Natural Treatments For Brain & Body

Steven H. Senart, DC, LMT mt0012099, D.PSC; Teri A. Stokes, ND, LMT mt002656 D.PSc
64 Bracketts Way, Suite 9, Blairsville, GA 30512; 706-781-4048

RE: New Patient Paperwork Package

To Our New Clients:

Please complete the attached paperwork to the best of your knowledge. Bring these papers with you for your initial consultation with Teri Stokes ND and Steven Senart DC. Your initial new patient consultation will consist of approximately 15 minutes. If you should have any recent x-rays, MRI or other medical records you feel is pertinent for Dr. Steven Senart to review, please bring them with you on this first visit.

Forms to be filled out by our new patients:

A. Patient New History
B. List All Past Surgeries
C. Pain Location
D. Review of Systems (Medical History)
E. Closed Head Injury Questionnaire
F. Dental History Form
G. Photographic Release / Consent to Treatment of a Minor

We are here to serve your health care needs with multiple advanced healing modalities. .

We look forward to meeting you and assisting you with your health care needs.

Sincerely,

Steven H. Senart, DC, LMT mt0012099, D.PSC; Teri A. Stokes, ND, LMT mt002656 D.PSc

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New Patient History Form

Last Name _____ First Name: _____BirthDate: ____/___/____
Address _____ Apt# _____
City: _____ State: _____ Zip: _____
Phone(H) _____ (W) _____ (Cell) _____
Spouse's Name: _____ E-Mail Address: _____
Your occupation: _____ Employer: _____
Employer Address: _____
Have you been to another doctor for this problem? Y N Who? _____
Who referred you to our office? _____

First Complaint: _____ No. ___

- Date Symptoms first appeared _____/_____/_____
- Did it begin Accident Gradually Suddenly Progressive over time
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _____
- What makes the symptoms increase? _____
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand Fingers
- Hip Knee Leg Foot Toes Head Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
    - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity : Please put a line on the scale below describing the intensity of your pain

No Pain _____ Unbearable Pain

Second Complaint: _____ No. ___

- Date Symptoms first appeared _____/_____/_____
- Did it begin Accident Gradually Suddenly Progressive over time
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _____
- What makes the symptoms increase? _____
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand Fingers
- Hip Knee Leg Foot Toes Head Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
    - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain _____ Unbearable Pain

CLIENTS SIGNATURE _____ DATE _____

Third Complaint: _____ No. ___

- Date Symptoms first appeared _____/_____/_____
- Did it begin Accident Gradually Suddenly Progressive over time
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _____
- What makes the symptoms increase? _____
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand Fingers
- Hip Knee Leg Foot Toes Head Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
    - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain _____ **Unbearable Pain**

Fourth Complaint: _____ No. ___

- Date Symptoms first appeared _____/_____/_____
- Did it begin Accident Gradually Suddenly Progressive over time
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _____
- What makes the symptoms increase? _____
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand Fingers
- Hip Knee Leg Foot Toes Head Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
    - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain _____ **Unbearable Pain**

