



NUTRITION & FUNCTIONAL MEDICINE INTAKE

Today's Date: _____

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 Maiden Name: _____

Spouse's Name: _____ Number of Children: _____

I consent to receive appointment reminders by email and text message: YES [] NO []

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 #: _____

REASON FOR BLOOD DRAW

What are your health goals 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: _____

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 | | |
|-----------|--------|--------|---------|-----|----------|--|--|
| | | | | | | | |
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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 / ALZHEIMER'S 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 and supplements you are currently taking:

HEALTH PROBLEMS AND CONCERNS

Please check all that you have had or currently have.

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

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 understand that if my account is inactive for 18 months any credit balance under the amount of \$20.00 will not be reimbursed.

By signing below, 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: _____

ONLINE SUPPLEMENT ORDERS THROUGH NUTRIDYN

Do we have your permission to set up an online account for you through our supplement provider under Burtis Chiropractic Center? (YES) or (NO)

(Allowing us to do so will simplify the process of ordering supplements at a discounted price online should Dr. Burtis recommend them for you.)

AUTHORIZATION

Name of Patient (Please Print): _____

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

Email: _____