



Intake Form

Dear Client: The following information is needed for our files so we can better serve you as a patient. Please fill in all portions of the form. If you need any help, the receptionist will be happy to assist you.

Is Visit Accident Related? YES NO (If Yes, Please Notify the Receptionist)

Date _____ How Did You Hear About Us? _____

Name _____ Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail Address _____

Social Security # _____ Driver's Lic # _____

Marital Status _____ Sex _____ No. of Children _____

Occupation _____ Employed by _____

Name of Spouse _____ Spouse's Date of Birth _____

Spouse's Occupation _____

Spouse's Employer _____ Spouse's SS # _____

Name of Nearest Relative Not Living With You _____

Address _____ Phone _____

MEDICARE ONLY: PHYSICIAN NOTICE TO BENEFICIARY

Medicare Part B pays only for services that are determined to be reasonable and necessary under Section 1862(a)(1) of Medicare law. If a particular service is not reasonable and necessary under Medicare standards, although it would otherwise be covered, Medicare Part B denies payment for that service. I believe that, in your case, **Medicare Part B is likely to deny payment for exam, x-rays, physical therapies, massage therapies, manual therapy techniques, nutritional and exercise consultations for the following reason: These services are not covered in this type of facility.**

MEDICARE ONLY: BENEFICIARY AGREEMENT TO PAY

I have been notified by my physician that in my case, Medicare Part B is likely to deny payment for the services identified above, for the reasons stated. If Medicare Part B denies payment, I agree to be personally and fully responsible for payment.

BENEFICIARY'S SIGNATURE _____ DATE _____



Confidential Patient Case History, part 1

NAME _____ DATE _____

What is your major health concern? _____

Other concerns? _____

How long have you had this condition? _____

Have you had this or similar conditions in the past? _____

How did it originally occur? _____

Is this condition getting progressively worse? Yes No Constant Comes and Goes

If yes, when and how? _____

How frequent is the condition? Constant Daily Intermittent Other _____

Are there any other conditions or symptoms you have that may be related to your major symptom?

Yes No If yes, describe. _____

Are there other unrelated health problems? _____

Describe the pain: Sharp Dull Numbness Tingling Aching Burning

Radiating to Other Areas? Where? _____

Is there anything you can do to relieve this problem? Yes No

If yes, describe: _____

If no, what have you tried that has not helped? _____

What makes the problem worse? Standing Sitting Lying Bending Lifting

Twisting Other _____

Is this condition interfering with your: Work Sleep Daily Routine Other _____

How long has it been since you have felt really well? _____

List previous diagnoses and treatments you have received for present condition. _____

What do you believe is wrong with you? _____

List surgical operations and years: _____



Confidential Patient Case History, part 2

Below is a list of conditions, which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall diagnosis and treatment plan. Please place the appropriate letter in the spaces provided for any symptoms you now have or have had within the last year.

O = Occasional F = Frequent C = Constant

GENERAL

- Allergies
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Fever
- Headache
- Loss of Sleep
- Loss of Weight
- Anxiety
- Depression
- Neuralgia
- Numbness
- Sweats
- Tremors

MUSCLE AND JOINT

- Arthritis
- Jaw Pain/Clicking
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Neck Pain/Stiffness
- Pain B/W Shoulders
- Painful Tail Bone
- Poor Posture
- Sciatica
- Swollen Joints
- Spinal Curvature

PAIN OR NUMBNESS IN:

- Shoulders
- Arms
- Elbows
- Hands
- Hips
- Legs
- Knees
- Feet

GASTROINTESTINAL

- Belching/Gas
- Colon Trouble
- Constipation
- Diarrhea
- Difficult Digestion
- Distension of Abdomen
- Excessive Hunger
- Gallbladder Trouble
- Hemorrhoids
- Intestinal Worms
- Liver Trouble
- Jaundice
- Nausea
- Stomach Pain
- Poor Appetite
- Vomiting of Blood
- Vomiting
- Heartburn

EYES, EARS, NOSE & THROAT

- Asthma
- Colds
- Deafness
- Dental Decay
- Earache
- Ear Discharge
- Ear Noises
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Far Sightedness
- Near Sightedness
- Gum Trouble
- Hay Fever
- Hoarseness
- Nose Bleeds
- Sinus Infection
- Sore Throat
- Tonsillitis
- Nasal Obstruction

