Champion Chiropractic and Wellness Center, Inc.
Clinical Nutrition Intake Form
Lexi Sandifer, FNTP

Date _____

Patient _____
Last Name First Name Initial

Street Address _____ City _____ State _____ Zip _____

Home Phone ( )_____ Cell ( )_____ Work ( )_____

Email _____

Age _____ Date of Birth _____ Sex: ☐M ☐F ☐Married ☐Single ☐Widowed ☐Separated ☐Divorced

Driver's License _____ Social Security Number _____

Primary Doctor's Name _____

Spouse's Name _____ Spouse's DOB _____

Who May We Thank for Referring You? _____

Emergency Contact Name: _____

Relationship _____

Phone Number ( )_____

Please give this page to the receptionist before completing the rest of the packet.

Medical and Legal Information

Are your present symptoms or conditions related to or the result of an auto accident, work-related injury or personal injury that someone else might be legally liable for? ___ Yes ___ No Your Initials _____

If you answered YES, please fill out the accident form at the front desk.

Pregnant ___ Yes ___ No Name of Family Doctor _____

Please explain the reason for this visit _____

When did it begin? _____ **Is it getting worse?** ___ Yes ___ No ___ Constant
___ Comes and Goes

Is this condition interfering with your ___ work ___ sleep ___ daily routine (check all that apply)

Have you had this or similar conditions in the past? ___ Yes ___ No If so, explain _____

Have you been treated by a Medical Physician for this condition? ___ Yes ___No If yes, where _____

List any past accidents/injuries and hospitalizations, the date of occurrence, including your childhood:

_____ _____

_____ _____

_____ _____

What are your top 3 health and wellness goals?

1.

2.

3.

Are you willing to change the way you eat to support obtaining these goals? ___Yes ___No

Are you willing to take supplements to support obtaining these goals? ___ Yes ___ No

Have you or your family recently experienced any major life crisis or changes in the past year? ___Yes ___No
If so, please comment:

What are the known family history diseases (i.e.: heart attack, stroke, cancer, high blood pressure, etc.) _____

_____

_____

_____

How many days have you been unable to attend work, school, or social functions in the past year due to your health?
___ 0 – 2 days ___ 3 – 14 days ___ 15+ days

Will other members of your household support a health and lifestyle change for you? ___ Yes ___ No

What are you allergic to, including household cleaners, latex, food, medications, iodine, etc.? Please list: _____

_____

_____

How often have you taken oral steroids (Cortisone, Prednisone, etc.) or antibiotics?

Infancy / Childhood _____

Teen _____

Adult _____

Do you consume a lot of sugar/candy? ___ Yes ___ No ___ Don't Know
Do you consume pop/soda or diet pop/soda? ___ Yes ___ No ___ Don't Know
Do you consume coffee or coffee drinks? ___ Yes ___ No ___ Don't Know
Do you consume Energy Drinks or Gatorade? ___ Yes ___ No ___ Don't Know

Do you use sugar substitutes? ___Yes ___ No ___ On Occasion
Do you feel worse at certain times of the year? ___Yes ___No
If yes, is it during ___Spring ___Summer ___Fall ___Winter

Do you have dental implants or mercury/amalgam fillings? ___ Yes ___No

Do you have any silicone implants, Teflon, titanium, etc.? ___Yes ___ No

Please check any of the following that apply to you:

___ Abuse (Verbal, Physical, Mental)	___ Anemic	___ Artificial Bones/Joints	___ Arthritis	___ Asthma
___ Bronchitis	___ Bi-Polar Disorder	___ Cancer	___ Cataracts	___ Hysterectomy
___ Chemotherapy	___ Chronic Fatigue Syndrome		___ Crohn's Disease	
___ Congenital Heart Defect	___Constipation	___ Dermatitis	___ Depression	___ Diabetes 1
___ Diabetes 2	___ Emphysema	___ Epilepsy	___ Erectile Dysfunction	___ Rape
___ Fibromyalgia	___ Gallstones	___ Gallbladder Removed	___ Gout	___ Glaucoma
___ Heart Attack	___ Heart Burn	___ Heart Murmur	___ Blood Issues	
___ Hepatitis	___ HIV / Aids	___ High Cholesterol	___ High Triglycerides	___ Hemorrhoids
___ High Blood Pressure	___ Hyper Thyroid	___ Hypo Thyroid	___ Incontinence	___ Irritable Bowel
___ Macular Degeneration	___ Low Blood Pressure	___ Low Sex Drive	___ Kidney Stones	___ Sleep Apnea
___ Molestation	___ Mononucleosis / Epstein Barr		___ Bruise Easily	___ Body Odor
___ Numbness in Fingers	___ Mouth Sores	___ Seizures	___ Shingles	___ Sinusitis
___ Bladder/Kidney Issues	___ Snore	___ Stroke	___ Ulcer	___ Gas
___ HCG Shots or Pills	___ Yeast Infections	___ Chronic Left Shoulder Pain		___ Always Cold
___ Fingertips Turn White	___ Fatigue	___ Chronic Left Neck Pain	___ Diarrhea	___ Bloated
___ Difficulty Swallowing	___ Burping	___ Sneezing	___ Red Bumps – Arms / Chest / Legs	
___ Headaches	___ Migraines	___ Fainting	___ Cough A Lot	___ Insomnia
___ Difficulty Breathing	___ Hair Loss	___ Clear Your Throat Frequently		

Do you have a bowel movement (poop) ___ More than 3 times per day ___ 1 – 3 times per day
___ 4 – 6 times per week ___ 2 – 3 times per week ___ 1 or less times per week

Does your poop ___ float ___ have oil present ___ pellet/hard ___ watery ___ loose
___ light in color ___ green in color ___ dark in color ___ stench
___ strain to pass ___ undigested food in stool ___ fast transit time – within 30 minutes of eating

Are you on a special dietary program? Yes No (Including Vegetarian)
If yes, please describe _____

Do you exercise? Yes No If yes, what do you do for exercise and how often? _____
_____

Do you smoke? Yes No If yes, how many packs per day? _____

Do you drink alcohol? Yes No If yes, what do you drink and how often? _____
_____

Do you use marijuana, prescription drugs, other drugs or alcohol to handle life stress? _____

-Women Only- (Menstruating and Menopause)

How old were you when you started your period? _____ Did you have difficulty as a teen? _____
Do you suffer from PMS? _____
Have you been diagnosed with endometriosis? _____
Do you experience rage, anger, weepy, or other mood swings? _____
Do you have food cravings? _____ If yes, what are they and when do they occur? _____

_____
Do you get painful breasts? _____
Do you suffer from depression with your cycle? _____
Do you have vaginal discharge? _____
Do you get yeast infections? _____
Do you have acne? _____
Do you have hot flashes? _____
Do you have heavy periods? _____
Do you have a decreased sex drive? _____
Do you have problems with anxiety or nervousness? _____
Do you have brain fog? _____
Do you have a problem concentrating? _____
Do you have heart palpitations or a racing heart? _____
Do you have chest pains? _____
Do you have difficulty maintaining your weight? _____
Do you have swelling or edema? _____
Do you have night sweats? _____
Do you have sleep difficulty? _____
Do you have hair loss? _____
Do you have dry skin? _____
Do you have vaginal dryness? _____
Do you have an eating disorder, such as Anorexia, Bulimia, etc.? _____
Do you do something to cause harm to yourself? (cut, drugs, etc.) _____
Have you ever been pregnant? _____ Number of births? _____
Have you ever miscarried? _____ How many? _____
Have you had difficulty getting pregnant? _____
Have you had your thyroid levels checked within the last 6 months? _____
Have you had your hormone levels checked within the last 6 months? _____
Have you had mental health counseling in your lifetime? _____

-Men Only- (Age 13+)

