

WELCOME TO WHOLE HEALTH CENTER
CONTACT INFORMATION

First Name: _____ Last Name: _____

Nickname: _____ Gender: Male _____ Female _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone – Preferred: _____ (circle: Home Cell Work)

Other: Home _____ Cell: _____

Work: _____ Date of Birth: _____

Do we have your permission to send appointment reminders, health newsletters,
and occasional promotions to your email address? Yes _____ No _____
We will not sell or give your email to any other agency.

Email Address: _____

Emergency Contact:

Name: _____ Telephone: _____

Relationship: _____

If you have health insurance, we will be happy to verify your benefits. If you have a discount plan through your insurance, please tell the front desk.

How did you learn about us? (Please circle)

Friend or Family (name) _____ Internet Search Facebook Radio
Physician (name) _____ Our Website Signholder Newspaper
Walk-in Insurance Company _____ Health Fair _____
Other _____

MISSION STATEMENT

Whole Health Center provides information, education, and access to complementary health services for people seeking wellness. Whole Health Center connects practitioners and neighbors to achieve optimum health. Healthy and happy people are the basis of a healthy and happy community.

DISCLAIMER

Merely an office location, through which independent practitioners conduct their business, Whole Health Center does not render any services or provide any care or treatment. The individual practitioner that performs the services is independent from Whole Health Center and is responsible for the services rendered. Additionally, not all of the practitioners at Whole Health Center are licensed medical doctors; some services available at Whole Health Center are complementary to and not a substitution for treatment by a licensed medical doctor. As such, by signing below, you indicate that you understand this disclaimer and agree to hold Whole Health Center harmless from any and all claims related to services obtained at Whole Health Center.

Signature: _____ **Date:** _____

Intake Questionnaire
Dr. Casey Strojny, DC
9075 Forsstrom Dr. Lone Tree, CO 80124 (303) 470-1995

Name _____ Age _____

Today's Date _____ Date of Birth _____

Email _____

Address _____

City _____ State _____ Zip _____

Phone (Cell) _____

Genetic Background:

- African American
- Hispanic
- Mediterranean
- Asian
- Native American
- Caucasian
- Northern European
- Other _____

When, where & from whom did you receive health care in the last year?

Emergency Contact: _____

Relationship _____

Phone (Cell) _____ (Work) _____

How did you hear about our practice?

- Clinic website
- Referral from doctor
- Friend/family member
- Social media
- Other _____

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Medical History

Surgeries/Hospitalization (include year and surgeon/hospital info)

Auto Accidents (include dates)

Over the counter and prescription medications used (current and past)

Have you ever received Chiropractic Treatment? Y N

Do you smoke?_____ Drink Coffee?_____ Consume alcohol?_____

Family Health history (Circle all that apply)

Cancer Diabetes Arthritis Heart Disease Back/neck problems

Neurological disease Other: _____

Current Complaint

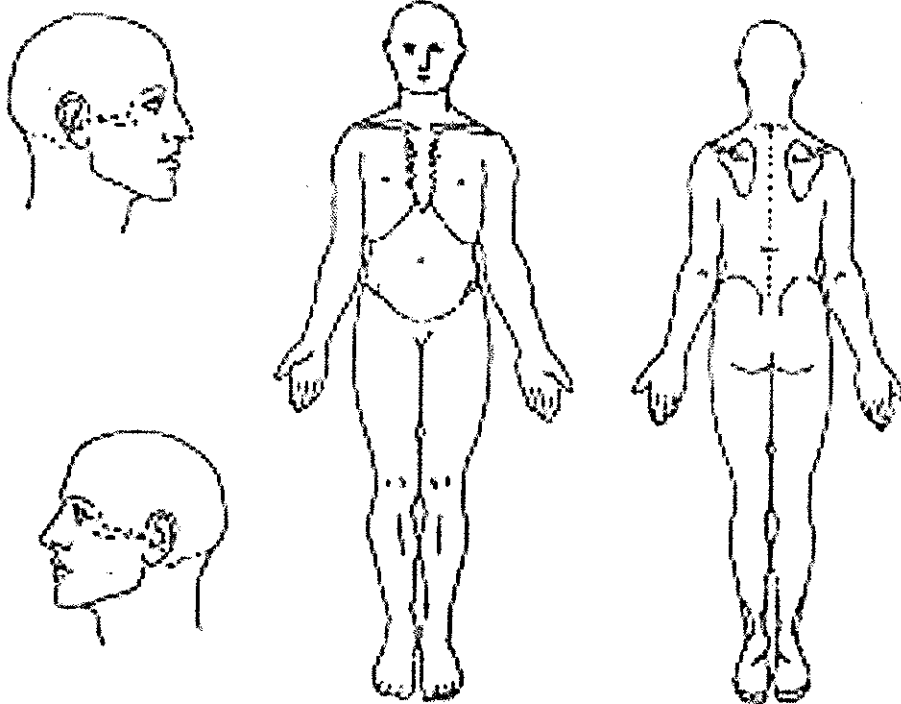
Please describe your current symptoms _____

How/when did they begin? _____

What makes your symptoms worse? _____

What makes them better? _____

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On the diagram to the Left, Please identify where you're currently experiencing symptoms and their quality

+++ Achy

**** Sharp

— — Shooting

//// Tightness

XXX Numbness

Regarding your current complaint, How severe are your symptoms on a scale from 0-10? Consider "0" to be no symptoms and "10" to be the worst pain/discomfort you've ever felt.

