1740 Weir Drive, Suite 24 Woodbury, MN 55125 (ph) 651-232-6830 (fax) 651-702-2636 www.NaturalCareWoodbury.com

**NEW PATIENT INTAKE FORM**

**Patient Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date of Birth**:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

(Last, First, Middle Initial) Gender at Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Gender and Pronouns\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone:** (C):\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_(H):\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_(W):\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_

**Email**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Social Security Number**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Healthcare Provider and/or Clinic:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

By checking the box to the right you consent to us communicating with your PCP if needed.

Who referred you to our clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your reason for seeking care at our clinic?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

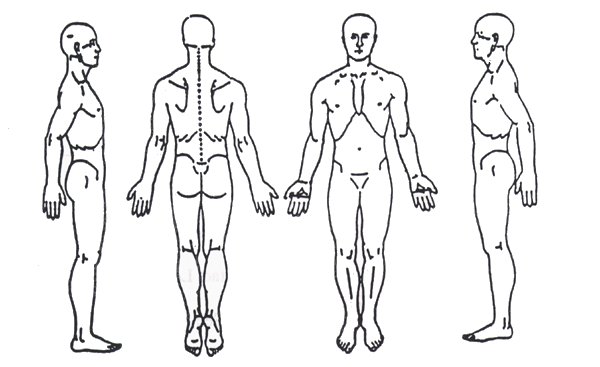
**When did your condition/symptoms begin?**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did your condition/symptom begin? \_\_\_\_\_\_**

**How often do you experience you symptoms?**

☐ Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

**Indicate on the picture below where you have pain or other symptoms, as well as the nature of your symptoms:**

Use the symbols below:

Numbness

=========

Pins and Needles

000000000

Burning

XXXXXXXXX

Stabbing

////////////

Aching

+++++++++

Other

\*\*\*\*\*\*\*\*\*

1. **During the past 4 weeks:**
   1. How much has pain interfered with your normal work (including work outside the home and housework)

☐Not at all ☐A little bit ☐Moderately ☐Quite a bit ☐Extremely

* 1. How much of the time has your condition interfered with your social activities (like visiting with friends, relatives, etc.)

☐All of the time ☐Most of the time ☐Some of the time ☐A little of the time ☐None

1. **How are your symptoms changing?**

☐ Getting Better ☐Not Changing ☐Getting Worse

1. **In general, would you say your overall health right now is:**

☐ Excellent ☐Very Good ☐Good ☐Fair ☐Poor

1. **Who have you seen for your symptoms?**

☐No one ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other

* 1. What treatment did you receive and when? \_\_\_\_\_\_\_\_
  2. What tests have you had for you symptoms and when were they performed?

☐X-rays date: \_\_\_\_\_\_\_\_ ☐CT Scan date: \_\_\_\_\_\_\_\_ ☐MRI date: \_\_\_\_\_\_\_\_ ☐Other date: \_\_\_\_\_\_\_\_

1. **Have you had similar symptoms in the past?** ☐Yes ☐No
   1. If you have received treatment in the past for the same or similar symptoms, whom did you see?

☐This office ☐Chiropractor ☐Medical Doctor ☐Physical Therapist ☐Other

**For each of the conditions listed below, place a check in the PAST column if you have had the condition in the past. If you presently have a condition listed below, place a check in the PRESENT column.**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Past | Present |  | Past | Present |  | Past | Present |  |
|  |  | Headaches |  |  | Heart Issues |  |  | Lung Disorder |
|  |  | Migraines |  |  | Stroke |  |  | Asthma |
|  |  | Dizziness |  |  | Chest Pain |  |  |  |
|  |  |  |  |  |  |  |  | Cancer |
|  |  | Spinal Pain |  |  | Kidney Disorders |  |  | Tumor(s) |
|  |  | Upper Extremity Pain |  |  | Bladder Disorders |  |  |  |
|  |  | Lower Extremity Pain |  |  | Bladder Incontinence |  |  | Allergies |
|  |  | Jaw Pain |  |  |  |  |  | Depression/Anxiety |
|  |  |  |  |  | Liver Disorders |  |  | Thyroid Disorders |
|  |  | Arthritis |  |  | Weight Gain/Loss |  |  | Epilepsy |
|  |  | RA |  |  | GI Disorders |  |  | HIV/AIDS |
|  |  | Autoimmune Disorder |  |  | Bowel Incontience |  |  | Hepatitis |
|  |  | Fatigue |  |  | Abdominal Pain |  |  | Skin Disorders |

**FAMILY HISTORY**

Please list any serious health conditions (cancer, diabetes, heart conditions, autoimmune disorders, etc.) within your immediate family (mother, father, grandparents, brothers, sisters, etc.):