CARDIOVASCULAR

- Hardening of the Arteries
- High Blood Pressure
- Low Blood Pressure
- Pain over Heart
- Poor Circulation
- Rapid Heart Beat
- Slow Heart Beat
- Ankle Swelling

RESPIRATORY

- Chest Pain
- Constant Cough
- Spitting up Blood
- Difficult Breathing
- Spitting up Phlegm
- Wheezing

SKIN

- Bruise Easily
- Boils
- Varicose Veins
- Dryness
- Hives or Allergy
- Itching
- Rash (Skin Eruptions)

GENITO-URINARY

- Pus in Urine
- Bed-Wetting
- Blood in Urine
- Frequent Urination
- Bladder Control Trouble
- Kidney Infection/Stones
- Painful Urination
- Prostate Trouble

FOR WOMEN ONLY

- Pregnant? Yes No Maybe
- Breast Fullness/Tenderness
- Vaginal Discharge
- Excessive Menstrual Flow
- Hot Flashes
- Irregular Cycle
- Menopausal Symptoms
- Painful Menstruation



Please check any of the conditions that apply to you:

- | | | | |
|---|---|------------------------------------|---|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Goiter | <input type="checkbox"/> Miscarriage |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Stroke | <input type="checkbox"/> Mumps | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Eczema | <input type="checkbox"/> Ulcers | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Influenza | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Lumbago | <input type="checkbox"/> Malaria | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> HIV Virus | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Measles | <input type="checkbox"/> Cholera | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Fever Blisters | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Polio | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Chronic Fatigue |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Migraines | <input type="checkbox"/> Crohn's Disease |

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Coffee/tea	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Drugs/recreational	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Sleep	_____	_____	_____	_____
Appetite	_____	_____	_____	_____
Negative Thinking	_____	_____	_____	_____
Fun	_____	_____	_____	_____
Relaxation	_____	_____	_____	_____

Date of Last:

Physical Exam _____ Blood Test _____ Urine Test _____
Spinal X-ray _____ Chest X-ray _____ Other _____

Please check any of the symptoms that apply:

THYROID

- | | | |
|---|--|--|
| <input type="checkbox"/> Stubborn Weight | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Intolerance to cold |
| <input type="checkbox"/> Cold hands/feet or low body temperature | <input type="checkbox"/> Dry or itchy skin | <input type="checkbox"/> Sluggish elimination/constipation |
| <input type="checkbox"/> Mental sluggishness or lethargy | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Flabby skin under arms or neck | <input type="checkbox"/> Heart palpitations |
| <input type="checkbox"/> Hair Loss | <input type="checkbox"/> Lack of interest in life | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Ridged nails (vertical) or brittle nails | <input type="checkbox"/> Pain in the wrist (carpal tunnel) | <input type="checkbox"/> Cravings for sweets |
| <input type="checkbox"/> Insomnia | | |

ADRENAL/HEART/BLOOD PRESSURE/CHOLESTEROL

- | | | |
|--|--|---|
| <input type="checkbox"/> Out of breath walking up stairs | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Excessive facial hair—female |
| <input type="checkbox"/> Perspiring after getting out of shower | <input type="checkbox"/> Fatigue during the day | <input type="checkbox"/> Difficulty getting out of bed in morning |
| <input type="checkbox"/> Waking up in the middle of the night | <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Afternoon headaches |
| <input type="checkbox"/> Arthritis or stiff and painful joints | <input type="checkbox"/> Bursitis | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Twitch under the eyelid | <input type="checkbox"/> Heel spurs | <input type="checkbox"/> Low back weakness or pain |
| <input type="checkbox"/> Itchiness or hives | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Fluid retention |
| <input type="checkbox"/> Dehydrated despite amount of fluid consumed | <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Craving salt (chips, pretzels) | <input type="checkbox"/> Enlarged abdomen |
| <input type="checkbox"/> Enlarged bump in upper back/lower neck | <input type="checkbox"/> Hands & feet go to sleep easily | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Aware of breathing heavily | <input type="checkbox"/> Frequent nose bleeds | <input type="checkbox"/> Muscle cramps, worse during exercise |
| <input type="checkbox"/> Dull pain in chest or radiating in left arm | <input type="checkbox"/> Ringing in ears | |



Please check any of the symptoms that apply:

DIGESTION/ARTHRITIS

- | | | |
|--|--|---|
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Difficulty sleeping through the night | <input type="checkbox"/> Early morning insomnia |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Stomach bloats when eating wheat or sugar | <input type="checkbox"/> Blood sugar problem | <input type="checkbox"/> Skin problems |
| <input type="checkbox"/> Burning feet | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Itchy skin and feet |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bowel movement light colored | <input type="checkbox"/> Pain between shoulder blades |
| <input type="checkbox"/> Sneezing attacks | <input type="checkbox"/> Nightmare type dreams | <input type="checkbox"/> Eating protein causes gas |
| <input type="checkbox"/> Coated tongue (white film) | <input type="checkbox"/> Indigestion, acid reflux | <input type="checkbox"/> Irritable bowel problems |
| <input type="checkbox"/> Difficulty getting out of bed in the morning | <input type="checkbox"/> History of birth control pills | <input type="checkbox"/> History of antibiotics |
| <input type="checkbox"/> History of eating refined carbohydrates/sugar | <input type="checkbox"/> Toenail fungus | <input type="checkbox"/> Headaches or migraines |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> Redness in eyes | <input type="checkbox"/> Fibromyalgia (tender spots in muscles) |
| <input type="checkbox"/> Painful joints | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Right shoulder pain or tightness |
| <input type="checkbox"/> Abdomen bloats after eating | <input type="checkbox"/> Full sensation under rib cage | <input type="checkbox"/> Belching/burping after eating |
| <input type="checkbox"/> Yellowish color in whites of eyes | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Itchy private parts | <input type="checkbox"/> Yeast or candida | |

MENOPAUSE (female only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Hot flashes | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Vaginal dryness |
| <input type="checkbox"/> Leaking bladder | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Fibroids |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Bone loss/osteoporosis |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> History of birth control pills | |

MENSTRUAL (female only)

- | | | |
|---|---|---|
| <input type="checkbox"/> Infertile (difficulty in getting pregnant) | <input type="checkbox"/> PMS | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Depression during menstruation | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Weight gain during menstruation |
| <input type="checkbox"/> Bloating and cramping during menstruation | <input type="checkbox"/> Weight gain during ovulation | <input type="checkbox"/> Difficulty losing weight after pregnancy |
| <input type="checkbox"/> Heavy bleeding during menstruation | <input type="checkbox"/> Pain in low back/pelvic area | <input type="checkbox"/> Pain in the front hip area |
| <input type="checkbox"/> Acne during menstruation | <input type="checkbox"/> Knee pain | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Enlarged swollen breasts during menstruation | <input type="checkbox"/> Bladder infections (recurrent) | |

BLOOD SUGAR

- | | | |
|--|---|---|
| <input type="checkbox"/> History of diabetes in family | <input type="checkbox"/> Tired at 3:00 p.m. (afternoon) | <input type="checkbox"/> Irregular periods |
| <input type="checkbox"/> Cravings for sweets, refined carbohydrates | <input type="checkbox"/> Awake after a few hours of sleep | <input type="checkbox"/> Weight gain during menstruation |
| <input type="checkbox"/> Wake early a.m. and can't get back to sleep | <input type="checkbox"/> Acne | <input type="checkbox"/> Difficulty losing weight after pregnancy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Pain in the front hip area |
| <input type="checkbox"/> Afternoon Headaches | <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Fibrocystic breasts |
| <input type="checkbox"/> Numbness or tingling in finger tips or toes | <input type="checkbox"/> Lightheaded if hungry | <input type="checkbox"/> Eating improves fatigue |
| <input type="checkbox"/> History of eating lots of sugars, refined carbohydrates | <input type="checkbox"/> Fatigue 1 to 2 hours after eating sugar or refined carbohydrates | |

PROSTATE (male only)

- | | | |
|--|--|--|
| <input type="checkbox"/> Urination difficulty or dribbling | <input type="checkbox"/> Frequent urination at night | <input type="checkbox"/> Pain on inside of heels or legs |
| <input type="checkbox"/> Lack of vigor or vitality | <input type="checkbox"/> Legs nervous at night | <input type="checkbox"/> Diminished sex drive |
| <input type="checkbox"/> Impotent | <input type="checkbox"/> Infertile | |