Do you have dry skin? ___ Yes ___ No
Do you have difficulty sleeping? ___ Yes ___ No
Do you have problems concentrating? ___ Yes ___ No
Do you take recreational drugs? ___ Yes ___ No
Do you use alcohol to deal with life stress? ___ Yes ___ No
Do you have a loss of muscle mass? ___ Yes ___ No
Do you have low energy? ___ Yes ___ No
Do you avoid activity? ___ Yes ___ No
Do you have restless legs at night? ___ Yes ___ No
Are you infertile? ___ Yes ___ No
Do you have hair loss? ___ Yes ___ No
Do you have memory loss / brain fog? ___ Yes ___ No
Do you have a decreased sex drive? ___ Yes ___ No
Do you have difficulty getting and sustaining an erection? ___ Yes ___ No
Do you get fatigued easily? ___ Yes ___ No
Do you have body aches and pains? ___ Yes ___ No
Do you have a low sex drive? ___ Yes ___ No
Do you get headaches? ___ Yes ___ No
Do you get chest pain? ___ Yes ___ No
Have you gained weight in the last year? ___ Yes ___ No
Do you have night sweats? ___ Yes ___ No
Do you have a loss of interest in life? ___ Yes ___ No
Do you have night time urination? ___ Yes ___ No **How many times per night?** _____
Do you have a slow start to your urination? ___ Yes ___ No
Do you have uneven flow to your urination? ___ Yes ___ No
Do you have emotional management problems (Rage)? ___ Yes ___ No
Do you have breast development? ___ Yes ___ No
Do you have both testicles? ___ Yes ___ No
Do you have swelling or edema in your legs or hands? ___ Yes ___ No
Have you had your hormone levels checked within the last 6 months? ___ Yes ___ No
Have you had your thyroid levels checked within the last 6 months? ___ Yes ___ No
Have you had mental health counseling in your lifetime? ___ Yes ___ No

Current Symptoms – Please circle all that apply:

Headaches and/or Migraines – front of head, temples, top of head, back of head, cluster, TMJ

Ear – hiss, pounding, ringing, fluid, wax, pop, ache, drainage, itch, dizzy, hearing loss, plugged

Tongue – coated, red, cracked down the middle, thick, yellow, green, spots

Eyes – burn, tear, ache, red, dry, film, itch, blur, floaters, spots, tired, puffy, stye, twitch, dark circles

Sinus – dry, drain, plugged, post nasal drip, discharge – white, green, yellow, gray, brown, blood, clear; sneezing, loss of smell, loss of taste, thirsty

Throat - sore, hoarseness, cough – dry, productive, allergies, swollen, difficulty swallowing

Other – fever, chills, bad breath, canker sores, blusters, flu, neck stiffness, shoulder tension, dry mouth, cold hands/feet, sweaty hands/feet, gum issues, teeth issues, gland issues, cracks in corners of mouth

Chest – breast pain, tight, tension, heavy, congestion, pressure, anxiety, pain, sharp heart pain, palpitations, tachycardia, bradycardia, murmur, arm pain

Lungs – shortness of breath, air hunger, yawning, asthma, fluid, wheeze, shortness of breath of exertion

Digestion – heartburn, indigestion, nausea, queasy, reflux, bloating, gas, belching, ulcer, hiatal hernia

Bowels – regular, sluggish, cramping, laxative use, suppositories, enemas, soft, ribbons, mucous, hard, pebbles, dry, painful to pass, diarrhea, constipation, hemorrhoids, greasy, dark, light, green, blood in stool

Prostate – burn, ache, pain, dribble with urination, swelling, emission, interrupted stream when urinating

Breasts – tender, swollen, lumps, nipple discharge, implants, other surgery

Vagina – burn, itch, dry, pain, blood, discharge, - clear, white, yellow, green, brown, odor

Menses – regular or irregular. Heavy flow, moderate flow, light flow. Long periods, short periods. Cramping, low abdominal puffiness, spotting, PMS, breast tenderness, pain at ovulation, clotting. Skip periods, Late/Early periods. On birth control. Periods are: heavy, moderate, light, long, brief. Cramping: mild, moderate, severe, in the back.

Ovulation – painful, cysts, fibroids, discharge, regular, irregular

Diagnosed endometriosis

Menopause – natural, surgical – partial/complete

Use of Hormones – patch, cream, natural, synthetic

Hot flashes or Night Sweats

Sex drive – high, low, normal, impotent

Other – acne, cellulite, increase in anxiety or depression, increase joint pain with periods

Nails – chip, break, ridges, grow up, grow under, fungal infections, spots

Hair – hair loss, dry, brittle, course, thin, faded color, limp, dandruff

Healing – slow to heal, bruise easily

Fluid Retention – face, hands, feet, whole body, with period

Urination – during the night, frequent, urgent, burn, pain, odor, leak, urinary tract infections