Current _____ Average _____ At Worst _____

Have you had any imaging (X-ray, MRI, CT) done regarding this complaint? _____

Have you experienced symptoms like this before? _____

I certify the statements I have made above are true to the best of my knowledge. I understand that if at any point I have questions, comments or concerns about my treatment plan I will not hesitate to ask.

Print Name _____

Sign _____ Date _____

Metabolic Assessment Form™

Name: _____ Age: _____ Sex: _____ Date: _____

PART I

Please list your 5 major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

PART II

Please circle the appropriate number on all questions below.
0 as the least/never to 3 as the most/always.

<p>Category I</p> <p>Feeling that bowels do not empty completely 0 1 2 3</p> <p>Lower abdominal pain relieved by passing stool or gas 0 1 2 3</p> <p>Alternating constipation and diarrhea 0 1 2 3</p> <p>Diarrhea 0 1 2 3</p> <p>Constipation 0 1 2 3</p> <p>Hard, dry, or small stool 0 1 2 3</p> <p>Coated tongue or "fuzzy" debris on tongue 0 1 2 3</p> <p>Pass large amount of foul-smelling gas 0 1 2 3</p> <p>More than 3 bowel movements daily 0 1 2 3</p> <p>Use laxatives frequently 0 1 2 3</p> <p>Category II</p> <p>Increasing frequency of food reactions 0 1 2 3</p> <p>Unpredictable food reactions 0 1 2 3</p> <p>Aches, pains, and swelling throughout the body 0 1 2 3</p> <p>Unpredictable abdominal swelling 0 1 2 3</p> <p>Frequent bloating and distention after eating 0 1 2 3</p> <p>Abdominal intolerance to sugars and starches 0 1 2 3</p> <p>Category III</p> <p>Intolerance to smells 0 1 2 3</p> <p>Intolerance to jewelry 0 1 2 3</p> <p>Intolerance to shampoo, lotion, detergents, etc 0 1 2 3</p> <p>Multiple smell and chemical sensitivities 0 1 2 3</p> <p>Constant skin outbreaks 0 1 2 3</p> <p>Category IV</p> <p>Excessive belching, burping, or bloating 0 1 2 3</p> <p>Gas immediately following a meal 0 1 2 3</p> <p>Offensive breath 0 1 2 3</p> <p>Difficult bowel movements 0 1 2 3</p> <p>Sense of fullness during and after meals 0 1 2 3</p> <p>Difficulty digesting fruits and vegetables; undigested food found in stools 0 1 2 3</p> <p>Category V</p> <p>Stomach pain, burning, or aching 1-4 hours after eating 0 1 2 3</p> <p>Use of antacids 0 1 2 3</p> <p>Feel hungry an hour or two after eating 0 1 2 3</p> <p>Heartburn when lying down or bending forward 0 1 2 3</p> <p>Temporary relief by using antacids, food, milk, or carbonated beverages 0 1 2 3</p> <p>Digestive problems subside with rest and relaxation 0 1 2 3</p> <p>Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine 0 1 2 3</p>	<p>Category VI</p> <p>Roughage and fiber cause constipation 0 1 2 3</p> <p>Indigestion and fullness last 2-4 hours after eating 0 1 2 3</p> <p>Pain, tenderness, soreness on left side under rib cage 0 1 2 3</p> <p>Excessive passage of gas 0 1 2 3</p> <p>Nausea and/or vomiting 0 1 2 3</p> <p>Stool undigested, foul smelling, mucous like, greasy, or poorly formed 0 1 2 3</p> <p>Frequent urination 0 1 2 3</p> <p>Increased thirst and appetite 0 1 2 3</p> <p>Category VII</p> <p>Greasy or high-fat foods cause distress 0 1 2 3</p> <p>Lower bowel gas and/or bloating several hours after eating 0 1 2 3</p> <p>Bitter metallic taste in mouth, especially in the morning 0 1 2 3</p> <p>Burpy, fishy taste after consuming fish oils 0 1 2 3</p> <p>Difficulty losing weight 0 1 2 3</p> <p>Unexplained itchy skin 0 1 2 3</p> <p>Yellowish cast to eyes 0 1 2 3</p> <p>Stool color alternates from clay colored to normal brown 0 1 2 3</p> <p>Reddened skin, especially palms 0 1 2 3</p> <p>Dry or flaky skin and/or hair 0 1 2 3</p> <p>History of gallbladder attacks or stones 0 1 2 3</p> <p>Have you had your gallbladder removed? Yes No</p> <p>Category VIII</p> <p>Acne and unhealthy skin 0 1 2 3</p> <p>Excessive hair loss 0 1 2 3</p> <p>Overall sense of bloating 0 1 2 3</p> <p>Bodily swelling for no reason 0 1 2 3</p> <p>Hormone imbalances 0 1 2 3</p> <p>Weight gain 0 1 2 3</p> <p>Poor bowel function 0 1 2 3</p> <p>Excessively foul-smelling sweat 0 1 2 3</p> <p>Category IX</p> <p>Crave sweets during the day 0 1 2 3</p> <p>Irritable if meals are missed 0 1 2 3</p> <p>Depend on coffee to keep going/get started 0 1 2 3</p> <p>Get light-headed if meals are missed 0 1 2 3</p> <p>Eating relieves fatigue 0 1 2 3</p> <p>Feel shaky, jittery, or have tremors 0 1 2 3</p> <p>Agitated, easily upset, nervous 0 1 2 3</p> <p>Poor memory/forgetful 0 1 2 3</p> <p>Blurred vision 0 1 2 3</p>
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Category X				
Fatigued after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category XI				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3
Category XII				
Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3
Category XIII				
Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3
Category XIV				
Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3
Category XV				
Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVI				
Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting"-type headaches	0	1	2	3
Category XVII (Males Only)				
Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3
Category XVIII (Males Only)				
Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3
Category XIX (Menstruating Females Only)				
Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3
Category XX (Menopausal Females Only)				
How many years have you been menopausal?			_____	years
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental foginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____ Rate your stress level on a scale of 1-10 during the average week: _____

