NEW PATIENT INTAKE FORM

Lighthouse Wellness
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Branson, MO 65616
417-334-2382
www.lighthousebranson.com

Please Print all Answers
Name ______________________ Age _______ Sex ________ Date ____________
Street Address ______________________ City / State ______________, ______ Zip ____________
Home Phone ____________ Work Phone ____________ Cell Phone ____________
E-mail ________________ Birth date ____________ Occupation ____________
How many hours per week do you typically work: ________ ❑ Married ❑ Single ❑ Separated ❑ Divorced ❑ Widowed
Emergency Contact: ____________________ Phone: ____________________

Insurance Information

Though much of our weight loss program is not covered by insurance, by providing this information, it allows us to check your benefits for the services offered at our practice.

Primary Insurance Name: ____________________
Policy #: ____________ Group #:____________
Subscriber Name: ____________________
Subscriber S.S.#: ____________
Subscriber Date of Birth: ____________
Relationship to Subscriber: ____________

Secondary Insurance Name: ____________________
Policy #: ____________ Group #:____________
Subscriber Name: ____________________
Subscriber S.S.#: ____________
Subscriber Date of Birth: ____________
Relationship to Subscriber: ____________

Referral Information

Who recommended you to our office? ❑ My Doctor ❑ Friend/Family ❑ Other ____________
Name ____________________ Phone or Address ____________________

Symptom Survey

Please list 3 Major Symptoms that you like Help with: 1.____________________
2. ____________________ 3.____________________

Health Information

Height: __________ Weight: __________ Waist Size: ______
Medications: If currently taking NO Medications, Please Check Here: ❑
____
____
Do you smoke? ❑ Yes ❑ No Consume Alcohol? ❑ Yes ❑ No If yes, how much/how often? ____________
Are you currently under the care of a physician? ❑ No ❑ Yes, for what reason(s)?____________
____
How stressed are you? (on a scale of 1 to 10, where 10 is the worst):____ How much water do you consume per day?____________
Have you ever had any health conditions that affected your liver? ❑ No ❑ Yes, explain: ____________
Have you ever had cancer? ❑ No ❑ Yes, explain: ____________
Do you exercise? ❑ No ❑ Yes How often?__________ What type?____________
Have you ever had cosmetic surgery? ❑ No ❑ Yes, type(s)/year(s): ____________
List any other surgeries and the year(s):____________
Food Allergies: ____________ Drug Allergies:____________ Other Allergies:____________

Weight Loss

Which do you want us to focus on? ❑ Abdomen ❑ Buttocks ❑ Thighs ❑ Chest ❑ Arms ❑ Neck ❑ Cellulite
How long have you been overweight? ____________ How much weight do you want to lose? ____________
Are you embarrassed about your weight/appearance? ❑ No ❑ Yes, explain: ____________
How important is weight or size reduction to you? (On a scale of 1 to 10, where 10 is the most important) ____________
Are other members of your family overweight? ❑ No ❑ Yes
Do you feel tired, run down, or out of energy? ❑ No ❑ Yes, explain: ____________

Please Initial ________

General Health

Mild	Moderate	Severe		Mild	Moderate	Severe	
❑	❑	❑	Urinary Incontinence/Infection	❑	❑	❑	Irregular Heartbeat
❑	❑	❑	Anti-Social	❑	❑	❑	Low Blood Sugar
❑	❑	❑	Bone Loss-Osteoporosis	❑	❑	❑	Gas & Bloated Stomach
❑	❑	❑	High Blood Pressure	❑	❑	❑	Loss of Confidence
❑	❑	❑	Unwanted Facial Hair	❑	❑	❑	Increase Thirst & Appetite
❑	❑	❑	Light headed	❑	❑	❑	Sugar Craving
❑	❑	❑	Abnormal Blood Sugar	❑	❑	❑	Craving Salt
❑	❑	❑	Numbness of Feet	❑	❑	❑	Acid Reflux
❑	❑	❑	Severe Acne & Pimples	❑	❑	❑	Capillary Fragility/Bruising
❑	❑	❑	Too Aggressive, Pushy, or Bossy	❑	❑	❑	Hemorrhoids