Sleep – difficulty falling asleep, insomnia, interrupted (_____ times per night), crave sleep, jolts, dreams, no dreams, nightmares, night sweats, restlessness, restless leg syndrome

Emotional Well Being – sad, depression, grief, moodiness, irritable, worry, angry, nervous, anxiety, panic attacks, cry a lot, fearful, shame, frustrated

Appetite – low, high, crave sweets, crave salt, crave coffee, crave chocolate, crave hard alcohol, crave ice cream, crave pop, crave beer, crave wine, crave ice, stress eat, emotional eater
Foods that cause irritation: _____

Energy – low, variable, up, slow start to the day that improves as the day progresses, or gets worse as the day progresses, decreases with exercise, increases with exercise

Stress Level: _____

Memory – can't remember names, numbers, words, confusion, fog, lack of concentration

Coordination – trip easily, fall easily

Other: _____

_____

Current Weight: _____

Pulse: _____

Blood Pressure: _____

Allergies – Please list all allergies and sensitivities: _____

_____

_____

_____

_____

1. **Have you had SARS Cov 2 (Covid 19)?** ☐ Yes ☐ No

2. **Did you have a positive Covid Test?** _____

3. **If yes, when?** _____

4. **Have you had the mRNA (Covid) shot?** ☐ Yes ☐ No

5. **If yes, which one?** _____

6. **If yes, when?** _____

7. **Have you not felt well in any way since your shot?** ☐ Yes ☐ No

8. **If yes, what have you been experiencing?** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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, trat 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

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments, other adjustments if applicable, co-pays and other payments you have paid, and finance charges, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements.

Payment if you have no insurance: Payment is due in full at the time of service for each service that you have per office visit.

Payment if you have insurance: We will bill your insurance if we are providers with them. Please check with us or your insurance company to see if we are providers. Not all of our providers are contracted with the same insurance companies. You are responsible for all charges not paid by your insurance company.

Payments: Unless other arrangements are approved by us, the balance on your statement is due and payable when the statement is issued, and is past due if not paid at the time of service.

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.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a copay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or pre-authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment or denial of payment from the insurance company. You are responsible for all charges not paid by your insurance company.

Non-Contracted Insurances: Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You are responsible to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or authorization, you are responsible for obtaining it. Failure to obtain the referral and/or pre-authorization may result in a lower payment from the insurance company.

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.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive copays at the beginning of your visit. Unpaid copays will result in a $10 billing fee added to your monthly statement.

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

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collections cost which we incurred. If we have to refer a collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Thurston County, Washington.

Champion Chiropractic and Wellness Center, Inc.
Financial Policy

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.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee, if you want to have copies of your records sent to another doctor organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you're requesting your records to be transferred from another doctor organization to us, you authorize us to receive all relevant information, including your payment history.

Worker's Compensation: We require a written approval/authorization or your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you'll be responsible for payment in full.

Personal Injury: Our financial relationship is with you, not your insurance company. It is imperative that you understand that you are the one ultimately responsible for your bill. It is the patient's responsibility to dispute your insurance company's decision by calling your claims manager. If your insurance company has not made a payment within 60 days or is withholding payment, for any reason, you will be personally responsible for any outstanding balances on your account. You also authorize Champion Chiropractic Center, Inc. to turn your claims into the Washington State Insurance Commissioner for assistance on payment of unpaid claims. If you reach the maximum benefits for your personal injury claim, you'll be responsible for obtaining an attorney before any further treatment is provided. You will also be responsible for making a minimum monthly payment on your account until settlement of your claim. A payment plan will be created by the financial manager to meet patient and office needs.

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.

Champion Chiropractic and Wellness Center, Inc.
2405 Evergreen Park Dr. SW #B1, Olympia, WA 98502
Phone: (360) 438-6559 Fax: (360) 352-4202

Current Medications / Supplements / Herbs

Please list all medications, supplements, herbal, injections, patches, drops and over the counter products, etc., you are taking, including the dosage. Please include the ones you take on occasion.

Medication Name	Dosage	How often do you take?	Reason	Start Date

**** Please use back of page if additional space is needed for medication / supplements**

Please list all known allergies:

_____

_____

_____

_____