



Champion Chiropractic Center, Inc.

Functional Nutrition Intake Form

2405 Evergreen Park DR SW Suite B1

Olympia, WA 98502

(360)438-6559 www.championchiropracticcenter.com

Today's Date: _____

Client: _____
Last Name First Name Initial

Street Address: _____ City _____ State _____ Zip _____

Phone Cell () _____ Work () _____

Email: _____

Date of Birth: _____ Age: _____

Primary Doctor: _____

Emergency Contact Name: _____

Relationship to Client: _____

Emergency Contact Phone Number: () _____

In case of emergency, I give Champion Chiropractic Center permission to call the above contact to seek help for me or to reach me if I can not be reached at my listed contact phone numbers.

_____ Initial

Who may we thank for referring you? _____

I give Champion Chiropractic Center permission to email me the monthly health update newsletter and discount coupons for supplement purchases. _____ Initial

I give Champion Chiropractic Center and/or Alexia Sandifer permission to answer any and all of my correspondence via email. I understand that my private medical information is at risk when communicating via the internet. I will not hold Champion Chiropractic Center nor Alexia Sandifer responsible if my personal medical data is breached during email correspondence. _____ Initial

Please explain the reason for this visit: _____

When did this condition begin? _____

Have you had this condition in the past? Yes No

Have you been treated by any medical or natural providers for this condition? If yes, where _____

I have had the following surgeries, accidents or hospitalizations. Date of injury

1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

I have the following diagnosis:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Date Diagnosed

I take the following prescribed drugs & non prescribed drugs (marijuana and OTC): Date Prescribed

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

I take the following supplements:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Date Started Taking

What are the known family history of diseases? (stroke, cancer, heart attack, high blood pressure, diabetes etc.)

Digestive System – Please mark all that apply to you

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Belching/Burp | <input type="checkbox"/> Gas | <input type="checkbox"/> Bloating | <input type="checkbox"/> Quickly Full When Eating |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Reflux | <input type="checkbox"/> Undigested Food in Poop | <input type="checkbox"/> Tongue is gray or black |
| <input type="checkbox"/> Use baking soda | <input type="checkbox"/> Constipated | <input type="checkbox"/> Reduced appetite | <input type="checkbox"/> Increased Appetite |
| <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> IBS | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Laxative Use | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Burning Feet |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Polyps | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Brain Fog |
| <input type="checkbox"/> Poor Focus | <input type="checkbox"/> Poor Memory | <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Food Sensitivities |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Rosacea | <input type="checkbox"/> Eczema | <input type="checkbox"/> Yeast Infections |
| <input type="checkbox"/> Sensitive to smells | <input type="checkbox"/> Frequently Sick | <input type="checkbox"/> Under Stress | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Thyroid Hyper | <input type="checkbox"/> Thyroid Hypo | <input type="checkbox"/> Jerk when sleeping |
| <input type="checkbox"/> Nightmares | <input type="checkbox"/> Wet Bed | <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Stomach pain or burning |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Postnasal Drip |
| <input type="checkbox"/> Congestion | <input type="checkbox"/> Infertility | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Intestinal Cramping |
| <input type="checkbox"/> Mood Swings | <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Low White Blood Cell Count |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Gain Weight Easily | <input type="checkbox"/> Gallstones |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Sleep Issues | <input type="checkbox"/> Skin Easily Turns Red | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Body Odor | <input type="checkbox"/> Food Cravings | <input type="checkbox"/> Rash on skin |
| <input type="checkbox"/> Swelling in body | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Dizzy/Vertigo | <input type="checkbox"/> Neurodivergent Spectrum |
| <input type="checkbox"/> Gastroparesis | <input type="checkbox"/> Drink milk/yogurt to stop gut pain | | <input type="checkbox"/> Can't eat fatty/fried foods |
| <input type="checkbox"/> Stringy mucous | <input type="checkbox"/> Pain between shoulder blades | | <input type="checkbox"/> Pain under right ribcage |
| <input type="checkbox"/> Difficulty digesting fruits & vegetables | <input type="checkbox"/> Gallbladder Removed | | |

Auto Immune Disease: _____

Other symptoms not listed:

Bowel movements: 1-3 per day More than 3 per day 4-6 per week 2-3 times per week
1 or less times per week

Bowel movements are: pellet hard light cored stools watery fast transit time within minutes of eating.