Fifth Complaint: _____ No. ___

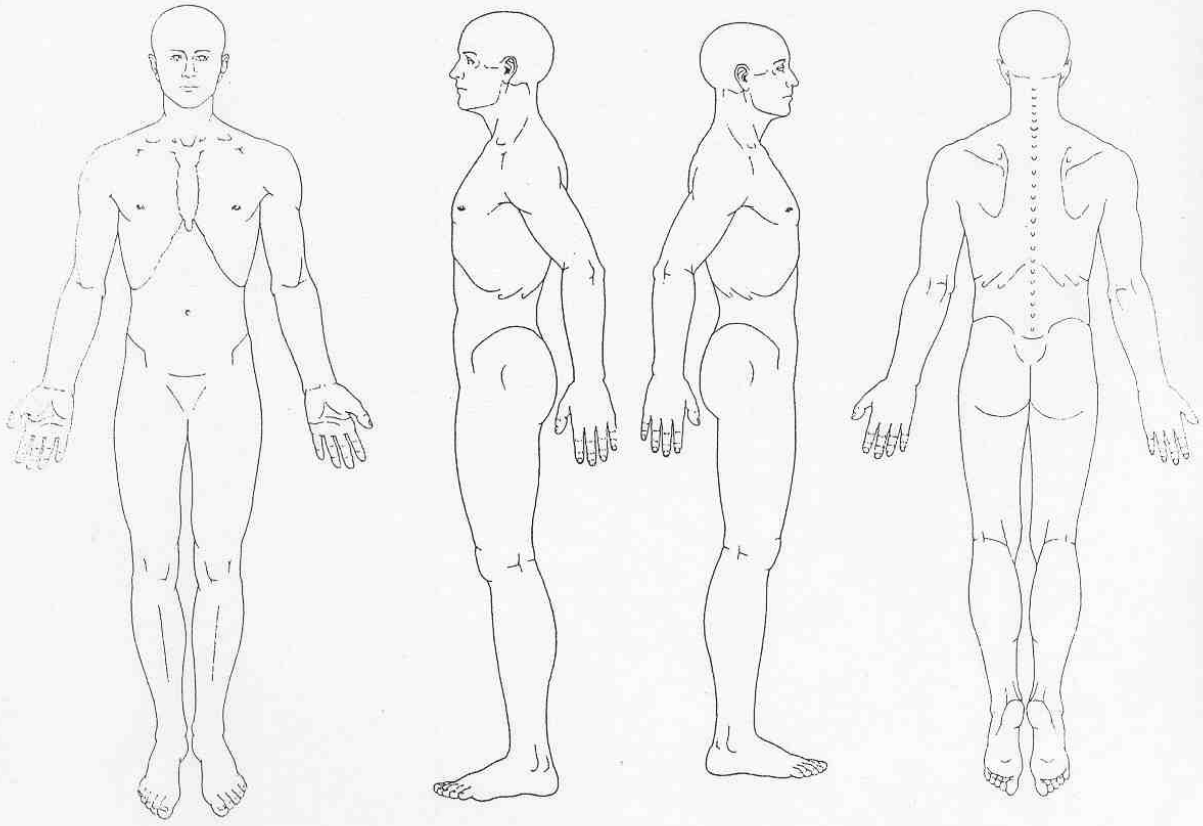
- Date Symptoms first appeared _____/_____/_____
- Did it begin Accident Gradually Suddenly Progressive over time
- Pain Value 0 = no pain, 10 = max pain; Current Pain Level 0-10 _____
- What makes the symptoms increase? _____
- Type of pain Sharp Dull Ache Burn Throb Discomfort
- Does the Pain Radiate into Shoulder Arm Elbow Hand Fingers
- Hip Knee Leg Foot Toes Head Chest Abdomen
- Do you experience numbness or tingling? YES NO
- How often do you experience these symptoms?
    - 100% 75% 66% 50% 33% 25% 10%
- Pain intensity: Please put a line on the scale below describing the intensity of your pain

No Pain _____ **Unbearable Pain**

CLIENTS SIGNATURE _____ DATE _____

PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	**Where you experience Pain**
NNN	**Where you experience Numbness**
TTT	**Where you experience Tingling**
BBB	**Where you experience Burning**
CCC	**Where you experience Cramping**

PATIENT SIGNATURE _____ DATE _____

CLIENTS SIGNATURE

Patient Medical & Injury History

Condition # 1 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 2 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 3 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 4 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 5 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 6 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 7 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

Condition # 8 Described: _____
Please List all previous treatments for this condition:
Treating Physician:_____ Date: _____
Type Treatment: _____ Date: _____

CLIENTS SIGNATURE _____ DATE _____

Please List all past Surgeries

Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____
Type _____ When _____ Doctor _____

Please List all past accidents and falls:

What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____
What _____ When _____

Please list any medications or vitamins you are currently taking:

MEDICATION

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

VITAMINS

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

CLIENTS SIGNATURE _____ DATE _____

Review of Systems
(Circle if you are experiencing any of the following)

General: Change in appetite, weight gain, weight loss, fever, chills, sweats

Head: Mild headaches, mild migraines, significant migraines, recent head trauma

Eyes: Near sighted, far sighted, double vision, blurred vision, cataracts

Ears: Ringing in the ears, hearing loss, infections, drainage, pain

Nose/Mouth/Throat: Recurring nosebleeds, chronic sinus congestion, gum bleeding, Sore tongue, difficulty swallowing, hoarseness

Respiratory: Shortness of breath, cough, coughing up blood, wheezing, snoring, Excessive daytime sleepiness, episodes of gasping, choking or long pause in breathing at night

Cardiac: Chest discomfort, palpitations, shortness of breath on exertion, waking up at night short of breath

Gastrointestinal: Intermittent diarrhea and constipation, bloating, abdominal pain, nausea, vomiting, blood in stool or by rectum

Genito-urologic (Male): Penile discharge, diminished stream, incomplete emptying of bladder, pain with urination, blood in urine, loss of libido, impotence

Genito-urologic (Female): Loss of urine with coughing or sneezing, sudden urge to urinate with loss of urine, blood in urine, pain with urination, loss of libido

Menstrual: Having regular periods, irregular periods, painful periods, no periods due to menopause since_____, No periods due to hysterectomy since _____

Musculoskeletal: Joint pain, joint swelling, back pain, leg weakness, muscle weakness

Neurological: Dizziness, fainting, numbness or tingling, seizures

Skin: Rashes, non-healing lesion, new or changed moles, previous skin lesions removed or destroyed _____

Psychiatric: Increased nervousness, mood changes, depression, feelings of hopelessness, problems with sleep, memory, or anxiety

Endocrine: Thyroid trouble, heat or cold intolerance, excessive thirst, hunger or urination.

Hematologic/Lymphatic: Anemia, easy bruising or bleeding, swollen lymph nodes

Allergic/Immunologic: Hay fever, environmental allergies

CLIENTS SIGNATURE _____ DATE _____

Closed Head Injury: What's Your Risk of Major Illness or Disease?

Find out if you may have a closed head injury or hidden brain injury? Check the boxes that applies!

Were you a forceps delivered baby? Difficult birth?
Have you ever worn braces? Mouth splint? Do you have crooked teeth?
Have you ever had teeth extracted? Any fillings, crowns, or root canal work?
Have you ever had cavitation surgery? Implants? Or other non-natural Teeth?
Have you ever been labeled as having TMJ problems?
Is your chin recessed or does it jut forward?
Does your head jut forward? Do you have Chronic Headache with this head posture?
Do you have difficulty keeping your head even with your shoulders?
Do you have dissimilar facial features?
Are your eyes, eyebrows, and ears of even height?
Have you ever fallen down? Hit your head or shoulder or tailbone?
Have you ever banged your head: on a cabinet, a door, getting out of the car?
Have you ever had a car accident even a fender benders?
(Nobody got hurt, because "some-body" did get hurt. Was it Your Body?)
Have you ever ridden a roller coaster, or bumper cars?
Have you ever banged your head playing sports, (soccer, basketball, football)?
Have you ever played football? (We've seen what can happen to prof players.
Think about your children)
Have you ever high dived (swimming) and hit your head on the bottom?
Have you ever done a bad belly flop off the side of the pool?
Have you ever been involved in gymnastics and fallen to the floor?
Have you ever been pregnant?
Have you ever been labeled, ADD, ADHD, dyslexic, learning disability?
Have you ever been on Ritalin to control hyperactivity? ADD, ADHD?
Have you ever been labeled as Chronic Fatigue Syndrome or Fibromyalgia?
Do you experience drops of energy on and off throughout the day?
Do you experience mood swings, emotional outbursts or hopelessness?
Are you overweight and can't seem to lose weight?
Do you gain weight in abdomen and thighs, pear shaped body?
Have you ever experienced an eating disorder?
Do you try to gain weight and can't?
Do you feel the need for coffee or sugar snacks to pick you up?
Do you have headaches? Unexplained body or joint pain?
Do you have irregular or painful menstrual cycles?
Do you have difficulty coping with stressful situations?
Do you "catch" colds/flu/bronchitis frequently?
Do you have trouble remembering things? Short term or long memory?
Do you have numbness or tingling in any part of your body?
Do your arms, hands, legs, or feet shake?
Have you ever experienced Bells Palsy Symptoms?
Have you ever experienced a stroke?
Do you have digestive problems? Gastric Reflux? Ulcers? Leaky Gut?
Do you have hemorrhoids, diverticulitis, colitis, or irritable bowel syndrome?
Do you have chest pain or shortness of breath?
Do you experience gallbladder pain? Have you had gallbladder surgery?

