William Lyden, D.C.,
D.A.C.B.N., D.A.B.C.I.,
D.C.B.C.N.
Diplomates in Nutrition - Board Certified 1989, 2009
Diplomate in Internal Disorders - Board Certified 1990

MICHIANA
WELLNESS & LONGEVITY CLINIC

605 W. Edison Rd., Suite G
Mishawaka, IN 46545-8823
PHONE: 574-258-4444 FAX: 574-258-4445
Email: MWLC@sbcglobal.net
Web: www.MichianaWellness.com

MWLC Patient Intake Form

Strictly Confidential:

In order to obtain the best use of our time during your initial consultation, please carefully complete the following questionnaire. Please *circle* or *underline* only those statements that apply to you or your condition. If there are additional comments outside the scope of this questionnaire, please *print* them in the space provided, or at the end of the report. Please answer *every* question. I do not conduct my consultation with you like a conventional Doctor. Your answers to these personal questions are of great assistance in helping me understand how your body works.

PLEASE ANSWER EVERY QUESTION POSSIBLE:

Name:_____ ____ _____
(First) (MI) (Last)
Address:_____
City: _____ State: _____ Zip Code:_____
Phone: Home(____)_____ Cell(____)_____ Work(____)_____
Date of Birth: _____/_____/_____ Age _____ Sex _____ Email: _____
SS#: _____-_____-_____ Weight:_____ Height:_____
Driver's License Number & State: _____
Marital Status (circle): Married/ Divorced/ Single/ Widowed; Other _____
Your Occupation: _____
Employer/School: _____
Work/School Address/Zip: _____
*Spouse/Parent's Name & Occupation _____
Spouse/Parent's Employer & Work Phone _____
*How would you like to be contacted? (Circle One) Email, Text to cell phone, Phone

Are your reasons for seeking treatment related to an **ACCIDENT or INSURANCE CLAIM?** YES/NO.
****Following information is required to submit claim to insurance so you can be reimbursed****
*Primary Insurance Co. or Plan Name_____
*Insurance Co. Address _____
City/State/Zip/Phone _____
*Insured's Name (If different from patient's) _____ ___ _____
*Insured's Address/City/State/Zip_____
*Insured's Date of Birth & Phone: _____/_____/_____ (_____) _____-_____
*Insured's SS# &/or I.D. Number _____ Group/Claim Number _____
*Amount of Deductible? _____ Amount Not Met for This Year? _____
** **Date of Injury or 1st Symptom**____/_____/_____ Policy Renewal Date_____/_____/_____
Have **Similar Symptoms Ever Been Experienced Before? Y/N, *Approx. Date ____/_____/_____
*Patient's Relationship To Insured (circle): Self/ Spouse/ Child/ Other (Employee, etc.) _____
Closest Relative Not Living With You _____
Address/City/State/Zip _____
Other Doctors Seen For This Condition _____
Address/City/State _____

Who recommended you to this clinic? _____

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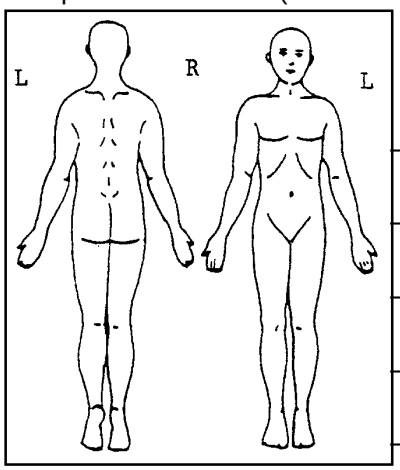
Please mark pain areas in figure below
on a pain scale of 0-10 (none to extreme): 0 __ __ __ __ __ __ __ __ __ __ 10



Describe your major symptoms and complaints in your words _____

_____

_____

_____

_____

_____

_____

_____

How long have you had this illness or health challenge? _____

What started it? _____

All MEDICATIONS: Please list ALL your Medications, including Naturopathic, Vitamins, Homeopathic, Herbal, Supplements, etc. _____

_____

All OPERATIONS/SURGERIES (When): Tonsils (_____), Adenoids (_____), Wisdom teeth (_____), Gall Bladder (_____), Appendicitis (_____), Hemorrhoids (_____), Hysterectomy (_____), Laparoscopy (_____), Root Canal (_____), Tooth Fillings (#___/_____), Stitches (_____), Other _____

_____

Special Tests: X-Rays, CT Scans, MRI's, _____

_____

ALLERGIES: Medications (e.g. Penicillin, etc.)_____
Foods and other substances: _____

