WELLBODY
INNOVATIONS

…dragonflies represent powers of light and transformation.

Dr. Lisa H. Upshaw
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NES INITIAL INTAKE FORM

Date:_____

Name:_____
Last First M.I.

Street:_____
City:_____ State:_____
Zip:_____

Birthdate___/___/___ Age_____ Sex: M/F
Marital Status: S/M/D # of Children:_____

Occupation: _____
Primary reason for visit:_____
_____

Phone
Mobile:_____ Home:_____
Email:_____

In case of emergency, please contact:
Name:_____ Phone:_____
Relationship:_____

PHYSICAL INFORMATION FORM

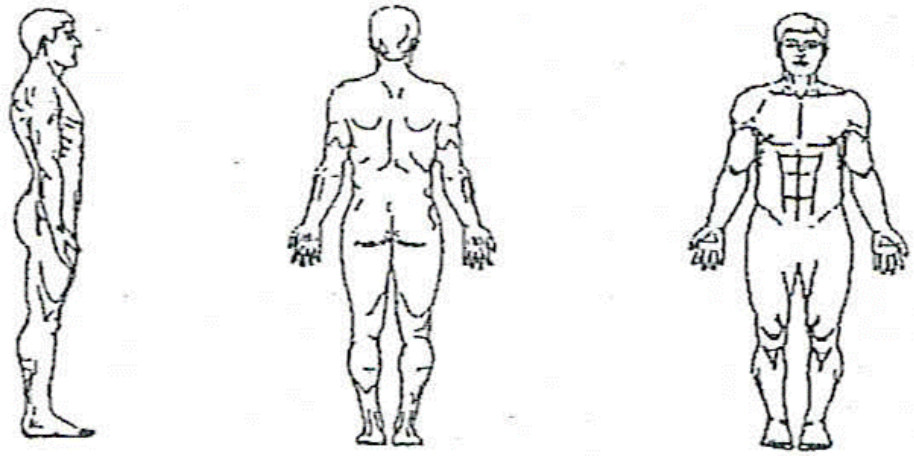
How your discomfort or pain began:

_____

_____

_____

Mark an X on the picture where you have pain, numbness, tingling, or other symptoms. Please number multiple areas of discomfort with "#1, 2" and so on.



Please rate your pain or discomfort on a scale of 0 to 10.
No Pain(0)_____Unbearable (10)

Please check mark all that apply. How often are your symptoms present?
___Constantly ___Frequently ___Occasionally

Since it began, is your problem: ____Improving ____Worsening ____No change

Describe your current symptom (s)?
____Sharp/Stabbing ____Throbbing ____Aches ____Dull ____Soreness
____Weakness ____Numbness ____Shooting ____Burning ____Tingling
____Other(please describe)_____

What makes the problem better?
____Nothing ____Lying down ____Walking ____Standing ____ Sitting ____Movement
____Exercise ____Inactivity/Rest
____Other(please describe)_____

What makes the problem worse?
____Nothing ____Lying down ____Walking ____Standing ____Sitting ____Movement
____Exercise ____Inactivity ____Other (please describe)_____

HEALTH HISTORY

Name_____Date_____

Past/Current Medical Conditions**:** _____

_____

What treatment (s) have you received for your condition?
____Medications ____Surgery ____PhysicalTherapy ____Chiropractic
____None ____Other (please describe)_____

Name & contact of doctor(s) that have treated you for this condition:

_____

_____

Date of Last:
Physical Exam_____ Spinal X-Ray_____ Blood Test_____
Spinal Exam_____ Chest X-Ray_____ Urine Test_____
Acupuncture Exam_____ MRI, CT, Bone Scan_____

Please place a check mark in the correct box:

AIDS/HIV	Y	N	CANCER	Y	N	HIGH BLOOD PRESSURE	Y	N	PCOS	Y	N
ALCOHOLISM			CHEMICAL DEPENDENCY			HIGH CHOLESTEROL			PROSTATE PROBLEM		
ALLERGY SHOTS			CHICKEN POX			HPV			PSYCHIATRIC CARE		
ANEMIA			DIABETES			KIDNEY DISEASE			RHEUMATOID ARTHRITIS		
ANOREXIA			(UTERINE) FIBROIDS			LIVER DISEASE			THYROID IMBALANCE		
APPENDICITIS			FRACTURES			MEASLES			TONSILITIS		
ARTHRITIS			GOITER			MENINGITIS			TUBERCULOSIS		
ASTHMA			HEADACHES			MIGRANIE			TUMORS		
AUTOIMMUNE CONDITION			HEART DISEASE			MISCARRIAGE			ULCERS		
BLEEDING DISORDER			HEPATITIS			MONONUCLEOSIS			VAGINAL INFECTIONS		
BREAST LUMPS			HERNIATED DISC			MULTIPLE SCLEROSIS			WHOOPING COUGH		
BRONCHITIS			HERNIA			OSTEOPOROSIS					
BULIMIA			HERPES			PARKINSON'S DISEASE					

HEALTH HISTORY

Family Medical History:

Please check if a family member has had:

___Heart Disease
___Diabetes
___High Blood Pressure
___Stroke
___Cancer
___Obesity
___Autoimmune Condition

Exercise:

___None
___Daily
___Moderate
___Heavy

Work Activity:

___Sitting
___Standing
___Active
___Light Labor
___Heavy Labor

Dominant Hand:

___Right
___Left
___Ambidextrous

Sleep Position:

___Back
___Stomach
___Left Side
___Right Side

Please describe any injuries, accidents, falls, broken bones, surgeries, dislocations:

_____
_____
_____
_____

Please list vitamins, supplements, medications:

_____
_____
_____
_____

FINANCIAL AGREEMENT

I, the undersigned comply and understand that I am responsible for payment in full at the time services are provided. Payments for Dr. Lisa Upshaw may be made in the form of insurance billing, cash, credit card or check made payable to Dr. Lisa Upshaw or Wellbody Innovations.

_____

Responsible Party Signature **Print Name**
(Signature of legal guardian if under 18)

Date_____

Print name if guardian has signed_____

CANCELLATION POLICY

By booking an appointment time, you are reserving time for your treatment. If you need to cancel or reschedule, we require 24 hours notice so that another patient can receive treatment.

If an appointment is cancelled within 24 hours or missed you will be charged in full for the session.

I, the undersigned comply and understand that I am responsible for canceling my appointment in advance or will be charge for the full cost of the session.

_____

Responsible Party Signature **Print Name**
(Signature of legal guardian if under 18)

Date_____

Print name if guardian has signed_____

CREDIT CARD AUTHORIZATION FORM (OPTIONAL)

Credit Card:_____

CC#:_____

Expiration Date:_____

Code (last 3 digits at signature strip for MC or Visa/4 digits on front of AMEX):
_____

Name (as it appears on credit card):_____

Billing Address for Credit Card:

STREET _____

_____

CITY _____

STATE _____ ZIP _____

EMAIL ADDRESS: _____

Credit Card Authorization:

I, the undersigned comply and understand that my credit card will be charged with my consent for a pre-negotiated amount for products and/or services rendered by Dr. Lisa H. Upshaw, consistent with the cancellation policy and/or services or products fees.

Print Name_____
Signature_____
Date_____