Immune System - Please circle all that apply

- | | | |
|----------------------------------|-----|----|
| I have had mono. | Yes | No |
| I get Epstein-Barr Flares. | Yes | No |
| I get cold sores | Yes | No |
| I have had a parasite infection. | Yes | No |
| I have a herpes infection. | Yes | No |
| I have had Hepatitis. | Yes | No |
| I have had Lyme Disease. | Yes | No |

Immune System - Please circle all that apply

I have had covid.	Yes	No
I have had long covid.	Yes	No
I get the flu on a regular basis.	Yes	No
I get bronchitis yearly.	Yes	No
I have had pneumonia.	Yes	No
I get easily sick.	Yes	No
I have had a heart attack	Yes	No
I have had a stroke	Yes	No
I am under excessive stress.	Yes	No
I have blood clots	Yes	No
I have an aneurysm	Yes	No
I have had several deaths in my family in the last 6 years.	Yes	No
I have or had cancer.	Yes	No
As a child I had antibiotics a lot.	Yes	No
I have ear symptoms.	Yes	No
I have eye symptoms.	Yes	No
I have sinus symptoms.	Yes	No
I have throat symptoms.	Yes	No
I have a STD	Yes	No

Mitochondria/Energy- Please circle all that apply

I am frequently tired.	Yes	No
I feel tired even after more than eight hours of sleep.	Yes	No
I am chronically stressed.	Yes	No
It's difficult for me to handle stress.	Yes	No
I am a night-shift worker.	Yes	No
I am anxious, nervous or worry a lot.	Yes	No
I am depressed	Yes	No
I work long hours.	Yes	No
I have little relaxation time during my days.	Yes	No
I get headaches frequently.	Yes	No
I don't exercise consistently.	Yes	No
I am or have been an endurance athlete or I do CrossFit.	Yes	No
I have erratic sleep patterns	Yes	No
I wake up in the middle of the night.	Yes	No
I toss and turn when I sleep.	Yes	No
I wake to pee multiple times at night.	Yes	No
I crave salt.	Yes	No
I crave sugar.	Yes	No
I have high sugar intake in my daily food intake.	Yes	No
I have difficulty concentrating.	Yes	No
I carry weight in my midsection.	Yes	No
I have low blood sugar issues.	Yes	No
I have irregular periods.	Yes	No
I have a low sex drive.	Yes	No
I have PMS or perimenopausal/menopausal symptoms.	Yes	No
I get sick frequently	Yes	No
I have low blood pressure.	Yes	No
I have high blood pressure.	Yes	No
I have muscle fatigue or weakness.	Yes	No
I rely on caffeine for energy. (coffee or energy drinks)	Yes	No
I have to put days between workouts due to muscle aches/pain and fatigue.	Yes	No
Other not listed:		

Emotional Trauma or Accidents – Please circle all that apply

I have been in an auto accident.	Yes	No
I was hit by a car as a pedestrian.	Yes	No

Emotional Trauma or Accidents – Please circle all that apply

I have served in the military.	Yes	No
I was in combat in the military.	Yes	No
I have been diagnosed with PTSD.	Yes	No
I have been diagnosed with Complex PTSD.	Yes	No
I have had a concussion or blow to the head.	Yes	No
I was raped.	Yes	No
I was molested.	Yes	No
I was emotionally abused.	Yes	No
I was mentally abused.	Yes	No
I was physically abused/beaten.	Yes	No
Your or your parents got a divorce.	Yes	No
You or your parent was incarcerated.	Yes	No
I had a house fire.	Yes	No
Long term illness.	Yes	No
Covid lockdowns strongly affected me.	Yes	No
Death of loved one.	Yes	No
I was adopted.	Yes	No
My biological parents did not raise me.	Yes	No
I was abused on the job.	Yes	No
I was stalked.	Yes	No
Other not listed: _____		