CIGARETTES: How many _____/day. For how long? _____ When stopped? _____
MARIJUANA: How many _____/day or ____/week. For how long? _____ When stopped?_____
ALCOHOL: How much _____/day or _____/week. Type: Beer/Wine/Other _____

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Head & Neck:

NECK: Sore/Tense/Radiating across top of shoulders.
How often?_____ When?_____
Where/Location? _____
What do they feel like? _____
SHOULDERS: Sore/Tense
Other comments: _____
_____
Swollen glands: Yes/No. Other _____

HEADACHES: How often?_____ When?_____
Where/Location? _____
What do they feel like? _____
MIGRAINES: Which side? _____ How often?_____
When? _____
Please describe each of your headaches in detail: _____
_____
_____
_____

SINUS: Congestion/Pain/Rhinitis/HAYFEVER (When) _____
Prone to Colds/Flu/Infections? _____
Where/Locations? _____ How often?_____

TOOTH FILLINGS: Amalgam/Silver/Gold/Composite/Bridges/Root Canal/Crowns/Missing teeth?
_____
Dentures: Top/Bottom - Complete/Partial - Plastic/Metal Gums bleed/gums sore
Teeth Grinding/Clenching TMJ/Popping/Jaw Joints Tender? Left/Right - Yes/No
Mouth Ulcers? Please describe: _____
TONGUE: Normal/Coated/Sore/Cracked/Scalloped

COMPLEXION: Normal/Pale/Atopic/Dark ring under the eyes.
ENERGY: Good/Lacking/Tired/Fatigued - All the time/Most of the time/Sometimes.
When is your energy at its worst?
_____
SLEEP: Well rested and Undisturbed/Difficulty falling asleep/Wake up and can't go back to sleep/
Poor quality, rate 0-10. Describe pattern: _____
WAKE: Refreshed/Tired/Stiff/Sore/Swollen. Describe: _____
_____

Central Nervous System:

Do you have: Blackouts/Strokes/Fits/Epilepsy/Convulsions/Dizzy Spells/Vertigo/Dizziness when standing up/Other? _____
_____

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Chest, Lungs, Heart:

Chest Pain: Yes/No Sharp/Dull/Crushing - Where? _____
_____
Shortness of Breath: Yes/No When? _____
LUNGS: Bronchitis - How often? _____
Emphysema - How often? _____
ASTHMA/Wheezing - When? _____
COUGH - Phlegm - When? _____
Medications: _____
HEART: Angina - Yes/No - Describe? _____
Heart Attack? - When? _____
Complications: _____
BLOOD PRESSURE: High/Low. What was your last BP measurement? _____/_____
CHOLESTEROL & Blood Fats: High/Low. When last measured? ____/____/____
Total _____ HDL _____, LDL _____, Triglycerides _____, Hemoglobin A1C _____
DIABETES: Type 1(Juvenile) Yes/No, Type 2(Adult Onset) Yes/No
EKG? _____ Lung Function test (Spirometry)? _____
Other Comments: _____
_____
Medications: _____
(Cardiovascular) _____

Abdomen:

FOOD ALLERGIES: What kind? _____
Type of testing: Muscle Test/IgG blood test/Other _____
PAINS: Where? _____ When? _____
Abdominal Distension/Bloating? Worse: After food/End of Day/Other _____
Burping/Belching/Flatulence/Farting: _____
Indigestion/Heartburn/Dyspepsia: _____
Nausea/Vomiting: _____
What makes it worse? _____
BOWEL MOVEMENTS: Daily/Every 2 Days/3 Days/Less Often/ Several Times a Day _____
_____
STOOLS: Normal/Constipated/Hard/Soft/Loose/Diarrhea/Fluid/Blood/Mucus/Slime
ITCHING around the back passage or anus: Yes/No. Hemorrhoids/Piles: Yes/No.
Have you ever had? Hepatitis/Yellow Jaundice/Gall Bladder Disease/Peptic - Gastric - Duodenal Ulcer/Hiatal Hernia/Glandular Fever/Dysentery/Colitis/Crohn's Disease/Amoeba Infection/Irritable Bowel Syndrome/Other (please name): _____
_____
_____
Other comments: _____
_____
Medications: _____

Kidney & Bladder:

How often do you pass urine during your waking hours? _____

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How often do you rise from your sleep to pass urine? _____
Kidney Infections: How often & when? _____
Cystitis or Bladder infections: How often & when? _____
Burning or Stinging when you pass urine: How often & when? _____
Blood in the urine: Cause? _____
Fluid Retention: Where and when? _____
Other comments: _____
_____
Medications: _____