How many caffeinated beverages do you consume per day? _____ How many times do you eat fish per week? _____

How many times do you eat out per week? _____ How many times do you work out per week? _____

How many times do you eat raw nuts or seeds per week? _____

List the three worst foods you eat during the average week: _____

List the three healthiest foods you eat during the average week: _____

PART IV

Please list any medications you currently take and for what conditions: _____

Please list any natural supplements you currently take and for what conditions: _____



CONDITIONS & CONSENT FOR CHIROPRACTIC TREATMENT

I understand that I am a patient of Dr. Casey Strojny who is an Independent Chiropractor at Whole Health Center in Lone Tree. My care is the exclusive responsibility of Dr. Casey Strojny (Dr. Strojny), not of any other practitioners who also may practice at this location.

Cooperation with treatment: In order for my treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with the recommendations Dr. Strojny and I discuss during my appointments. If I have trouble with any part of my treatment program, I will discuss it with Dr. Strojny.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that Dr. Strojny will outline and discuss goals of treatment for my condition and will discuss treatment options with me.

Informed consent for treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of chiropractic treatment have been explained to you. The therapist provides a wide range of services and I understand that I will receive information during the initial visit or report of findings concerning the treatment and options available for my condition, as well as any individual risks that may be specific to my condition or group of conditions.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in 24-48 hours, I agree to let Dr. Strojny know.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increased strength, awareness, flexibility and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater understanding about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the program outlined by Dr. Strojny, I will let her know as soon as possible, and there will be no repercussions. I will discuss my medical, surgical or pharmacological alternatives with my physician or primary care provider.

Financial and insurance responsibilities: I agree to pay for my treatments at time of service, by cash, check, or charge card unless other mutually agreed upon arrangements have been made. I understand it is my responsibility to call my insurance company ahead of time, and obtain any pre-authorization that is necessary, and get an estimate of my benefits. I understand my therapist will provide me with a receipt that is my responsibility to submit to my insurance company if I choose to seek reimbursement.

I have read the above information and I consent to Chiropractic and/or functional evaluation and treatment.

Print name _____ Sign _____

Date _____



Out of Network Provider Explanation

In order to treat chronic conditions as well as conditions that may not be caught within traditional medical models, Dr. Casey chooses to spend more time with her patients in order to truly get to the root cause of the issue. Treatment times are longer, and she spends more hands-on time with patients. This allows her to provide more comprehensive care that is often different and more effective than what patients have received at other chiropractic clinics. Since Dr. Casey's practice beliefs are different from what insurance companies often prefer, she has opted to be an out-of-network provider. The good news is that this allows her to give you the best care she can, without limitations, which should bring your overall costs down. Dr. Casey and/or the front desk staff at Whole Health Center collects payment at the time of service. She can provide you with a receipt and all the information you will need to submit claims yourself.

I _____ understand that payment is due at the time of service.

Signed _____

Date _____