Dr. Nicole Krakora, ND

Flatiron Functional Medicine
400 McCaslin Blvd. Suite 210
Louisville, CO 80027

Phone: 303-993-7910 **Fax: 303-993-4674**

Please fill out this confidential health history form as completely as you can. The more information you provide us the better we will be able to help you.

Today's Date: ___/___/___ Whom may we thank for referring you to our office:_____

PERSONAL HISTORY

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Home Phone: (___) _____ - _____ Cell phone: (___) _____ - _____Email: _____

Birth Date: _____/_____/_____ Age: _____ Gender: ❑Female ❑ Male

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Drivers License Number: _____ Social Security Number: _____ - _____- _____

Employer: _____ Type of Work: _____

Address: _____City: _____ State: _____

Zip Code: _____ Work Phone: (___) _____ - _____

Spouse's Name: _____ Work Place: _____ Phone: (_____) _____ - _____

Name & Ages of Children (if applicable): _____

In an emergency, whom do we contact? _____ Phone: (_____) _____ - _____

CURRENT HEALTH CONDITIONS

Primary health complaint(s): _____

How long have you suffered with this problem? _____

How often does this problem currently bother you? _____

Does anyone else in your family have the same or similar problem? ❑ Yes ❑ No

If yes, who? _____

Before you began to suffer with this problem, was there an earlier accident, injury, or other condition that could have brought this about or be related to it? ❑ Yes ❑ No

If yes, was it: ❑ Job related ❑ Auto Accident ❑ Other: _____

If work related, has the accident been reported to your employer? ❑ Yes ❑ No

If auto related, what is the date and time of accident? _____

What other health practitioners have you consulted for this/these complaints? _____

_____

Have you become discouraged that this problem has not been resolved? ❑ Yes ❑ No

When this problem is at its worst, how does it make you feel? _____

When this problem is at its worst, how does it interfere with your:

Work? _____ Family Life? _____

Recreation/Hobbies? _____

What effect is this problem having on other people in your life? _____

What effect is this problem having on your level of stress? _____

What daily habits do you have that could make this worse? _____

On a scale of 1-10 (ten highest) rate your commitment to getting rid of this problem: _____

Is getting rid of this problem, and what caused it, a top priority for you? _____

PAST HEALTH HISTORY

Surgeries/Operations: Appendix _____ Tonsils ____ Hernia _____Spinal____ Cosmetic _____ Other: _____

Major accidents or falls since birth: _____

Hospitalizations (other than above): _____

Please list all medications you presently take: (please include all medications, including over the counter and vitamins):

_____

Are you currently under the care of a physician? ❑ Yes ❑ No If yes, please indicate for what condition:

_____

Please list the physician's name, phone number, and approximate date of last treatment:

_____

Have you had previous chiropractic care? ❑ Yes ❑ No Please list doctor's name and approx. date of last visit:

_____

Are you presently under the care of any other healthcare practitioners?

❑ Acupuncturist ❑ Massage Therapist ❑ Nutritionist ❑ Other: _____

Is there anything else that you would like the doctor to know about your health? _____

_____

Please check any of the following conditions that you have had in the past:

❑ Pneumonia
❑ Mumps
❑ Arthritis
❑ Heart Disease
❑ Measles
❑ Pleurisy
❑ Tuberculosis
❑ Thyroid Disorder
❑ Influenza
❑ Polio
❑ Cancer
❑ Anemia
❑ Rheumatic Fever
❑ Small Pox
❑ Eczema/Psoriasis
❑ Whooping Cough

Do you have allergies? ❑ Yes ❑ No If yes, what kind? _____

Do you smoke cigarettes, cigars, or chew tobacco? ❑ Yes ❑ No If yes, how much? _____

Do you drink alcohol? ❑ Yes ❑ No If yes, how much? _____

Do you drink coffee? ❑ Yes ❑ No If yes, how much? _____

Do you drink soda/soft drinks? ❑ Yes ❑ No If yes, how much? _____

Do you eat fried foods? ❑ Yes ❑ No If yes, how much? _____

Do you use white sugar/artificial sweeteners? ❑ Yes ❑ No If yes, how much? _____

Your doctor will be making specific dietary recommendations and prescribing an individual supplementation program just for you. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to follow the recommended dietary and nutritional supplementation program. _____

ERGONOMIC HEALTH HISTORY

How you treat and support your body on a daily basis has a direct impact on your health. Please help us help you by providing us with the following information:

Exercise Habits

Do you currently exercise? _____

Do you wear orthotics/foot inserts? _____

Your doctor may recommend a cardiovascular, strength training, and/or stretching program. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to incorporate the prescribed exercise into your health care program.