Men Only - Prostate:
Is your urine stream: Strong/Weak/Hesitant
Is there any obstruction to your urine stream: Yes/No
Vasectomy: Yes/No. When? _____
Venereal infection: Yes/No When and what kind? _____
Other comments: _____
Medications: _____

Women Only - Gynecology:
BREASTS: Examine your breasts? Never/Occasional/First day of menses.
Are your breasts: Tender/Painful/Lumpy (Fibrocysts)/Other _____
When was your last mammogram - X-ray/Thermographic? _____
When did you last have a PAP/Cancer smear? _____
How often do you have a Gynecological check? _____
MENSES: Periods - Regular/Irregular. How often? _____ Days. How long? _____ Days.
Heavy/Light/Clots _____
Painful: Please describe: Back/Lower belly/Legs _____
Abdominal distension: for how many days? _____
Fluid retention: For how many days? _____ Sore BREASTS: For how many days? _____
Pre-Menstrual Tension/Depression: For how many days? _____
Other comments: _____
_____

VAGINAL DISCHARGE: Clear/White/Green/Blood/Other. Please describe: _____
_____
Vaginal Thrush (white): Yes/No Please describe: _____
Venereal Infection: Yes/No Please describe: _____
Pain with intercourse: _____

PREGNANCY HISTORY: Contraception: Yes/No. Please describe: _____
_____
Pregnancies: How many _____ How many boys _____ How many girls _____
Miscarriages: How many _____ Post-Partum Blues/Depression: _____

MENOPAUSE: When was your last period? _____
Any Menopausal Discomfort? Dry Vagina/Hot Flashes/Other _____

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Have you had an Osteoporosis X-ray or Bone Scan? _____
Other comments: _____
_____
Medications: _____

Hormonal System:
THYROID: Overactive (Hyper-)/Underactive (Hypo-)/Enlarged (Goiter)/Lumps? _____
Do you feel the Cold/Heat/Weather Unduly? _____
Do you have a Sweet/Salty/Savory Tooth? _____
Any blood test results? TSH _____, T4 _____, T3 Uptake _____, Free T4 _____
Other comments: _____
_____
Medications: _____

Bones, Joints, Ligaments, Muscles:
Which joints hurt? _____
Stiffness: When is it worse? _____
Swelling: When is it worse? _____
Affected areas: Neck/Mid Back/Low Back/Arms/Hands/Legs/Feet/Sciatica
Fibromyalgia/Arthritis/Rheumatoid Arthritis/Osteoarthritis/Gout/Other: _____
_____
Other comments: _____
_____
Medications: _____

Nervous Conditions:
Do you feel: Worried/Anxious/Guilty/Nervous/Bad Tempered/Depressed/Neurotic
Do you have: Obsessions/Phobias/Fears/Other: _____
_____
Have you ever felt like ending your life? When, how often? _____
Have you ever had a nervous breakdown? Please give details: _____
_____
Other comments: _____
_____
Medications: _____

Skin:
Do you have Dermatitis/Eczema/Dry Skin/Acne/Psoriasis/Rashes/Tinea/Other: _____
Other comments: _____
_____
Medications: _____

Social:
Are you Single/Married/De Facto/Widow(er)/Divorced/Other: _____
Do you have any children? How many? ___ Do your children have any health problems? _____
_____

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Other comments: _____
_____

Family History:
Sinus/Asthma/Chest Complaints/Heart Disease/Strokes/Lung Diseases/Arthritis/Cancer/Allergies
Other comments: _____
_____

Additional Comments:
_____
_____
_____

MINI CONTEXT OF CARE:

1. What are the areas of your lifestyle that you would like to improve? _____
_____

2. What percentage (out of 100) do you feel you are currently using of your body healing potential? 10%,20%,30%, etc.? _____

3. What is your present level of commitment to address any underlying causes of the signs and symptoms which relate to your lifestyle? (Rate from 1-10, with 10 being 100% committed) _____
_____

4. What resources do you currently allocate to your health and well-being? i.e. How much time, money and energy do you invest in your health? _____
_____

5. How much time, energy and money are you willing to invest in your health and happiness? i.e. What limits do you place here? _____

6. How confident are you that you will follow through with healthy lifestyle changes, nutrition and exercise that it will take to achieve your wellness goals? _____

7. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? _____
_____

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CHIROPRACTIC PROCEDURE INFORMED CONSENT:

This information is provided to inform you of the risk factors associated with chiropractic adjustment (manipulation) of the spine. There are risks to all medical and health procedures. Statistically, chiropractic is one of the safest health procedures.

