DIVINE DESIGN NATURAL HEALTH
NEW PATIENT INFORMATION FORM

YOUR ABILITY TO FOLLOW THESE DIRECTIONS WILL DETERMINE WHETHER OR NOT YOU ARE ACCEPTED AS A PATIENT. IF A QUESTION IS NOT APPLICABLE, PLEASE PUT N/A SO WE KNOW EVERY QUESTION HAS BEEN READ AND ANSWERED CORRECTLY.

Full Name:	Today's Date:
Mailing Address:	Drive Time to This Office:
City and State:	Zip:
Email Address:	Cell Phone: (for text messages)
How did you discover us?	
PLEASE READ CAREFULLY: During the course of your lifetime, what has been spent in total on your healthcare (including premiums, deductibles, co-pays, prescription costs, office visits, surgeries, medications, etc.)? Circle one below: $1000-$5000 $5000-$10,000 More than $10,000	

Occupation:		Employer:		
Date of Birth:	Age:	Sex: M / F	Height:	Weight:

Please list no more than ten of your top health concerns below. List your symptoms rather than diagnosis names.

Health Concerns:	Severity: Rate 1-10 (10 is the worst):	Duration (years):	Other info:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Previous treatments for these health concerns:	
Current medications:	Current nutritional supplements:

ELECTRONICS

Are you consistently around Bluetooth/smart devices (ex: smart watch, bluetooth headphones, smart bed, smart cooking devices)? If so, please list them:

HEALTH HISTORY

List any major illnesses that required surgery or organ removal (including c-sections):	List the location of all implants, scars, tattoos, and piercings:
List any vaccinations (since January 2020):	

FAMILY

Marital Status: Single Married Divorced Widowed	Name of Spouse:
On a scale of 0-10 (10 is the worst), what is your spouse's knowledge and level of support regarding natural health:	On a scale of 0-10 (10 is the worst), how would you rate the health of your marriage:
Spouse's Occupation:	

Names of children:	Sex:	Age:	Any physical conditions or concerns:
1.	M / F		
2.	M / F		
3.	M / F		
4.	M / F		
5.	M / F		

Do you have any animals with which you or your family members are in close contact?
Is there anything you are completely unwilling to change in order to reach your health goals?
How would you describe your spiritual health? Be specific. "Good" is not an adequate answer.
What single change in your health would make you happier and more productive?

FINANCES

Your initial care plan will span three to five months. The average cost of services during this time frame ranges from $3000 - $6000. This does not include supplements as those are unique to each person and the cost varies. Are you able to make this financial commitment? Yes:____ No:____ Initials:____
Your initial care plan does not represent the total duration of your care. Averages of six months to two years are normal in many cases before patients are ready for maintenance care. Are you willing and able to commit to the healing process? If so, please initial below. Yes:____ No:____ Initials:____

(If you answered no to any of the questions above, please contact the office before your appointment)

DIETARY INTAKE FOR THREE DAYS BEFORE APPOINTMENT (INCLUDING BEVERAGES)

Day 1:		
Breakfast (time):	Lunch (time):	Dinner (time):
Midmorning snack:	Midday snack:	Nighttime snack:
Bowel movements (number & consistency):	Hours of sleep:	Quality of sleep:
Day 2:		
Breakfast (time):	Lunch (time):	Dinner (time):
Midmorning snack:	Midday snack:	Nighttime snack:
Bowel movements (number & consistency):	Hours of sleep:	Quality of sleep:
Day 3:		
Breakfast (time):	Lunch (time):	Dinner (time):
Midmorning snack:	Midday snack:	Nighttime snack:
Bowel movements (number & consistency):	Hours of sleep:	Quality of sleep:

DIVINE DESIGN NATURAL HEALTH

3800 Keith Street NW | Cleveland, TN 37312

CONSENT: NUTRITION ANALYSIS

I authorize practitioners at Divine Design Natural Health to perform a nutrition analysis and to develop a natural health improvement program for me which will include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health and not for the treatment of any disease.

I understand this to be a safe, non-invasive, natural method of analyzing the body's physical and nutritional needs and that deficiencies or imbalances in these areas could cause or contribute to various health problems. I understand that this is not a method for diagnosing or treating any diseases. I wish to gain a better understanding of my health rather than any disease.

No promise or guarantee has been made regarding the results of any natural health, nutritional, or dietary programs recommended, but rather I understand this to be a means by which the body's natural organ responses can be used as an aid to determining possible nutritional imbalances so that safe, natural programs can be developed for the purpose of bringing about a more optimum state of health in my body.

I have not been told to cease any medications and will not do so other than by my own will. I understand that nutritional counseling, recommendations, advice, and supplement schedules are provided solely to upgrade the quality of foods in my diet in order to support the natural physiological processes of the human body. I also understand that vitamins, minerals, homeopathic remedies, and other supplements are not drugs but may have an effect on disease processes and symptoms that I prefer over medications.

CONSENT: CHIROPRACTIC AND DETOXIFICATION

Divine Design Natural Health maintains equipment, personnel, and facilities to assist in the delivery of chiropractic adjustments, therapeutic procedures, and recommendations of whole food nutritional supplements with the goal of supporting the natural physiology of the body. As with any comparable intervention, these adjustments, procedures, and supplements may involve a calculated risk of complication or injury, and no guarantee has been made as to treating, curing, or preventing the occurrence of disease. These adjustments and procedures are therefore not performed on patients unless and until a patient has been examined and thus had an opportunity to discuss his or her concerns with the doctor. Each patient reserves the right to receive or refuse any proposed procedure or therapy based upon the prescription or explanation received.

Care plans are specifically designed for each patient. Details of the care plan will be covered with you prior to the commencement of services. The success of a care plan is largely due to your compliance and ability to follow the treatment plan as it is prescribed, however no action will take place without your full consent. Your initiation of the care plan is the agreement that you will complete the plan for the recommended duration regardless of whether payments are made in full or multiple payments are made.

OFFICE POLICIES

We believe that you alone are responsible for your health choices and not your insurance company. Insurance companies and their representatives have become increasingly selective in denying reimbursement for services while also increasing deductibles and copays. Knowing this, many doctors across the country are choosing to forego insurance. Our office operates as a private pay practice which allows us to offer affordable care to patients without interference or influence from any third-party company.

If you are unable to make a scheduled appointment, we respectfully request that you cancel a minimum of 12 hours in advance so that your appointment time can become available for another patient. By cancelling at least 12 hours in advance, you can avoid a missed appointment fee which will be deducted from prepaid treatment plans. Naturally, our desire is to make appointment time available to other patients – not to collect missed appointment fees.

Your signature below constitutes your acknowledgement that: (1) You have read and agreed to the above treatment and office policies and; (2) The procedures and possible alternate means of therapy have been adequately explained to you by your doctor; (3) You consent to additional procedures and tests arising from presently unforeseen conditions which your doctor may suggest in the course of treatment; (4) Your attendance/attention is required for patient education and to clarify at-home requirements of your individual treatment plan; (5) You acknowledge that you are responsible for payment at time of service and that there is no guarantee your insurance company or health savings account will reimburse you for exams, services, or supplements; (6) You agree not to publish misrepresentative or libelous statements about the doctor(s) or staff of Divine Design Natural Health on any social media or public internet website; (7) Written, picture, or video testimonials may be used with your permission. (8) You authorize Divine Design Natural Health to contact you via text message in order to serve you more efficiently. You may see relevant terms and conditions and opt out at any time.

I have read and understand the foregoing. This permission form applies to exams, subsequent visits, services, and products.

Patient Signature: _____ Date: _____