HEALTH HISTORY & NEW PATIENT INTAKE FORM

Eastern Shore Natural Health | 2720 E. 50th St. Minneapolis, MN 55417 | 612.721.0036 | www.easternshore.mn

Bold fields are required.

Date		***Emergency contact***	
Name (First, Last, MI)		***Phone #***	
Address		PCP or referring Physician	
City/State/Zip		*Address*	
Age / Date of Birth		*Suite Number*	
Sex		*City/State/Zip*	
Home phone		*Phone number*	
Work phone		*Fax Number*	
Mobile phone		I give my manual therapist permission to consult with my referring health care provider regarding my health and treatment.	Signature
e-Mail			
Medicare Patient?	☐ Yes ☐ No		
How did you hear about us?			

Current Health Information

Please list concerns and check all that apply

What is your Primary Complaint?

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symptoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received

What is your Secondary Concern?

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symptoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received

Any Additional Complaints?

☐ mild ☐ moderate ☐ severe

☐ constant ☐ intermittent

☐ symtoms ⇧ w/activity ☐ symptoms ⇩ w/activity

☐ getting worse ☐ getting better ☐ no change

Treatment received

Have you ever received Manual Therapy before?

☐ Y ☐ N Frequency?

Are you receiving treatment for other conditions?

☐ Y ☐ N If yes, what are they?

Daily activites

Describe how your condition functionaly limits the following activities.

Work

Home/Family

Recreational

Check other activities affected: ☐ sleep ☐ washing ☐ dressing ☐ fitness

How do you reduce stress?

In general, do you prefer to sit or stand?

If you're in acute pain, what is your most comfortable position?

Health History (continued on back)

Are you taking any medications?

List and explain. Include dates and treatment received.

Surgery

Accidents

Major Illnesses

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General

Current | Past | Comments

- ☐ ☐ Headaches
- ☐ ☐ pain
- ☐ ☐ sleep disturbances
- ☐ ☐ fatigue
- ☐ ☐ infections
- ☐ ☐ fever
- ☐ ☐ sinus
- ☐ ☐ other

Skin Conditions

Current | Past | Comments

- ☐ ☐ rashes
- ☐ ☐ athlete's foot
- ☐ ☐ other

Allergies

Current | Past | Comments

- ☐ ☐ scents, oils, lotions
- ☐ ☐ detergents
- ☐ ☐ other

Muscles and Joints

Current | Past | Comments

- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ osteporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones
- ☐ ☐ spinal problems
- ☐ ☐ disc problems
- ☐ ☐ lupus
- ☐ ☐ TMJ, jaw pain
- ☐ ☐ spasms, cramps
- ☐ ☐ sprains, strains
- ☐ ☐ tendonitis, bursitis
- ☐ ☐ stiff or painful joints
- ☐ ☐ weak or sore muscles
- ☐ ☐ neck, shoulder, arm pain
- ☐ ☐ low back, hip, leg pain
- ☐ ☐ other

Nervous System

Current | Past | Comments

- ☐ ☐ head injuries
- ☐ ☐ concussions
- ☐ ☐ dizziness
- ☐ ☐ ringing in ears
- ☐ ☐ loss of memory
- ☐ ☐ confusion
- ☐ ☐ numbness
- ☐ ☐ tingling
- ☐ ☐ sciatica
- ☐ ☐ shooting pain
- ☐ ☐ chronic pain
- ☐ ☐ depression
- ☐ ☐ other

Respiratory & Cardiovascular

Current | Past | Comments

- ☐ ☐ heart disease
- ☐ ☐ blood clots
- ☐ ☐ stroke
- ☐ ☐ lymphedema
- ☐ ☐ high/low blood pressure
- ☐ ☐ irregular heart beat
- ☐ ☐ poor circulation
- ☐ ☐ swollen ankles
- ☐ ☐ varicose veins
- ☐ ☐ chest pain
- ☐ ☐ shortness of breath
- ☐ ☐ asthma
- ☐ ☐ COPD

Cancer/Tumors

Current | Past | Comments

- ☐ ☐ Benign
- ☐ ☐ Malignant

Digestive/Elimination system

Current | Past | Comments

- ☐ ☐ bowel dysfunction
- ☐ ☐ gas, bloating
- ☐ ☐ bladder/kidney dysfunction
- ☐ ☐ abdominal pain
- ☐ ☐ other

Endocrine System

Current | Past | Comments

- ☐ ☐ thyroid dysfunction
- ☐ ☐ diabetes

Reproductive System

Current | Past | Comments

- ☐ ☐ pregnancy
- ☐ ☐ painful menses
- ☐ ☐ fibrotic cysts

Habits

Current | Past | List Frequency

- ☐ ☐ tobacco
- ☐ ☐ alcohol
- ☐ ☐ drugs
- ☐ ☐ coffee
- ☐ ☐ ergogenic aides

Movement & Exercise

Current | Past | List Frequency

- ☐ ☐ Stretching/Yoga
- ☐ ☐ Cardiorespiratory
- ☐ ☐ Strength/Resistance
- ☐ ☐ balance/speed/agility

Contract for Care & Consent for Care

Contract for Care. I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my *manual therapist* and other members of my health care team, and my experience of those suggestions. I agree to participate in the self care program we select. I promise to inform my *manual therapist* any time I feel my well being is threatened or compromised. I expect my *manual therapist* to provide safe and effective treatment.