CLIENTS SIGNATURE _____ DATE _____

Patient Dental History Form

Please circle the questions that apply to you with Y for Yes or N for No.

Y	N	Have you had braces – orthodontics?
Y	N	Have you had crowns?
Y	N	Have you ever had dental materials tested for compatibility?
Y	N	Do you have bridge work?
Y	N	Do you wear false teeth?
Y	N	Do you have gum disease?
Y	N	Do you have silver mercury amalgam fillings?
Y	N	Do you have missing teeth?
Y	n	Where are the missing teeth located? Check below __ right upper __ right lower __ Left upper __Left lower.
Y	N	Does your jaw joint pop or make noises?
Y	N	Have you had teeth pulled to accommodate the use of orthodontic appliances?
Y	N	Have you had your false teeth adjusted in the last five years?
Y	N	Have you had any dental surgery?
Y	N	Do you now have crooked teeth?
Y	N	Do you have an overbite?
Y	N	Does opening or closing your jaw cause discomfort or pain?
Y	N	Have you ever had an arch expander?
Y	N	Have you ever worn a splint?
Y	N	Have you had wisdom teeth removed?
Y	N	Do you grind your teeth at night while asleep?
Y	N	Do you have difficulty breathing though your nose or mouth?
Y	N	Do you have neck, shoulder or chest pain while opening or closing your mouth?
Y	N	Have you ever hit your head in a car accident or fall?
Y	N	Have you had any accidents that injured your head – even minor accidents?
Y	N	Do you have more than one headache a month?
Y	N	Do you have to take drugs to control face pain or headaches?
Y	N	Have you been to a neurologist for head or face pain?
Y	N	Have you had a cat scan, MRI or myelogram associated with head or neck pain?
Y	N	Has your jaw ever locked open or closed?
Y	N	Do you have teeth that wear unevenly on your top or bottom teeth?

_____ _____

CLIENTS SIGNATURE Date

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PHOTOGRAPHIC RELEASE

Whereas, I understand that because of the complexity of my problem, that a holistic approach utilizing various health professionals may be necessary in the treatment of my problem. To aid the doctor in visualizing changes that take place in your body, various parts of the body which show abnormal joint motion will be photographed along with normal joint motion and may be studied on computer. If you are involved in a legal claim then these videos or still pictures may be used upon request of your attorney or appointed advisor. These photographs will be sent only with your understanding, acknowledgement and only by written permission.

The undersigned confirms that he/she has authorized Dr. Steven Senart and associates, or either of them, to take photographs or videos of him/her and use them in preparation of scientific articles or for the purpose of professional lectures. If you decide to maintain the privacy of your identity we will either hide part of your face and name or eliminate the use of your photographs from our scientific study completely. Your Name will not be used in any articles, yet your initials may be used to identify you from other patients in the study.

Your approval will enable the dissemination of scientific information and in addition help others who may have the same type of problem.

_____	_____/_____/_____	_____
CLIENTS SIGNATURE	Date	Witness
_____	____/_____/_____	_____
CLIENTS or Guardian if a Minor	Date	Witness