As A Child (birth to age 18) I Had The Following – Please circle all that apply

Childhood vaccines.	Yes	No
I had the Measels	Yes	No
I had the Mumps	Yes	No
I had Chicken Pox	Yes	No
Other childhood disease: _____		
Frequently Sick	Yes	No
Constipated	Yes	No
Diarrhea	Yes	No
Bronchitis	Yes	No
Pneumonia	Yes	No
Whooping Cough	Yes	No
Grew up on a farm.	Yes	No
Exposed to hazardous chemicals.	Yes	No
Frequent nose bleeds.	Yes	No
Frequent ear aches.	Yes	No
Frequent rashes or hives.	Yes	No
Severe acne or cystic acne	Yes	No
Headaches/Migraines	Yes	No
Allergies	Yes	No
Tubes in ears.	Yes	No
Vomited a lot	Yes	No
Prescribed antibiotics frequently.	Yes	No
Easily broke bones	Yes	No
Cancer	Yes	No
I was in a car accident.	Yes	No
I was in contact sports.	Yes	No
Diagnosed on the autistic/neurodivergent spectrum	Yes	No
I got car sick easily	Yes	No
ADD/ADHD	Yes	No
Dyslexic/Dyscalculia/Dysgraphia	Yes	No
Born by forceps or suction	Yes	No
PANDAS	Yes	No
Other childhood notes:		

Women: When you had your period as a teen

Severe menstrual cramps	Yes	No
Severe Premenstrual Syndrome	Yes	No
Started period before age 10 or after age 14	Yes	No

Stimulant Use

Do you consume coffee or coffee drinks on a daily basis?	Yes	No
Do you consume energy drinks or Gatorade on a daily basis?	Yes	No
Do you use sugar substitutes?	Yes	No
Do you use recreational drugs?	Yes	No
Do you use alcohol to manage stress or help you sleep?	Yes	No
Do you vape or smoke cigarettes?	Yes	No
Do you use a nicotine patch?	Yes	No

Seasonal Symptoms/Histamine Intolerance

Do you feel worse in the spring, summer, fall, or winter?	Yes	No	which season(s) _____
What happens during this time of year ? _____			

Certain foods cause heartburn/indigestion.	Yes	No
I have ringing in the ears.	Yes	No
I have sinus issues.	Yes	No
I have stuffy ears.	Yes	No
My hands, face, or feet swell.	Yes	No
I get hives.	Yes	No
Headaches/migraines	Yes	No
Can't drink wine	Yes	No
Easily drunk	Yes	No
Do not tolerate caffeine	Yes	No
Vomit to feel better	Yes	No
Face flushes/turns red easily	Yes	No
When I scratch myself the marks last a long time.	Yes	No
My allergies are: _____		

Teeth/Mouth

Do you have any dental implants?	Yes	No
Do you have any teeth that are bothering you right now?	Yes	No
Do you have to have deep dental cleanings?	Yes	No
Do you have a white coated tongue?	Yes	No
Do you have any sores in your mouth?	Yes	No
Do you get canker sores in or out of your mouth?	Yes	No
Have you had oral cancer or throat cancer?	Yes	No
Do you wear a mouth guard?	Yes	No

Women Only – Menstruating

Premenstrual Syndrome	Yes	No
Endometriosis	Yes	No
Mood swings	Yes	No
Food cravings	Yes	No
Painful breasts	Yes	No
Depression only with cycle	Yes	No
Hot flashes	Yes	No
Heavy periods	Yes	No
Diagnosed PMDD	Yes	No
Night sweats	Yes	No
Heart palpitations	Yes	No
Vaginal dryness	Yes	No

Women Only – Menstruating

Do you currently have or did you have an eating disorder?	Yes	No
Do you do something to cause harm to yourself around your period?	Yes	No
Have you had a hysterectomy?	Yes	No
Fibroids	Yes	No
Cysts	Yes	No
PCOS	Yes	No
Irregular cycles	Yes	No
I had the injectable birth control.	Yes	No
I went over a year without a period.	Yes	No
I had a copper IUD.	Yes	No
List all of the types of birth control you have been on since you started using birth control:		