STUBBORN WEIGHT

- | | | |
|---|---|---|
| <input type="checkbox"/> Cravings for junk food | <input type="checkbox"/> Drinks wine in evenings | <input type="checkbox"/> Crave refined carbohydrates |
| <input type="checkbox"/> Frustrating stubborn weight | <input type="checkbox"/> History of low-calorie diets | <input type="checkbox"/> History of up and down weight |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> History of birth control pills | <input type="checkbox"/> High protein diets don't work |
| <input type="checkbox"/> History of Hormone Replacement Therapy | <input type="checkbox"/> Poor willpower | <input type="checkbox"/> Can't lose weight despite exercise |
| <input type="checkbox"/> History of blood sugar problems | <input type="checkbox"/> History of menstrual problems | |



Chemical Balance Questionnaire

Speed of healing is greatly affected by the chemical balance within the body. This chemical balance is determined, in large part, by what you eat and drink. Please indicate the amounts and frequencies of which you partake in the following: **BE HONEST.**

	PER DAY	PER WEEK
1. Coffee (caffeinated/decaffeinated)	_____ cups	_____ cups
2. Tea (herbal/regular)	_____ cups	_____ cups
3. Soda (regular/diet/caffeine-free)	_____ oz.	_____ oz.
4. Sugar, sweets, desserts, candy	_____ times	_____ times
5. Salt, salty snacks, chips, etc.	_____ servings	_____ servings
6. Red meat (beef, pork, bacon, ham, etc.)	_____ times	_____ times
7. Chicken/fish	_____ times	_____ times
8. Dairy (milk, cheese, ice cream, etc.)	_____ servings	_____ servings
9. Water (city, well, distilled, RO, etc.)	_____ glasses	_____ glasses
10. Fresh fruit	_____ pieces	_____ pieces
11. Fresh vegetables (non-canned)	_____ servings	_____ servings
12. Pasta, breads (made with white flour)	_____ servings	_____ servings
13. Whole grain foods	_____ servings	_____ servings
14. Artificially sweetened products (Sweet-N-Low, Aspartame, Equal, splenda, etc.)	_____ serving	_____ servings
15. Fast food (McDonald's, Hardee's, etc.)	_____ times	_____ times
16. Do you add salt to food at mealtime?	_____ Yes _____ No	_____ Occasionally
17. Smoking/alcohol	_____ Yes _____ No	_____ Occasionally

Past and Current Diet

Give some examples of types of foods you were raised on *as a child*:

Breakfast: _____
 Lunch: _____
 Supper: _____
 Snacks: _____
 Liquids: _____

Give some examples of how your eating patterns have *changed since childhood*:

Breakfast: _____
 Lunch: _____
 Supper: _____
 Snacks: _____
 Liquids: _____

List all supplementation you are currently taking (vitamins, minerals, homeopathics, etc.):

Major life changes (divorce, losses, trauma, etc.):



Treatment Acknowledgement

People seek care from physicians for a variety of reasons. Some only want relief from the pain or discomfort of the specific symptoms they are currently experiencing (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Still others want to bring themselves to the highest state of wellness possible (comprehensive care). The doctor will factor your desires into her recommendations when preparing your treatment program.

Relief Care Corrective Care Comprehensive Care Doctor to Select Appropriate Care

I hereby authorize Dr. Marianne Hoyle, DC to treat my condition, as she deems appropriate through the use of treatments, therapy, and such additional procedures as are considered therapeutically necessary in the course of said treatment. I hereby certify that I have read and fully understand this authorization for treatment. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor any medical diagnosis.

PATIENT'S NAME (Please Print) _____

PATIENT'S SIGNATURE _____ DATE _____

SIGNATURE OF GUARDIAN AUTHORIZING CARE _____ DATE _____

I hereby acknowledge that Dr. Marianne Hoyle, DC is evaluating me to determine whether I have nutritional deficiencies. If so, at my request, she will suggest a nutritional program as an adjunctive procedure provided solely to upgrade my diet in order to supply good nutrition for support of the physiological and biochemical processes of the human body. This treatment is not intended to replace any existing or future care by a medical doctor for any specific condition. I understand I am solely responsible for discussing with my medical doctor any such medical conditions for purpose of evaluation, diagnosis or treatment.

PATIENT'S SIGNATURE _____ DATE _____

SIGNATURE OF GUARDIAN AUTHORIZING CARE _____ DATE _____

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Marianne Hoyle, DC and whomever she may designate as assistants to administer treatment, as they so deem necessary, to my son/daughter.

CHILD'S NAME _____

SIGNATURE OF GUARDIAN AUTHORIZING CARE _____ DATE _____