BURTIS CHIROPRACTIC CENTER

Today's Date: _____

NUTRITION & FUNCTIONAL MEDICINE INTAKE

First Name: _____ Middle Name:_____ Last Name:_____

Address:_____

City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____/_____/_____ Social Security #: _____-_____-_____

Gender: [male] or [female]

MARITAL STATUS: Single / Married / Divorced / Widowed / Other

Spouse's Name: _____ Number of Children: _____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail / Text Message
1day before appointment or 2 hours before appointment

Cell Phone Carrier (Circle one): Verizon / Sprint / AT & T / Virgin Mobile / Other _____

EMERGENCY CONTACT
Name: _____
Relationship: _____
Phone: _____

HOW DID YOU FIND OUT ABOUT OUR OFFICE?
Google Search [ ] Referral [ ] Who referred you?_____
Facebook/Instagram [ ] Advertisement [ ]
Drove By [ ] Other [ ] Please specify: _____

EMPLOYMENT

Regular Work Status: (*circle one*)
EMPLOYED / PART-TIME EMPLOYED / RETIRED / UNEMPLOYED / FULL-TIME STUDENT / PART-TIME STUDENT

Employer/School Name: _____
Employer City and State: _____
Occupation: _____ Employer Phone #:_____

******Current Burtis Chiropractic patients start here******

Reason for Blood Draw

Which blood draw are you getting: [ ] Wellness Female [ ] Wellness Male [ ] Thyroid Panel [ ] Cardio Panel
[ ] Bredesen/Alzheimer's [ ] Other _____.

What is your main interest for this blood draw/ What are you hoping to learn from your results?

_____
_____
_____
_____
_____

Please list any health conditions that you have been treated for in the last year: (condition, cause, current/resolved)

_____
_____
_____
_____

FEMALE ONLY

Are you pregnant, or have had any signs of pregnancy? [YES] or [NO]

First date of your last cycle: _____.

PERSONAL INCIDENT HISTORY

Broken any bones? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Had any major sprains or strains? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been hospitalized? [YES] or [NO]

Briefly explain: _____

Had surgery? [YES] or [NO]

Briefly explain: _____

Been in an Auto Accident? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been Struck Unconscious? [YES] or [NO]

If yes, did you get professional treatment? [YES] or [NO]

Briefly explain: _____

Been diagnosed with an eating disorder? [YES] or [NO]

Briefly explain: _____

Had a stroke? [YES] or [NO]

Briefly explain: _____

FAMILY HEALTH HISTORY

List diagnosed health conditions and untimely deaths of your blood-related family members:
(*Condition and relationship to you*) (ex: arthritis, cancer, diabetes, heart disease, high blood pressure)

FAMILY MEDICAL HISTORY (RECORD ONE DIAGNOSIS IN YOUR FAMILY HISTORY AND THE AFFECTED RELATIVE)

Diagnosis	Father	Mother	Sibling	Son	Daughter		

SOCIAL HISTORY AND LIFE CHOICES

Alcohol:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Diet Food Products:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Energy Products & Over-the-Counter Stimulants:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Caffeine Drinks & Products:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Soft Drinks:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Water:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Fresh & Homemade Foods:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Preprocessed, Packaged, & Restaurant Food:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Exercise:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Drugs:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Tobacco:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never
Vitamins/Supplements:	[ ] Daily [ ] Weekly [ ] Occasionally [ ] Never

BREDESEN PROTOCOL PATIENTS ONLY

Caretaker Information

Caretaker Name: _____

Caretaker Phone Number: _____.

Caretaker Address: _____

Does your caretaker live with you? YES NO

If NO, then how often is your caretaker around? _____

Please list any other blood draws or genetic testing you have had done:

_____

_____

_____

_____

_____

Please list any Medications that you are currently taking:

_____

_____

_____

_____

_____

_____

_____

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

[ ] Allergies
[ ] Alcoholism
[ ] Anemia
[ ] Arteriosclerosis
[ ] Arthritis
[ ] Asthma
[ ] Autoimmune Disease
[ ] Back Pain
[ ] Bleeding Disorders
[ ] Breast Lump
[ ] Bronchitis
[ ] Bruise Easily
[ ] Cancer
[ ] Cataracts
[ ] Chest Pain
[ ] CHF (congestive heart disease)
[ ] Cold Extremities
[ ] Constipation
[ ] COPD/emphysema
[ ] CVA (stroke/TIA)
[ ] Cramps
[ ] Dementia/Alzheimer's
[ ] Depression
[ ] Diabetes
[ ] Digestion Problems
[ ] Diagnosed emotional/ mental disorders
[ ] Dizziness
[ ] Epilepsy
[ ] Excessive Menstruation
[ ] Eye Pain or Difficulties
[ ] Fatigue
[ ] Frequent Urination
[ ] Gallbladder disease/ stones
[ ] Glaucoma
[ ] Gout
[ ] Headache
[ ] Hemorrhoids
[ ] High Blood Pressure
[ ] Hot Flashes
[ ] Irregular Heart Beat
[ ] Irregular Menstrual Cycle
[ ] Kidney Infection
[ ] Kidney Stones
[ ] Liver disease/cirrhosis
[ ] Loss of Memory
[ ] Loss of Balance
[ ] Loss of Smell
[ ] Loss of Taste
[ ] Lung disease
[ ] Macular Degeneration
[ ] Migraines
[ ] Nosebleeds
[ ] Pacemaker
[ ] Parkinson's
[ ] Polio
[ ] Poor Posture
[ ] Prostate Trouble
[ ] Retinal Disease
[ ] Sciatica
[ ] Seizures
[ ] Shortness of Breath
[ ] Sinus Infection
[ ] Sleep Problems/Insomnia
[ ] Skin Sensitivity
[ ] Spinal Curvatures
[ ] Stroke
[ ] Swelling of Ankles
[ ] Swollen Joints
[ ] Thyroid Condition
[ ] Tuberculosis
[ ] Ulcers
[ ] Varicose Veins
[ ] Venereal Disease(STD)
[ ] Other:
_____
_____
_____

AUTHORIZATION

I certify that I'm the patient or legal guardian listed below. I understand the information given on this intake form is true and accurate to the best of my knowledge. I consent to the collection and use of that information to this office. I authorize this office and its staff to examine and treat my condition as the doctors see fit. I hereby authorize the doctor to release all information necessary to any insurance company, attorney, or adjuster for the purpose of claim reimbursement of charges incurred by me. I grant the use of my signed statement of authorization with my signature for required insurance submissions. I understand and agree that all services rendered to me will be charged to me, and I'm responsible for payment in full for all services unless other arrangements have been made with the business manager. If my account is not paid within 90 days of the date of service and no financial arrangements have been made, I will be responsible for any expense incurred in collecting my account. If my bill becomes delinquent and you have to employ an outside agent to collect the bill, all collection expenses will become my responsibility. I understand and agree that health/accident insurance policies are an arrangement between an insurance carrier and me.

☐ I agree with this statement of authorization.

If signing for your child:

☐ I hereby, authorize Dr. Scott Burtis to administer treatment as he so deems necessary, even in the absence of a legal guardian to my child. (In cases where another family member/friend might bring the patient into our office.)

Name of Patient (Please Print): _____

Patient's/Guardian's Signature: _____ Date: _____