1 2 3 4 5 6 8 9 10

Sleep Habits

What is your most common sleep position? ❑ Back ❑ Side ❑ Stomach

Do you use a pillow? ❑ Yes ❑ No What type? ❑ Regular ❑ Cervical (neck)

What type of mattress do you sleep on and how old is it? _____

How many hours of sleep do you average per night? _____

Work Habits

How many hours per day are you:

Sitting: _____ Standing: _____ Crouching or bending over: _____

Lifting: _____ Walking: _____ Working at a computer: _____

Electronic Radiation Exposure

Do you use any of the following daily? Check all that apply.

❑ Blow dryer/curling iron ❑ Microwave ❑ Sleep within 3 feet of an electrical outlet

❑ Cell phone/cordless phone ❑ Electric razor/toothbrush ❑ Spend more than 1 hour/day in the car

Scientific studies are now showing that repeated exposure to the above items can be extremely hazardous to your health. Your doctor will discuss with you ways to reduce your exposure to these harmful elements.

MENTAL/EMOTIONAL HEALTH HISTORY

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please answer the following questions as accurately and completely as possible:

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

Please circle the appropriate number:	Low									High
Financial/Money matters	1	2	3	4	5	6	7	8	9	10
Relationship/Family	1	2	3	4	5	6	7	8	9	10
Job/Career/Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/Religious/Ethical	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check all of the following life events that you currently (or previously) experience stress with:

- ❑ Birth of siblings
- ❑ Toilet training
- ❑ Babysitters
- ❑ Death of a pet
- ❑ First year of school
- ❑ Teachers
- ❑ Peer relationship
- ❑ Onset of puberty
- ❑ Fights
- ❑ Romance/dating
- ❑ Illness/operations
- ❑ Parental conflict/separation
- ❑ Divorce
- ❑ Prom
- ❑ College
- ❑ Abortion/miscarriages
- ❑ Any betrayal
- ❑ Marriage
- ❑ Moving
- ❑ Accidents
- ❑ Loss of job/layoff
- ❑ Financial disruptions
- ❑ Illness of a loved one
- ❑ Diagnosis of a fatal condition
- ❑ Death of a loved one
- ❑ Other: _____

NET (Neuro-emotional technique). They are able to determine through this method if stress is affecting your present condition and overall health. They will discuss this with you in your consultation. If your doctor can show you how your health can improve and your level of stress can be dramatically reduced, would you be interested in learning more about this technique? ❑ Yes ❑ No

Please check any of the following that you have had in the past six months:

Musculoskeletal
- ❑ Low back pain
- ❑ Pain b/w the shoulders
- ❑ Neck pain
- ❑ Shoulder/arm/wrist pain
- ❑ Hip/knee/ankle pain
- ❑ Joint pain or stiffness
- ❑ Difficulty walking
- ❑ Jaw/head pain

Nervous System
- ❑ Cold/tingling extremeties
- ❑ Numbness/loss of sensation
- ❑ Dizziness
- ❑ Seizures
- ❑ Paralysis
- ❑ Nervousness/Stress

Cardiovascular
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Stroke
- ❑ Lung congestion
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Lung symptoms

General
- ❑ Allergies
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Unexplained fevers
- ❑ Headaches

Gastrointestinal
- ❑ Poor Appetite/Underweight
- ❑ Excessive Thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver problems
- ❑ Colitis/Crohn's/IBS
- ❑ Gall bladder problems
- ❑ Abdominal Cramps
- ❑ Gas/bloating after meals
- ❑ Heartburn
- ❑ Blood in stool

Male Only
- ❑ Prostate dysfunction
- ❑ Loss of libido
- ❑ Sexual dysfunction

Women Only
- ❑ Menstrual cramps
- ❑ Irregular/absent periods
- ❑ Vaginal pain/infection
- ❑ PMS
- ❑ Loss of libido
- ❑ Menopausal symptoms
- ❑ Breast pain
- ❑ Uterine/ovarian fibroids
- ❑ Date of last period?

