

TENOLD CHIROPRACTIC HEALTH & REHAB CLINIC

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Eau Claire, WI 54701
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*Diplomate of the American Chiropractic
Board of Nutrition*
Certified Chiropractic Sports Practitioner

NUTRITION FORM

About you...

Name: First	M.I.	Last	Date:
Street	City	State	Zip
Home Phone ()	Work Phone ()		
Birthdate / /	Age:	Male / Female	Marital Status: married / single / divorced / widowed
Number of Children:	SS#		
Employment: full / part / self / retired / unemployed / military			
Employer:	Address:	Occupation:	
Emergency Contact (not a member of your household):			Phone ()

About your spouse...

Spouse's name:	Work phone ()
Spouse's employer:	Address:

Billing Information...

Person responsible for account:

If different from patient's, what is their: Address:

Phone ()

Insurance will not be billed for nutritional evaluation &/or therapy. Payment is due on the day of service.

Health Information...

Currently pregnant? yes / no Under another doctor's care? yes / no Name of doctor:

Ever had same or similar condition? yes / no

In order of importance, what condition are you most interested in correcting?

1.)

2.)

3.)

Do you take vitamins or minerals? yes/ no Please list:

Do you have any allergies? Yes / no Please describe:

List all prescriptions/medication you take:

Surgeries:

Other past injuries, including auto accidents, falls, sports injuries:

Serious illnesses:

Habits...

Please circle that which is appropriate.

- Alcohol: _____ per day / week / month
- Coffee, tea (decaf or reg) _____ per day / week / month
- Soda (reg / diet / decaf) _____ per day / week / month
- Tobacco (smoke / smokeless) _____ per day / week / month
- Drugs – recreational _____ per day / week / month
- Exercise _____ hours per day / week
- Sleep _____ hours per night
- Water intake..... _____ glasses per day

I authorize the release of any medical or other information necessary to process this claim. I understand and agree that any amount authorized to be paid directly to Tenold Chiropractic Clinic will be credited to my account on receipt. I clearly understand that if I suspend or terminate my care and treatment, any fee for professional services rendered me will be immediately due and payable, I further understand that in the event that my responsible party, insurance co., etc. does not cover the full amount, I will pay the balance of my account in full.

I understand that I am accepted as a patient of Tenold Chiropractic Clinic. I am authorizing them to proceed with any further treatment that may be necessary. Furthermore, any risks involving chiropractic treatment will be explained to me upon request.

Patient's signature _____ Date _____

Parent or guardian authorizing care _____ Date _____