Consent for Care. It is my choice to receive *bodywork/manual therapy*, and I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my *manual therapist* of any changes in my health.

Signature/Date_____ Signature/Date of parent or guardian if patient is a minor. _____

Eastern Shore Natural Health- Consent for Treatment

Please review each statement and sign at the bottom

___ I understand that the therapeutic bodywork, massage therapy, and health and herbal consultations provided by Eastern Shore Natural Health are done with intent to support my goals of health and wellbeing. I understand that the process of healing naturally takes many forms, including healing crises, where symptoms may worsen before they get better.

___I understand that Eastern Shore Natural Health and its associated practitioners do not diagnose illness, disease or any other physical or mental disorder. The therapists do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear that I use the recommendations made by practitioners at my own discretion and accept sole responsibility for any complications arising from recommendations or therapeutic treatments offered at Eastern Shore Natural Health.

___I understand that services and products offered by Eastern Shore Natural Health are not necessarily approved by the FDA, or endorsed by any doctor. And that any information provided by the therapist is for educational purposes **only**, and is **not** diagnostically prescriptive in nature.

___ I have stated all of my known medical conditions on the Intake Form. I have consulted a medical doctor or licensed medical health care practitioner regarding these conditions and the services I seek.

___ I realize it is solely my responsibility to keep my practitioner updated on any changes in my physical health and I understand that neither Eastern Shore Natural Health and the practitioner shall not be liable should I fail to do so.

___If at any time during a treatment session I experience pain or discomfort of any kind, I agree to inform the practitioner immediately. Your practitioner will take the necessary steps to correct the discomfort or pain. Slight pain or discomfort may be part of the therapeutic effects, but you will be informed if that is the case.

___By signing this release, I hereby waive and release Eastern Shore Natural Health, and the independent practitioners, from all liability relating to any of the holistic health services provided.

Due to the nature of meridian and holistic approaches the body, including Yogic therapies, acupuncture, massage, shiatsu, Reiki, cranial sacral work and other treatments of this type, the client may sometimes experience what is known as a " healing crisis". A healing crisis may include both physical and mental\emotional manifestations, where temporary symptoms will become temporarily worse as the body begins to heal itself. Transformations of your mental and emotional state including personal perceptions of your life and your relationships to others, may cause challenges, pain, injury and you agree to assume all the risks associated with services and guidance received.

In addition, I agree to indemnify them from any and all claims, demands, fines, suits, actions, orders, or damages of any kind which may arise or result out of a healing crisis.

I have received and read the Medical Waiver Form and agree to the policies therein.
I have been offered a copy of the Health and Information Act (HIPAA) and understand my information is confidential except with written consent or under a court's jurisdiction.

I agree to pay the cancellation fee (price of service) for any appointment I miss or fail to cancel or reschedule within 48 hours of set appointment.

Name: _____

Signature: _____ Date: _____

EASTERN SHORE
Natural Health

Additional Consent Form

In the course of treating the body holistically, it may be necessary given symptoms or dysfunctions present for your practitioner to palpate (therapeutically touch) and treat sensitive areas. All techniques use a gentle manual movement of the soft tissues to help restore function to systems of the body (arterial, visceral, lymphatic, venous, dural, periosteal, and nervous systems). Benefits include stress reduction, circulation enhancement, increased relaxation, and relief from muscular tension, soreness, and pain. Some of the pressure points used for this technique are located on sensitive areas like the chest, ribs and groin. In men and women the region around the groin and buttocks, as well as the treatment of the pelvic floor may be deemed therapeutically necessary to help maximize the benefits you receive from your treatments. Pelvic floor work done at Eastern Shore by any of the practitioners is done externally, and mostly with a barrier like a towel to make the techniques as comfortable and non-invasive feeling as possible. Additionally, in women palpation and treatment of areas around and through the breast tissue, as well as into and on the ribs may also been warranted.

Each patient has their own comfort level and boundaries, please indicate your preference below.

____Yes, I am comfortable receiving the full treatment, including on the areas mentioned above

____No, I am not comfortable receiving treatment in the areas mentioned above. Note: this may limit the effectiveness of some treatments

Name: _____

Signature: _____

Date: _____