Women Only – Peri Menopause through Post Menopause

Mood swings	Yes	No
Cry easily	Yes	No
Brain fog	Yes	No
Loss of concentration	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Stroke	Yes	No
Heart Attack	Yes	No
Chest pain	Yes	No
Heart palpitations	Yes	No
Hot flashes	Yes	No
Night sweats	Yes	No
Vaginal dryness	Yes	No
Unexpected bleeding	Yes	No
Sound sensitive	Yes	No
Becoming more introverted	Yes	No
Hair loss	Yes	No
Irritable	Yes	No
Sleep issues	Yes	No
Headaches	Yes	No
Muscle or joint pain	Yes	No
Physical exhaustion	Yes	No
Mental exhaustion	Yes	No
Itchy or dry skin	Yes	No
Bladder issues	Yes	No
Low sex drive	Yes	No
Osteopenia or osteoporosis	Yes	No
Sleep apnea	Yes	No
Snore	Yes	No
Frequent urination	Yes	No
Nighttime urination	Yes	No
Avoid physical activity	Yes	No
Hormones checked in the last 6 months?	Yes	No

Men Only (Age 18+)

Dry skin	Yes	No
Difficulty sleeping	Yes	No
Snore	Yes	No
Sleep apnea	Yes	No
Difficulty concentrating	Yes	No
Gain weight easily	Yes	No

Men Only (Age 18+)

Man boobs	Yes	No
Loss of muscle mass	Yes	No
Difficulty building muscle	Yes	No
Low energy/fatigue	Yes	No
Low blood count	Yes	No
Avoid activity	Yes	No
Osteoporosis	Yes	No
Memory loss	Yes	No
Brain Fog	Yes	No
Genital numbness	Yes	No
Decreased sex drive	Yes	No
Difficulty maintaining erection	Yes	No
Hair loss	Yes	No
Body hair loss	Yes	No
Headaches	Yes	No
Depression	Yes	No
Heart Attack	Yes	No
Stroke	Yes	No
Diabetes	Yes	No
Chest pain	Yes	No
Night sweats	Yes	No
Loss of interest in life	Yes	No
Night time urination	Yes	No
Slow start to urination	Yes	No
Have to push to empty bladder	Yes	No
Rage issues	Yes	No
Testosterone levels checked in last 6 months?	Yes	No

Sleep – Please check all that apply

- I can fall asleep easily, sleep all night and wake up refreshed.
- It takes me awhile to fall asleep. Once I fall asleep, I sleep all night.
- It takes me awhile to fall asleep and then I wake up multiple times a night, but I easily fall back to sleep.
- It takes me awhile to fall asleep and then I wake up multiple times a night and stay awake for a half hour or more with each waking.
- I can fall asleep easily but wake up one to two times at night but easily fall back to sleep.
- I can fall asleep easily but wake up multiple times a night tossing and turning.
- I can fall asleep easily but wake up multiple times a night and stay awake for a half hour or more with each waking.
- I sleep less than 6 consecutive hours a night.
- I sleep more than 8 consecutive hours a night.
- I have to take a prescribed drug, an OTC drug, or marijuana to sleep.
- I use melatonin to sleep.

Answer this question: “I have never been the same since.”

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Payment is due in full at the time of service for each service that you have per office visit.

Charges to Account: We have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within 30 days of the time the item was added to the account. The FINANCE CHARGE will be computed at the rate of 1% per month ANNUAL PERCENTAGE RATE of 12% or \$5.00 per month, whichever is larger. The finance charge on your account is computed by applying the periodic rate to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed 30 days ago and then subtracting any payments or credits applied to the account during that time.

Returned Checks: There is a fee for any checks returned by the bank. Currently, this fee is \$60..

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to the credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Divorce: In the case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After the divorce or separation, the parent authorizing treatment for a child will be the parent responsible for the subsequent charges. If the divorce requires the other parent to pay for all or part of the treatment cost, it is the authorizing parent's responsibility to collect from the other parent.

Missed Appointments: Our doctors & therapists value your time and request that you value their's. We make every attempt to respect our patient's time by scheduling appropriate times for treatment and minimizing the amount of time a patient waits for care. If a patient is unable to keep their scheduled appointment, they must notify the office 24 hours in advance for Chiropractic, Massage Therapy, Cold Laser Therapy, and Clinical Nutrition. Appointments canceled the same day as they are scheduled is considered a missed appointment. While calling just before your appointment time is better than not showing up, the end result is the same. If a patient arrives 10 minutes late for an appointment, they have missed their appointment. We will try to fit them in around other scheduled patients, but it may involve a wait. Your failure to notify the office of your intention to cancel and reschedule within the listed time frame, for each profession, will result in the following fee:

- Chiropractic: \$52.00
- Cold Laser Therapy: \$52.00
- Massage Therapy: \$60.00
- Clinical Nutrition: \$52.00

Please note: Missed appointment fees must be paid at the next scheduled appointment. Medical Insurance, Auto Insurance, and Workers Compensation WILL NOT cover these charges.

