

Carrico Muscle Therapy & Naturopathic Center

CONFIDENTIAL INFORMATION

Welcome. We want to make your appointment as pleasant and comfortable as possible.
If at any time you have questions regarding your visit, please let us know.

First Name		Last Name		Primary Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home		Secondary Phone <input type="checkbox"/> Cell <input type="checkbox"/> Home	
Referred by		Address		City		State	ZIP
Birth Month/Day	Sex <input type="radio"/> F <input type="radio"/> M	Last Four Digits of SS#	Occupation	Have you ever visited a Naturopath (natural Health) before? <input type="checkbox"/> Yes Have you ever visited a massage therapist before? <input type="checkbox"/> No			
Are you taking medication? <input type="radio"/> No <input type="radio"/> Yes. Describe:							
Would you like to receive promotional emails such as discounts? If yes, please print your email address below.							

Do you have a history of the following?

<ul style="list-style-type: none"> <input type="radio"/> accident <input type="radio"/> neck pain <input type="radio"/> whiplash <input type="radio"/> headaches <input type="radio"/> disk problems <input type="radio"/> mid back pain <input type="radio"/> low back pain <input type="radio"/> joint ache <input type="radio"/> decreased range of motion <input type="radio"/> broken bones 	<ul style="list-style-type: none"> <input type="radio"/> sprains <input type="radio"/> seizures <input type="radio"/> abdominal pain <input type="radio"/> nervous tension <input type="radio"/> arthritis, bursitis or gout <input type="radio"/> allergies to oils or perfumes <input type="radio"/> wear contacts or other prosthesis <input type="radio"/> surgery 	<ul style="list-style-type: none"> <input type="radio"/> breast augmentation <input type="radio"/> diabetes <input type="radio"/> varicose veins <input type="radio"/> high blood pressure <input type="radio"/> stroke <input type="radio"/> heart attack <input type="radio"/> cancer <input type="radio"/> colitis <input type="radio"/> HIV
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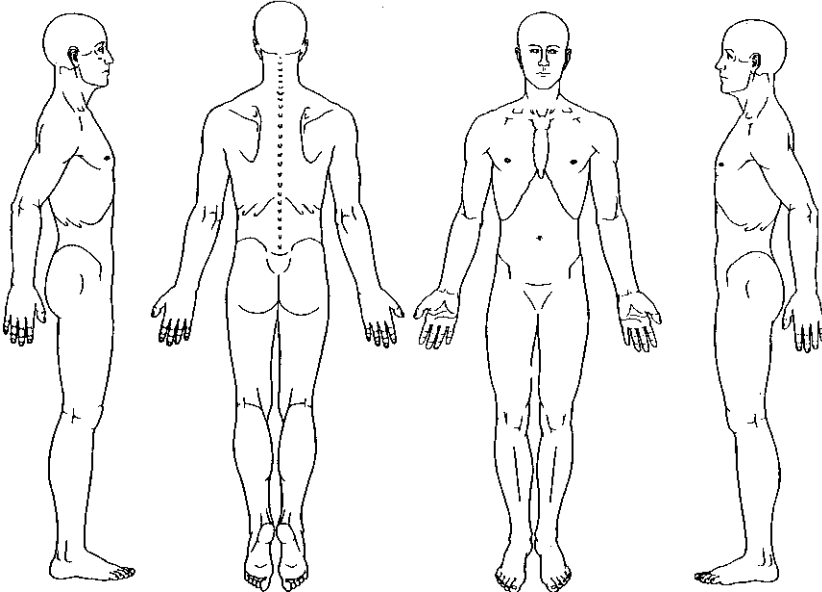
Do you have any of the following today?

<ul style="list-style-type: none"> <input type="radio"/> sunburn <input type="radio"/> severe pain <input type="radio"/> open cuts <input type="radio"/> poison ivy <input type="radio"/> bruises <input type="radio"/> pregnancy 	<ul style="list-style-type: none"> <input type="radio"/> inflammation <input type="radio"/> headache <input type="radio"/> irritated skin rash <input type="radio"/> cold/flu <input type="radio"/> burns <input type="radio"/> other _____
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What is the reason for your visit to our office today?

<ul style="list-style-type: none"> <input type="radio"/> Life Style Analyze <input type="radio"/> Muscular Skeletal Assessment <input type="radio"/> Medical Massage <input type="radio"/> Homeopathy and Herbology <input type="radio"/> General Relaxation Massage <input type="radio"/> Foot Reflexology <input type="radio"/> Acupressure <input type="radio"/> Cranial Sacral Therapy <input type="radio"/> Deep Tissue Therapy <input type="radio"/> Sports Massage <input type="radio"/> Naturopathic Counseling
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Please indicate with an (X), the places you are feeling discomfort



Please circle the number below that indicates the level of pain you are experiencing.

1	2	3	4	5	6	7	8	9	10
Less Pain							More Pain		

Please read the following and sign below:

- I understand that this service is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

DATE: ____/____/____

Signature: _____

Please fill out the information listed below if an insurance claim is to be filed.

