bringing about a more optimum state of health.

Nutritional Assessment: I understand that MFT 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 imbalances in these areas could cause or contribute to various health problems.

Chiropractic/Structural Assessment: If determined necessary as part of your treatment, chiropractic or soft tissue manipulation may be used. Dr. Patterson may use his hands or a mechanical instrument 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
- Inflammation

Dr. Patterson will make every reasonable effort during the examination to screen for contraindications to care; it is your responsibility to inform 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

I will notify my doctor if I am PREGNANT, have a PACE-MAKER, or have any other METAL/ELECTRONIC device in or on my body.

It is my understanding with the aforementioned procedures that physical touch, magnets or other mechanical instruments may be used.

_____ *Patient Initials or Guardian if Under 18 years of age* _____ *Today's Date*

Scheduling and Office Polices

We do not accept insurance as payment for services. All appointments must be paid in full at the time of service. *Note:* You must notify the office of any *Cancelations* or *Scheduling Changes* within 24 hours of the scheduled appointment in order to avoid a $30.00 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. Patterson'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. Patterson **WILL REQUIRE** more time with you so that he can re-evaluate your health concerns. As a result of 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*