Printed Name: _____ Date: _____

Signature: _____

Champion Chiropractic and Wellness Center, Inc.
Receipt of Privacy Practices

Your healthcare information is state mandated to be kept private from any and all parties. Champion Chiropractic Center, Inc. has a brochure that tells me how my health information is taken care of. This brochure is called "Notice of Privacy Practices." Champion Chiropractic Center, Inc. provided me with the most current "Notice" and may update this "Notice" at any time. Any updates to the "Notice" will be posted in the office. Please initial each statement that you agree upon:

1. _____ I have been given a current brochure of the "Notice of Privacy Practices which describes how my health care information will be used and disclosed to carry out treatment, payment, and health care options.

OR

2. _____ I have been informed how my health care records and information will be kept private, and I choose not to take a brochure at this time.

ALSO

3. _____ I give Champion Chiropractic Center, Inc. staff permission to call me on the phone to make reminder calls or to discuss my account information.

4. _____ I agree that messages may be left on my answering machine or voicemail.

The following people may obtain my medical information in case of my absence, hospitalization, or incapacitation:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

Patient or Legally Authorized Individual Signature

Today's Date

Relationship to patient if signed on behalf of the patient by parent, legal guardian, etc.

NUTRITIONAL THERAPY INFORMED CONSENT WAIVER AND DISCLAIMER

Alexia Sandifer, Functional Nutritional Therapist of Champion Chiropractic Center, Inc.

Before you choose to use the services of a Functional Nutritional Therapist, please read the following information FULLY AND CAREFULLY.

GOAL: The basic goal of an FNT is to encourage people to become knowledgeable about and responsible for their own health, and to bring it to a personal optimal level. Functional Nutritional Therapy is designed to treat any specific disease or medical condition. Reaching the point of optimum health, absent other non-nutritional complicating factors, requires a sincere commitment from you, possible lifestyle changes, and a positive attitude. A nutritional therapist is trained to evaluate your nutritional needs and make recommendations of dietary change and nutritional supplements. We do NOT provide medical diagnoses, and no comment or recommendation should be construed as such. Since every human being is unique and has their own biochemistry, we cannot guarantee any specific result from our programs.

HEALTH CONCERNS: If you suffer from a medical or pathological condition, you will need to consult your appropriate healthcare provider. A Functional Nutritional Therapist is not a substitute for your family physician or specialist. It is not to be used in lieu of medical needs. We are not trained nor licensed to diagnose, treat pathological conditions, illnesses, injuries, or diseases.

If you are under the care of a physician, it is important to contact them and let them know you are taking nutritional supplements. Functional Nutritional Therapy may be a beneficial adjunct to more traditional care, and it may also alter your need for medication, so it is important that you always keep your physician informed of changes in your nutritional program. If you are using medications of any kind, you are required to alert the Functional Nutritional Therapist to such use, as well as to discuss any potential interactions between medications and nutritional products with your pharmacist. However, healing reactions are very normal when correct changes occur to the body.

COMMUNICATION: Every client is an individual, and it is not possible to determine in advance how your system will react to the supplements you need. If you choose to use supplementation, it is sometimes necessary to adjust your program as we proceed until your body can begin to properly accept products geared to correct the imbalance. It is your responsibility to follow nutritional guidelines and recommendations, exercise your body and mind to stay in positive balance, eat a proper diet, get plenty of rest and stay abreast of nutrition. You must stay in contact with your nutritional therapist so that the correct course of action can be taken.

You should request your other healthcare provider, if any, to feel free to contact me at 360-438-6559 to address any questions they may have regarding functional nutritional therapy.

LICENSURE: A Functional Nutritional Therapist is not licensed or certified by any state. However, a Certified FNT is trained by the Nutritional Therapy Association, Inc. which provides a certification of completion to the program to students who have successfully met all course requirements, including a written and practical exam. A license to practice Functional Nutritional Therapy is not required in some states. Laws and regulations regarding certification and licensure requirements differ from state to state.

Signature

Date

Printed Name