Hypothyroid/Adrenal Fatigue

Mild	Moderate	Severe		Mild	Moderate	Severe	
❑	❑	❑	Anxiety/Nervousness	❑	❑	❑	Heart Palpitation
❑	❑	❑	Irritable/Moody	❑	❑	❑	Sleep Difficulties/Insomnia
❑	❑	❑	Drowsy/Sleepiness During Day	❑	❑	❑	Fuzzy/Cloudy Thinking
❑	❑	❑	Memory Problems	❑	❑	❑	Fat Waist & Hips/Overweight
❑	❑	❑	Severe Headaches/Migraines	❑	❑	❑	Loss of Muscle/Strength
❑	❑	❑	Lack of Libido	❑	❑	❑	Increased Fatigue/Tiredness/Lack of Energy
❑	❑	❑	Skin Aging/Thin/Wrinkles	❑	❑	❑	Bone & Joint Pain/Arthritis
❑	❑	❑	Water Retention	❑	❑	❑	Carpal Tunnel Syndrome
❑	❑	❑	Hoarser/Deeper Voice	❑	❑	❑	Decreased Immunity/Frequent Colds
❑	❑	❑	Depressed	❑	❑	❑	Pessimistic
❑	❑	❑	Lack of Orgasm	❑	❑	❑	Stressed
❑	❑	❑	Mental Fatigue	❑	❑	❑	Muscle Pain/Fibromyalgia
❑	❑	❑	Excessive Cold Hands & Feet	❑	❑	❑	Constipation
❑	❑	❑	Dry Skin & Dry Hair	❑	❑	❑	Unsteady Gait

Hyperthyroid

Mild	Moderate	Severe		Mild	Moderate	Severe	
❑	❑	❑	Tachycardia – Rapid Heartbeat	❑	❑	❑	Unintentional Weight Loss
❑	❑	❑	Shakiness – Hands	❑	❑	❑	Loss of Appetite
❑	❑	❑	Severe Oily Skin	❑	❑	❑	Increased Sweating

Female Only

Mild	Moderate	Severe		Mild	Moderate	Severe	
❑	❑	❑	Pre-Menstrual Syndrome	❑	❑	❑	Breast Swelling/Tenderness/Cystic
❑	❑	❑	Polycystic Ovaries	❑	❑	❑	Uterine Fibroids
❑	❑	❑	Excessive Menstrual Bleeding	❑	❑	❑	Sagging Breast
❑	❑	❑	Vaginal Dryness	❑	❑	❑	Menopause
❑	❑	❑	Lack of Menstruation	❑	❑	❑	Hot Flashes
❑	❑	❑	Dry Eyes	❑	❑	❑	Night Sweats

Are you pregnant? ❑ No ❑ Yes, how far along? ______ First date of your last Menstrual Period, if applicable: __________
Age of Menopause, if applicable: _______________

Male Only

Mild	Moderate	Severe		Mild	Moderate	Severe	
❑	❑	❑	Enlarged Man Breast	❑	❑	❑	Prostate Enlargement
❑	❑	❑	Soft Difficult Erection	❑	❑	❑	Difficulty Urinating
❑	❑	❑	Frequency of Urination				

Please Initial ________

PATIENT CONSENT, ACKNOWLEDGEMENT & SIGNATURE

By my signature below I acknowledge that I have read or have had read to me and have received a photocopy upon my request of this document including the Health Care Privacy Notice, Facility terms & conditions, credit policies and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original. I have made my decision voluntarily and freely to submit for healthcare services in this facility. I acknowledge and agree that all services rendered are charged directly to me, and that I am personally responsible for payment. I further understand that Lighthouse Wellness is a division of Healing Arts Center, LLC.

Signature: _____________________________________ Date: ________________

PHOTOGRAPHY CONSENT

I, _________________________________, consent to the taking of photographs by Lighthouse Wellness, Healing Arts Center, LLC (Dr. Matthew Sams or designee) of me or parts of my body in connection with the weigh loss programs intended, offered, or performed. I understand that photographs may be taken before, during, and after my treatment(s) as part of my care. I further understand that these photographs will be kept strictly confidential. I further acknowledge and consent that these photographs may be reviewed by the licensed providers of this facility (Chiropractic and Physical Therapy) in order to offer additional direction towards my wellness journey.

Signature: _____________________________________ Date: ________________