**MEDICAL HISTORY**

Please list any surgeries and their date(s): Please list any trauma(s) or injuries and their date(s):

**List current medications and herbs/supplements you are taking:**

Medication/Supplement: Dose: Purpose: Prescribed By:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**Females only, please list:**

Number of pregnancies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of births:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Are you currently pregnant? Yes / No If yes, how many weeks?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PREVENTATIVE HEALTH HISTORY** (Please circle health screenings performed within the last year)

Blood Pressure Yes / No Fasting Blood glucose Yes / No

Breast Exam Yes / No Cholesterol Yes / No

Pap Smear Yes / No Dental Yes / No

Prostate Exam Yes / No Vision Yes / No

Colonoscopy Yes / No

**SOCIAL HISTORY**

**Alcohol Use Yes/No Drinks per week?\_\_\_\_\_ Caffeine Use Yes/No Drinks per day?\_\_\_\_\_ Tobacco Use Yes/No Type/Amount\_\_\_\_\_\_\_\_\_\_\_\_**

**Exercise Yes/No Times per week?\_\_\_\_\_ Recreational Drug Use Yes/No Type\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dietary Restrictions\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Text

Description automatically generated

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**MASSAGE THERAPY INFORMED CONSENT AND CAM BILL OF RIGHTS**

I understand that massage therapy may be accessed for relaxation or clinical purposes depending on how the patient presents. I understand a massage therapist will never touch genitals, breast tissue, or any other areas I instruct them not to touch.

I understand that the potential risks of massage therapy include: mild, short term muscle soreness due to movement of irritating metabolic wastes; mild surface level bruising. I understand I have the right to refuse massage therapy treatment at any time during the session.

I understand that I may be refused treatment if I appear obviously intoxicated or under the influence of drugs.

**Consent** I authorize the performance of massage therapy technique and procedures and understand that I will receive them from a certified massage therapist.

**COMPLIMENTARY AND ALTERNATIVE HEALTH CARE BILL OF RIGHTS (CAM)**

1. Name of Complementary and Alternative Health Care Practitioner: Natural Care Center of Woodbury, 1740 Weir Drive Suite 24, Woodbury, MN 55125; 651-232-6830.
2. Education Level of Massage Therapists: All massage faculty have graduated from accredited massage therapy programs and are certified massage therapists.

**THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIAL IS FOR INFORMATION PURPOSES ONLY.**

Under Minnesota law, and unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other types of health care providers, the client may seek such services at any time.

1. As a complementary and alternative health care client, you have the right to file a complaint with the massage therapists’ employer/supervisor. Any such complaint should be directed to the attention of the employer/supervisor, be in writing, and should include supporting details sufficient to permit an investigation into the complaint to commence.
2. **Office of Complementary and Alternative Health Care Compliance (OCAP), Health Occupations Program**: P.O Box 64882, St. Paul, MN 55164-0882; 651-201-3721. As a client, you may file complaints with such offices.
3. Massage is the systematic and scientific manipulation of the soft tissues of the body to prevent and alleviate pain, discomfort, muscle spasm and stress; and to promote health and wellness. Massage therapists utilize Western massage techniques from the Swedish tradition including: gliding, kneading, friction, vibration, percussion, and passive stretching, and depending on their training level, advanced techniques that address pain and dysfunction in the muscle and connective tissues. Relaxation Technique is defined as massage therapy modalities that have the intent of relaxation and general wellness. Two forms of Relaxation Technique are (1) Relaxation Technique provided for enjoyment with no clinical intent and (2) Relaxation Technique provided to produce a global outcome with clinical intent which the complexity of the case requires a higher level of critical thinking skills. Relaxation Technique modalities and methods utilized may include: Reflexology, Pregnancy Massage, Infant Massage, Geriatric Massage, healing Touch. Clinical or Advanced Technique is defined as massage therapy modalities with clinical intent that require advance training and highly skilled techniques for the purpose of meeting the patients’ individual needs and are condition/injury/symptom related. The session is focused on 103 areas and coordinated within a clinical care plan that has specific short and long term goals. Clinical or Advanced Technique is often used to specifically aid in decreasing pain, increasing range of motion, and decreasing myofascial restrictions massage modalities/techniques with are more advanced and applied with a higher level of critical thinking may include: Manual Lymph Drainage, NeuroMuscular Therapy (NMT), Tigger Point Therapy, Myofascial Release, CranioSacral Therapy, and/or Reflexology.
4. Fees for massage therapy are based on increments of time and are scheduled in blocks of 30, 45, 60, and 90 minutes. Payment is expected at time of service by cash, check or credit card for services not covered by insurance.
5. You have the right to reasonable notice of changes in services or charges.
6. You have the right to complete and current information concerning your assessment, recommended services to be provided, including the expected duration of the services to be provided.
7. You may expect courteous treatment and to be free from verbal, physical or sexual abuse by massage therapists.
8. You records and transactions at the Natural Care Center of Woodbury are confidential, unless release of these records is authorized by you or as otherwise provided by law.
9. You have the right to be allowed access to records and written information from records in accordance with Section 144.335 of the Minnesota Statues.
10. Other massage and bodywork services may be available to you in the community. Please ask for any information you would like.
11. You have the right to choose freely among available massage and bodywork practitioners and to change practitioners after services have begun, within the limits of health insurance or other health programs.
12. You have the right to coordinated transfer of your records when there will be a change in the provider of services. You records will be transferred at your request.
13. You have the right to refuse services or treatment, unless otherwise provided by law.
14. You have the right to assert your right without retaliation from the massage therapists.