_____/_____/_____

Are you pregnant?

❑ Yes ❑ No ❑ Not sure

Genitourinary
- ❑ Painful/excessive urination
- ❑ Discolored urine
- ❑ Bladder infections
- ❑ Urinary leakage

EENT
- ❑ Vision problems
- ❑ Dental problems
- ❑ Earache/infection
- ❑ Difficult hearing
- ❑ Ringing in Ears
- ❑ Cold/Flu
- ❑ Sinus problems
- ❑ Sore throat

Other Health Issues

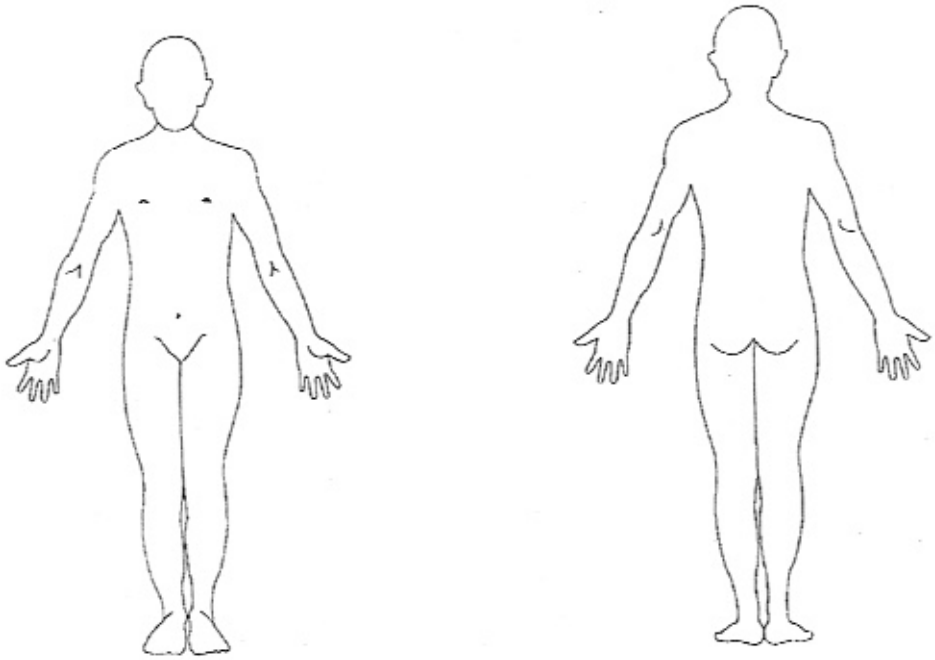
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Pain Chart

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
_____	000000000000000	XXXXXXXXX	**********	///////////////

Please mark on the pain scale from 1-10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.



DIET/NUTRITIONAL HEALTH HISTORY

What you eat and what you supplement your diet with has a direct effect on your health. Please help us help you by providing us with the following information:

What do you commonly eat for breakfast? _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you regularly take nutritional supplements? ❑ Yes ❑ No If yes, please list them:

_____

SENSITIVE HEALTH INFORMATION

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

1) History of alcohol use/abuse: ❑ Yes ❑ No If yes, how much, what kind, and for how long have you consumed these? _____

2) History of recreational drug use/abuse: ❑ Yes ❑ No If yes, what kind, how much, and how long? _____

_____

3) Have you been diagnosed with a mental illness? ❑ Yes ❑ No Diagnosis? _____ When? _____

Treatment? _____

4) Have you ever been tested for the HIV virus? ❑ Yes ❑ No Results? _____

5) Have you ever been diagnosed with HIV or an HIV related illness? ❑ Yes ❑ No If yes, what type of treatment are you under?

