Rapha Wellness Center

Nutritional Response Testing

New Patient Information Form

Please complete all questions, please ask the receptionist if you have any inquiries. If something does not apply to you, please write 'NA' **PLEASE PRINT USING BLUE OR BLACK INK.**

Name: _____ Date: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Address: _____ Apt#: _____ City: _____

State: _____ Zip: _____ Email Address: _____

Birthdate: _____ Sex: M/F Marital Status: S/M/W/D

Employer: _____ Occupation: _____

Whom may we thank for referring you: _____

IN CASE OF EMERGENCY, CONTACT: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Are you currently under the care of a physician or other health care professional? (If yes please give name and date of last visit): _____

_____

List any surgery or operations with approx. dates: _____

_____

Do you smoke, drink coffee, soda, or alcohol? (If yes, indicate how much): Cigarettes: _____ packs/day

Coffee: _____ cups/day Soda: _____ cans or oz Alcohol: _____ drinks/week

What is your current Stress Level?: ____Low ____Medium ____High Reason: _____

How often do you exercise?: _____None _____1-2 times/week _____3-5 times/week _____6-7 times/week

How many bowel movements do you have?: _____ per day/week (circle one)

I understand that all medical records are the property of Rapha Wellness Center and he original shall remain in their office as required by Florida Low. Should I need copies of said records, an appropriate fee may be assessed for the cost of making such copies as provided by Board of Chiropractic Medicine Rule 64B2-17.0055.

I authorize Raph a Wellness Center to send me written correspondence, including their monthly health newsletter, notices of classes, specials, hours changes, and other health information by email when appropriate. I authorize my name to appear on the New Patient Referral Board if I refer a new patient to this office.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Rapha Wellness Center

Wellness Rooted in Nature, Guided by Rapha

Patient Name: _____

Metabolic Health Form

MEDICAL HISTORY

01 Do you or any family member have/had any of the following? Please put an "**X**" for you, and "**F**" for family

- ☐ Depression
- ☐ Heart Attack
- ☐ Diabetes
- ☐ Thyroid Disease
- ☐ Gallbladder Disease
- ☐ Kidney Disease
- ☐ Stroke
- ☐ Fatigue
- ☐ Knee Pain
- ☐ Brain Fog
- ☐ Hypoglycemia
- ☐ Anemia
- ☐ Cancer
- ☐ High Blood Pressure
- ☐ Intestine Problems
- ☐ Shortness of Breath
- ☐ High Cholesterol
- ☐ Headache
- ☐ Poor Sleep
- ☐ Dizziness
- ☐ Arthritis
- ☐ Weight Gain
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Shoulder Pain

02 Is there a certain time of day any of these problems are better or worse?

_____

_____

03 Main Concerns:

1. _____ 3. _____
2. _____ 4. _____

04 How long have you had this/these concerns?

_____

_____

05 What effect does this have on your body functions or quality of life?

_____

_____

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Patient Name: _____

06 What would be different or better without this/these concerns?

- ☐ Diminished Stress
- ☐ Family
- ☐ Confidence
- ☐ Work
- ☐ Improved Self-Esteem
- ☐ Sleep
- ☐ More Energy
- ☐ Outlook

07 Are you taking any medications/supplements? If yes, please list.

_____

_____

08 Are you pregnant? _____ How many children? _____ How many Pregnancies? _____
Are you breast feeding? _____

09 Any known allergies? If yes, please list.

_____

_____

10 How have you addressed weight management in the past?

☐ Medications ☐ Vitamins ☐ Exercise ☐ Diet and Nutrition ☐ Other: _____

11 How did the previous methods work for you?

_____

_____

12 What potential barriers do you foresee that would prevent the change you are looking for?

_____

_____

13 Do you feel it possible to eliminate or prevent these potential barriers?

_____

14 What outcome would you like to see for this to be a success for you?

_____

_____

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Patient Name: _____

15 Please rate on a scale of 1-10 (1 being the lowest and 10 being the highest)

Energy Level	1	2	3	4	5	6	7	8	9	10
Quality of Sleep	1	2	3	4	5	6	7	8	9	10
How Important It Is For You To Resolve Your Health Concerns	1	2	3	4	5	6	7	8	9	10
What Is Your Level of Preparedness To Make Necessary Lifestyle Changes To Achieve Your Goals?	1	2	3	4	5	6	7	8	9	10

I AM INTERESTED IN:

- ☐ Weight Loss
- ☐ Inch Loss
- ☐ Anti-Aging
- ☐ Metabolism Support
- ☐ Long-Term Results

PERMISSION AND AUTHORIZATION

Dietary guidelines, nutritional supplements, red light therapy and whole body vibration are used at CARE Natural Wellness Center (CNWC) to enhance weight management and overall metabolic health. It is not a substitute for medical treatment and is not be used to diagnose or treat any medical condition. Consult your Medical Provider (including doctor/ physician, nurse, physician's assistant, or any other health professional) before using any of the above therapies, especially if you have any pre-existing health concerns. Individual results may vary, and no guarantees are made regarding the effectiveness of treatment.

You are acknowledging that you are participating voluntarily in using our services and information, and you alone are solely and personally responsible for your choices, actions and results. I also understand that my health insurance will not be billed for the natural therapies offered at CNWC.

I have read and understand the foregoing and this permission form applies to subsequent visits and consultations.

Patient's Signature _____ Date _____

Or Guardian Signature _____ Date _____

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Quality of Life Survey

Name: _____ **Date:** _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Emergency Room
- ☐ Routine Medical
- ☐ Exercise
- ☐ Nutrition/Diet
- ☐ Holistic Care
- ☐ Vitamins
- ☐ Chiropractic
- ☐ Other (please specify): _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Some Results
- ☐ Great Results
- ☐ Nothing Changed
- ☐ Did Not Get Worse
- ☐ Did Not Work Very Long
- ☐ Still Trying
- ☐ Confused

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ Haven't Noticed Any Problem
- ☐ They Tell Me To Do Something
- ☐ People Avoid Me

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Patient Name: _____

04 **What are you afraid this might be (or beginning) to affect (or will affect)?**

- ☐ Job
- ☐ Kids
- ☐ Future Ability
- ☐ Marriage
- ☐ Self-Esteem
- ☐ Sleep
- ☐ Time
- ☐ Finances
- ☐ Freedom

05 **Are there health conditions you are afraid this might turn into?**

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 **How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:**

_____

_____

_____

_____

07 **What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:**

1. _____
2. _____
3. _____

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Patient Name: _____

08 **What are you most concerned with regarding your problem?**

_____

_____

_____

_____

09 **Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.**

_____

_____

_____

_____

10 **What would be different/better without this problem? Please be specific.**

_____

_____

11 **What do you desire most to get from working with us?**

_____

_____

12 **What would that mean to you?**

_____

_____

Rapha Wellness Center

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Patient Name: _____

WELLNESS EVALUATION

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help our doctors determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:

- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:

- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:

- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:

- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:

- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:

- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:

- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:

- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:

- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL _____

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Name: _____ **Date:** _____

DIETARY INTAKE FORM

Please record your dietary intake for the 2 days prior to your appointment.
(Record everything you eat and drink, including snacks/gum, and be specific.)

Day 1:
Breakfast:

Lunch:

Dinner:

Day 2:
Breakfast:

Lunch:

Dinner: