IN SYNC HEALTH
WHOLISTIC KINESIOLGY

New Patient Paperwork - In Sync Health, LLC

11005 Spain Rd. NE, Suite 5 / Albuquerque, NM 87111 / (505) 463-4143
3600 Cerrillos Rd, Unit 501/ Santa Fe, NM 87507

Name: _____ Date: _____

Address: _____ Home Phone: _____

_____ Office/ Cell Phone: _____

E-mail Address: _____

PERSONAL HISTORY

Date of Birth: _____Current age: _____ Height: _____Weight:_____

Marital Status: Single _____ Married _____ Divorced _____ Widowed _____

Occupation: _____FT: _____ PT: _____ Hrs. per Wk: _____

Spouse's Name: ___ _____ Occupation: _____

Number and Ages of: Siblings:_____

Children: _____

Grandchildren: _____

Family members now deceased and cause of death:_____

_____

_____

Parent's marital status during childhood: _____

Where did you grow up? _____

List any significant events, accidents, traumas and the date they occurred:

_____

_____

_____

List any medications you are currently taking: _____

_____

_____

Do you Smoke? Yes ____ No ____ If yes, how often/ for how long: _____

Do you drink alcohol? Yes ____ No ____

If yes, what types and how often: _____

Do you use stimulants (Coffee, tea drugs, etc.)? Yes ____ No ____

If yes, what types and how much: _____

Physician's Name: _____(MD, DO, DC, OMD) Phone: _____

Who referred you to In Sync Health & Design, LLC? _____

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MEDICAL HISTORY

Date of last Physical Exam: _____ Blood Work: _____ Urinalysis: _____

Have you ever had surgery: Yes _____ No _____

If yes, Year: _____ Please describe: _____

_____

Please indicate below by marking as follows: 1 = present condition 2 = previous condition

_____ Headaches	_____ Disc Problems	_____ Ulcers
_____ Dizziness	_____ Hip Pain	_____ Diarrhea
_____ Neck Pain	_____ Leg Pain	_____ Constipation
_____ Lightheadedness upon standing	_____ Knee Pain	_____ Prostate Problems
_____ Neck Tightness	_____ Ankle	_____ Impotence
_____ Shoulder Tightness	_____ Foot Pain	_____ Implanted Virus
_____ Numbness & Tingling	_____ Arthritis	_____ Urinary Tract Problems
_____ Elbow Pain	_____ Tendonitis/Bursitis	_____ High Cholesterol
_____ Upper Back Pain	_____ Fatigue	_____ High Blood Pressure
_____ Mid- Back Pain	_____ Frequent Colds	_____ Heart Condition
_____ Low-Back Pain	_____ Asthma/Bronchitis	_____ Diabetes Type I
_____ Back Stiffness	_____ Allergies	_____ Diabetes Type II
_____ Blood Clots	_____ High Stress	_____ Varicose Veins

Other _____

_____

Please list below any family members who have had the following:

Heart Disease:_____

Stroke: _____

Kidney Disease: _____

Diabetes: _____

Liver Disease: _____

Cancer:_____

High Blood Pressure: _____

Other:_____

Do you have skin rashes, irritations, or open sores? Yes ____ No ____

If yes, please describe: _____

Do you exercise regularly or participate in any sports? Yes ____ No ____

If yes, how often/ what kind: _____

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Have you had any problems keeping weight off/on in the past or present? Yes ____ No ____

If yes, what do you feel is the most likely cause? Improper diet: ____ Lack of or inconsistent exercise: ____

Mental/emotional stress: ____ Other: _____

Any particular food cravings_____

Which, if any, of the following medications are you presently taking:

_____ Antacids
_____ Antidepressants
_____ Aspirin/Tylenol/Ibuprofen
_____ Anti-inflammatories
_____ Antibiotics/Antifungal
_____ Anti-diabetic/Insulin
_____ Chemotherapy
_____ Heart Medications
_____ High Blood Pressure Medication
_____ Hormones
_____ Oral Contraceptives
_____ Pain Killers
_____ Relaxants/Sleeping Pills
_____ Thyroid Medication
_____ Ulcer Medication
_____ Other _____

Please list any vitamin/mineral supplementation you are presently taking: _____
_____

Have you ever had a professional therapeutic massage? Yes ____ No ____ If yes, how long ago? _____

Do you wear contact lenses? Yes ____ No ____

Any problems with: Sleep ____ Dreaming ____ Appetite ____ Digestion ____
If yes, please elaborate: _____

_____

REASONS FOR SESSION

What is the primary reason for your appointment today?
Briefly describe any symptoms and how long you have had them.

_____
_____
_____
_____

Has your condition been professionally diagnosed and, if so, by whom?

_____
_____

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Based upon your own experience with the condition, share any additional information or personal insights which you feel might be helpful.

_____
_____

What results would you like to see from this initial session? _____
_____
_____

RESULTS TRACKING RATIO

Using a rating scale from 1 - 10 (highest), please rate the degree of dis-ease, pain or discomfort.

Before session _____ Where located? _____

UNDERSTANDING AND CONSENT

I understand that muscle testing accesses my innate bodily intelligence – that part of me which governs my heart rate, breathing and other bodily functions that occur without my conscious awareness. Any information revealed by my innate bodily intelligence is for educational purposes and is to be weighed by me and discussed with my medical doctor(s) as needed and is not to be misconstrued as a medical diagnosis.

I understand that the practitioner does not diagnose illness, disease or any other physical or mental disorder. As such, the practitioner does not prescribe medical treatment or pharmaceuticals, nor does the practitioner perform any spinal manipulations. It has been made very clear to me that this energy/body work is not a substitute for medical examination and /or diagnosis and it is recommended that I see a physician for any physical ailment that I might have.

Because it is important for this practitioner to be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the practitioner updated on my physical health.

I consciously consent to this and subsequent sessions should I choose to continue treatment.

****AS A COURTESY TO ALL CLIENTS, A 24-48 HR NOTICE IS REQUIRED FOR ALL CANCELLATIONS. IF APPOINTMENT IS ON A MONDAY, CANCELLATION IS REQUIRED BY FRIDAY, 12 NOON. IF NOTICE IS NOT RECEIVED IN THIS TIME FRAME A $49 FEE WILL BE CHARGED TO YOUR ACCOUNT. ALSO RETURNS ON SUPPLEMENTS CAN ONLY OCCUR ON FULL UNOPENED BOTTLES WITHIN 14 DAYS OF LAST VISIT.**

THANKS FOR YOUR CONSIDERATION!**

Signature: _____ Date: _____
Witnessed: _____ Date: _____