_____

I hereby authorize the doctor to provide me with a consultation and examination in order to determine if my case can be helped by Naturopathic care. I also understand that other exams and tests may be necessary to gain more information regarding my health. I understand that if I am accepted as a patient here by Dr. Nicole Krakora, she will discuss with me which course of care would be best for my case

_____	_____
Patient Signature	Patient Name
_____	_____
Parent/Guardian Signature	Date

Missed Appointments

Unless the office is given a 24 hours notice of cancellation for an appt you will be charged for half of the following for appointment (follow up $225 – charge is $112.50)
Initials _____

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder, any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _____. Effective as of the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT, YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION, AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ___ OF THIS CONTRACT.

(Date)

PATIENT SIGNATURE X

(Or Patient Representative) (Indicate relationship if signing for patient)

(Date)

OFFICE SIGNATURE X

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE

NCC-CA

Metabolic Health Assessment

Directions: Rate each of the following based upon your typical health profile:

1. Occasionally have symptom
2. Frequently have symptom, not severe
3. Frequently have symptom, effect is severe

List top 4 Health Concerns

1._____ 3._____

2._____ 4._____

1	Thyroid Symptoms
	*Difficulty gaining weight, even with large appetite
	*Nervous, emotional, can't work under pressure
	*Flush easily
	*Fast pulse at rest
	*Inward trembling
	*Intolerance - high temperatures
	Difficulty losing weight
	Mentally sluggish, reduced initiative
	Easily fatigued, sleepy during the day
	Sensitive to cold, poor circulation (cold hands and feet)
	Excessive hair loss and/or coarse hair
	Morning headaches, wear off during the day
	Loss of lateral 1/3 of eyebrow
	Infrequent bowel movements
*	(*) Referring to Hyperthyroid

3	Adrenal Symptoms
	*Cannot fall asleep; wake up after a few hours of sleep
	*Perspire easily
	*Wake up tired – after 6+ hours of sleep
	*Tend to be "keyed up" during the day
	*Clenched or grind teeth
	*Excessive thirst
	Crave salty foods
	Cannot stay asleep. Awaken after a few hours of sleep
	Slow starter in the morning
	Afternoon fatigue
	Become dizzy when standing up suddenly
	Weak nails
	Weakness / Dizziness
	Afternoon yawning
	Allergies or hives
	Arthritic tendencies
*	(*) Referring to Hyperadrenal

5	Leaky Gut Symptoms
	Bloating and distention after eating
	Intolerance to sugars & starches - upset the stomach
	Abdominal swelling
	Increased reactions to eating foods
	Pains, aches and swelling throughout the body
	Unpredictable food reactions
	Skin issues: acne, rosacea

6	Digestion Symptoms
	Bad breath (halitosis)
	Heartburn or acid reflux
	Excessive belching or burping
	Undigested foods in stool
	Gas after meals
	Difficult bowel movements
	Sense of excess fullness after meals
	Sleepy after meals

2	Sugar Handling Symptoms
	Crave sweets
	Awaken a few hours after falling asleep; hard to get back to sleep
	Light headed if meals are missed
	Frequent urination
	Frequent thirst
	Fatigue after meals
	Eating relieves fatigue
	Agitated or easily upset
	Blurred vision
	Headache if meals are missed
	Poor memory/forgetful
	Shaky if missed meals
	Binge or uncontrolled eating

4	Environmental Symptoms
	Chemical & odor sensitivities
	Headaches after exposure to chemicals
	Intolerance to household chemicals (e.g. shampoo, lotion, laundry detergent, etc.)
	Skin outbreaks
	Excessive mucus

7	Liver & Gallbladder
	Nausea
	Hormone imbalances
	Light colored stools
	Pain between shoulder blades
	Stomach upset after greasy foods
	Acne or unhealthy skin
	Hemorrhoids or varicose veins
	Dry or flakey skin
	Itchy skin
	Removal of gallbladder
	Gallbladder attacks
	Headache over eyes