However, in extremely rare circumstances (i.e. less than the chance of being hit by lightning), manipulation may damage a blood vessel giving rise to a stroke or stroke-like symptoms. Statistics to date show this risk to be 1 in 5.85 million manipulations of the cervical spine (Haldemann, et al, SPINE. Vol. 24-8, 1999). While this has never occurred in this practice, we are still legally responsible to warn you of the risks involved, as all doctors should. If it is shown that you require adjustment of the cervical spine, you will be first tested using orthopedic tests to ascertain if it is safe to adjust your neck. This has always been the practice at this clinic and will continue to be so. Other very slight risks involve strain/injury to a ligament or disc in the neck (less than 1 in 139,000) or the lower back (1 in 62,000). (Haldemann Dvorak study in Principles and Practice of Chiropractic, 2nd Edition)

Chiropractic adjustments (manipulations) of the spine are internationally recognized as being far safer in dealing with neck and lower back pain than medication and other alternatives (A risk Assessment of Cervical Manipulation, JMPT, 1995. Manga Report, Ontario Ministry of health, 1993). The procedures to be used in your case will be described to you, including any other associated procedures: physical examination, tests, diagnostic x-rays, physio-therapy, physical medicine, physical therapy procedures, after which you will be asked if you have any questions. **After speaking with the Chiropractor,** we request that you sign below, **as your consent to proceed is required.** Please note that there may be a considerable degree of variation in individual patient response.

I give my consent for Chiropractic Physician, Dr. William Lyden, to use the skills necessary to examine and care for me each time I consult or treat with him.

SIGNED BY PATIENT, PARENT OR GUARDIAN: _____
PRINT NAME HERE: _____ DATE: _____
CHIROPRACTOR'S SIGNATURE: _____ DATE: _____

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NEURO EMOTIONAL TECHNIQUE INFORMED CONSENT:

The effect of emotions on health is well documented in scientific literature and for over 100 years Chiropractors (since 1895) have attributed emotions to being one of the three causes of a misaligned vertebra (a vertebral subluxation). Neuro Emotional Technique (NET) was developed in 1988 to treat vertebrae that misalign/subluxate in an acquired reflex to unresolved emotional triggers.

NET is an interactive process that requires the Patient's participation. The Chiropractor is merely a facilitator. The NET process establishes the stuck (unresolved) emotion relating to an original event or experience, by determining weakness in the Patient's acupuncture meridian system and the body's response to particular words. To release the unresolved emotion, the Chiropractor will contact, or ask the Patient to contact, particular body points while the Patient pictures the original event or experience. Needles are NOT used.

NET does not deal with "REALITY" but with "EMOTIONAL REALITY". Any conceivable life experience may be the subject of an unresolved emotion. Such experiences may include but are not limited to those appearing at the bottom of this page. The Patient is in complete control and can discontinue the treatment if any topic arises which the Patient does not wish to discuss. Occasionally, Patient's may become emotional during or after an NET treatment. This is perfectly normal and can be likened to the purging effect of coughing or sneezing. Appropriate referrals to other Health Care Professionals are made where appropriate. NET is a highly specialized technique requiring significant training. Should you be provided with an expert opinion on NET by any Health Care Professional who is not trained in NET please contact this clinic immediately.

I have been provided a brochure entitled "What Patients Want to Know About Neuro Emotional Technique" and an introductory DVD entitled "Neuro Emotional Technique" and have clarified any questions with the attending Chiropractor.
I give my consent for Chiropractic Physician, Dr. William Lyden, to use the skills necessary to examine and care for me each time I consult him.
SIGNED BY PATIENT, PARENT OR GUARDIAN: _____
PRINT NAME HERE: _____ DATE: _____
CHIROPRACTOR SIGNATURE: _____ DATE: _____

Topics that may arise during an NET Treatment:

Any conceivable life experience may be the subject of an NET treatment. Topics may include but are not limited to the following:

Abortion.	Eating Disorders.	Mortality.	Sexual Experiences.
Abuse of any kind.	Enemies.	Obesity.	Sexual Preferences.
Adultery.	Ethnicity.	Personal Inadequacies.	Sexuality.
Addictions.	Family Dynamics.	Phobias.	Spirituality.
Animal Cruelty.	Failure.	Politics.	Success.
Authority Figures.	Genetic Flaws.	Public Figures.	Terrorism.
Belief in Past Lives.	Injustice.	Rape.	The Supernatural.
Control Issues.	Intimacy.	Religion.	Traumatic Events.
Death.	Love.	Self Image.	Violence.
Divorce.	Money.	Self Worth.	War.