**\*PATIENT PLEASE REVIEW \* PRINT & SIGN NAME\***

I attest that I have received this copy of the Complementary and Alternative Health Care Client Bill of Rights.

Patient Name (print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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(Patient/Guardian Signature) (Date) (Translator/Interpreter Signature) (Date)

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

(Massage Therapist Signature) (Date)



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**PATIENT FINANCIAL ACKNOWLEDGEMENT**

**Please read thoroughly. Initial your acknowledgements, then sign and print your name and the date. Thank you.**

VERIFICATION OF BENEFITS

If you have medical insurance and would like to receive the maximum benefits available to you from your insurance company, it is important that **YOU** contact your insurance company **PRIOR to your first visit in our office**. We are happy to answer any insurance questions you may have, but please understand, The Natural Care Center can only assist you and **CANNOT** guarantee payment from your insurance company. Please note that it is your responsibility to understand your insurance benefits and coverage. Giving the Natural Care Center all of your insurance information, including any secondary insurances, will help us to **estimate** your benefits to the best of our ability.

ASSIGNMENT OF BENEFITS

I assign all benefits payable to me for my care at the Natural Care Center of Woodbury. I understand that this health care facility will be paid directly by the insurance company or other payer. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered as valid as the original.

GUARANTEE OF PAYMENT

I guarantee payment of all charges incurred for treatment in accordance with the rates and terms of this health care facility. I acknowledge that any exams not covered by insurance are due in full at the time of service. Your initials are a guarantee of payment for all charges incurred for treatment in accordance with the rates and terms of this health care facility. In the event that you have insurance coverage for chiropractic care and your diagnosis, but have an unmet deductible, the clinic may use the insurer’s provided fee schedule to calculate your owed amount and collect a portion, or all, of your fee up front. In the event that payment cannot be made on the account and it is sent to collections, a 35% fee will be added to cover the cost of the collections agency. In the event that the clinic must take legal action against any persons with an outstanding debt, the patient is responsible for all legal and attorney fees.

APPOINTMENT FEES AND CANCELLATION POLICY

We require a **$50 deposit** on all new patient chiropractic, acupuncture and massage appointments to secure your time; naturopathic appointments require **a full amount deposit**. This will be applied to your appointment/account or refunded if insurance pays in full for services. **We require a 48-hour cancellation notification** for our Acupuncture/Oriental Medicine, Massage, and Graston Therapy appointments; **we require one business weeks’ notice for naturopathic appointment cancellation**. Please note**: a $50 fee will be assessed for acupuncture and massage, and a $25 fee for Graston cancellations made with less-than 48-hour notice, and the full deposit amount will be forfeited for naturopathic appointments without proper notice**. Monday appointments must be cancelled on the Thursday prior to your scheduled visit to meet the 48-hour window.

ACUPUNCTURE COVERAGE

Your initial Acupuncture exam may, or may not, be covered. Please check with your insurance carrier about your specific plan and condition to ensure coverage. Even if your health plan covers general Acupuncture, your specific diagnosis may not be covered for treatment. If this is the case, you must pay out-of-pocket, but at a discounted rate for Acupuncture.

FOR ACUPUNCTURE AND CHIROPRACTIC **MEDICARE** PATIENTS

**Acupuncture is not a covered** service since licensed Acupuncturists are not able to credential with Medicare. We are not able to submit claims to them at any time. Also, **Chiropractic examinations and re-examinations are never covered** by Medicare. Your provider must do these to provide you with safe, accurate care even though they are not covered by the insurance. Medicare also **does not cover therapies such as electric muscle stimulation, ultrasound, or traction.** **Please note:** Medicare is your primary insurance carrier; this means that your supplement plan or secondary coverage will not pay the cost of these services even though they cover them. They only pay any additional costs after your primary insurance pays its portion.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

**SIGNATURE (PATIENT/GUARDIAN) PRINT NAME DATE**