Policy/Group # _____ Claim # _____

Insurance Co _____

Address _____

Contact Agent _____ Phone # _____

Date of Accident _____

Referring Doctor _____

Letter of Prescription Attached: Yes No On file

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of any information acquired in the course of my examination & treatment to insurance carrier.

Date _____ Signature _____ Do you have
cardiovascular or heart disease?

Yes No

Fill out this form if you are here for Naturopathic Consultation and or Lifestyle Analyze

Traditional Naturopaths teaches clients how to live a healthy, holistic lifestyle. Traditional Naturopaths are not medical doctors and neither practice Western Medicine. Instead, Traditional Naturopaths perform lifestyle analyzes educating clients on how to assist their own healing system. Other practices among Traditional Naturopaths are but not limited to: Food intake, herbology, homeopathy, vitamins and minerals, fresh air, massage, acupressure, cranial sacral therapy, stress management, and exercise.

Traditional naturopaths follow these principles:

1. Do no harm: Traditional Naturopaths do not use harmful, artificial substances such as drugs and pharmaceuticals; nor do they use invasive procedures, such as surgery.
2. Recognize the healing power of nature: Traditional Naturopaths understand the body's innate capacity for self-healing. They educate clients in creating external and internal environments conducive to healing.
3. Find and eliminate the cause of poor health: Traditional Naturopaths help clients evaluate lifestyle choices to identify both the cause of a problem and how to correct it.
4. Teach health: Naturopaths teach clients how to achieve and maintain good health. They empower clients, enabling them to participate in the process of staying well.

I understand that all information shared in this visit is confidential and for educational purposes only and that it is not intended to replace your general medical practitioner.

Signed _____ Date _____

What is the reason for your visit today? Explain about your concerns.					
Age	Height	Weight	Blood Pressure <input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low	Blood Type (circle one) A - O - B - AB Rh + or -	Cholesterol Levels <input type="checkbox"/> Normal <input type="checkbox"/> High <input type="checkbox"/> Low
Diet (What do you eat? What do you know about certain foods?)					
Fresh Fruits <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Fresh Vegetables <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Red Meat <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Poultry <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Fish <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Eggs <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Cereal <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Bread <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Rice <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Beans <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Coffee <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Tea <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Water <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Fruit Juice <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Sweets <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Milk <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Alcoholic Drinks <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Soda <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Do you know what food additives are? <input type="checkbox"/> Yes <input type="checkbox"/> No		Are you currently taking any vitamins or herbal supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you eat organic or whole grains? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have food allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No		Fast foods? <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7		Pasta <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	
Do you drink cold fluids such as ice water during your meals? <input type="checkbox"/> Yes <input type="checkbox"/> No		How many meals do you eat a day? <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4		Do you watch TV during meals? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Naturopathic Consultation and or Lifestyle Analyze Continuing

Clients Name		
Physical Activities and Assessment		
Sports <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Aerobics <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Walking <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7
Stretching <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Yoga (India exercise) <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Tai Chi- (Chinese) <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7
Chi Gong (Chinese) <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Weightlifting <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7	Dancing <input type="checkbox"/> Yes <input type="checkbox"/> None <input type="checkbox"/> Daily Times per week <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7
Flexibility <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent	Endurance <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent	Strength <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent
Balance <input type="checkbox"/> Poor <input type="checkbox"/> Good <input type="checkbox"/> Excellent	Do you get easily tired when exercising? <input type="checkbox"/> Yes <input type="checkbox"/> No	What time of the day would you be more prone to exercise? <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening

Stress Management Assessment		
I am satisfied with my life <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I am happy with the way I look <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I have a good relationship with my family <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What
I am happy with my job/work <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I have supportive friends <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	My health is good <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What
I feel hopelessness about the future <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I feel worthless <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I can easily become upset or angry <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What
I'm always thinking about future events <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I consider myself a relaxed person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I am a very hyperactive person <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What
I meditate to relax <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I sleep well at night <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What	I am sexually active <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Some What

Lifestyle Habits		
Smoking <input type="checkbox"/> Never <input type="checkbox"/> Currently <input type="checkbox"/> In the past	Alcohol Use <input type="checkbox"/> Never <input type="checkbox"/> Currently <input type="checkbox"/> In the past	Narcotics <input type="checkbox"/> Never <input type="checkbox"/> Currently <input type="checkbox"/> In the past

Health Assessment		
Last received vaccination <input type="checkbox"/> Never <input type="checkbox"/> Yearly <input type="checkbox"/> In the past	Do you have any allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you bruise easily? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you suffered major trauma in your life? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from constipation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from diarrhea? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from acid reflex? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from muscular pain? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from joint pain? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you suffer from skin rashes? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you on disability? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you take medications? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had surgeries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had cancer? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have breathing problems? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been part of a military war? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have cardiovascular or heart disease? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you suffer from depression? <input type="checkbox"/> Yes <input type="checkbox"/> No

Do you suffer from any other health condition not listed above? If yes, explain

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