New Dimensions WELLNESS
#BeHappy

# INTAKE FORM

## General Questions:

Today's date: _____ / ____ / _____

Last name: ______________________________ First name: _____________________________ MI: _____

Birthdate: _____ / ____ / _____ Gender: ☐ M ☐ F

Mailing address: _________________________________

City: ___________________ State: _______ Zipcode: __________

Email address: ___________________________

Home phone: ___________________ Cellphone: ___________________

Occupation: ____________________

Emergency contact: ______________________ Contact's phone number: ___________________

Relationship to patient: ___________________

Who referred you? ______________________

Follow us:

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(407) 421-4737
4470 35th Street
Orlando, FL 32811
MyNewDimension.com

## Primary Health Concerns: *Please list in order of importance.*

| Concern: | Onset: | Frequency: | Severity: |
|---|---|---|---|
| *Ex. Headaches* | *June 1992* | *4-times/week* | *mild/mod/severe* |

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

**What are your goals for this visit?** ______________________________

______________________________

______________________________

**Please list any life threatening allergies:** ______________________________

**Other allergies, sensitivities, or intolerances (ex. food, medication, environmental, chemical, etc.)**

______________________________

**What are the major stressors in your life? Do you consider severity of stress low, moderate, or high?**

______________________________

______________________________

______________________________

## Previous Therapy History:

**Check all that apply to you. Please specify the date of diagnosis where applicable.**

☐ Dietary modification ☐ Fasting ☐ Herbs ☐ Vitamins/Minerals ☐ Chiropractic

☐ Homeopathy ☐ Acupuncture ☐ Conventional drugs ☐ Other

## Health Habits:

### Nutrition & Diet

☐ Mixed food diet (animal and vegetable) ☐ Vegetarian ☐ Vegan ☐ Organic food

☐ Salt restriction ☐ Fat restriction ☐ Starch/carbohydrate restriction ☐ Calorie restriction

Please list any food restrictions (dairy, gluten, soy, etc) ______________________________

### Sleep

Hours per night: _______ Sleep quality: ☐ Poor ☐ Fair ☐ Good

### Body Composition

☐ Lose weight ☐ Gain weight ☐ Burn more body fat ☐ Be stronger

☐ Have better muscle tone ☐ Be more flexible

**Today's weight: ___________ lbs Height: ______ ft. ______ in.**

### Energy-Vitality I Woud Like to:

☐ Feel more vital ☐ Have more energy ☐ Have more endurance ☐ Be less tired after lunch

☐ Sleep better ☐ Be pain free ☐ Get less colds and flus ☐ Get rid of allergies

☐ Not be dependent on over-the-counter medications, like aspirin, Ibuprofen, anti-histamines, sleeping aids, etc. ☐ Improve sex drive

### Stress, Mental, Emotional

☐ Be more focused ☐ Improve memory ☐ Be less depressed ☐ Be less moody

☐ Feel more motivated ☐ Feel less stressed

### Please list any vitamin, minerals, herbal supplements, homeopathic, over-the-counter and/or prescribed medications and creams you are taking:

| Product: | Dosage: | How long taken: | What is this taken for: |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Please use back of this form for additional medicines.

I have indicated all of my known medical conditions above. I will alert the practioner to any changes in my health status. It is my choice to recieve naturopathic care.

Signature: ______________________________ Date: ____________

# New Dimensions Wellness

Informed Consent WAIVER AND RELEASE OF ALL LIABILITY

I, ___________________________, seek and consent to the services of **New Dimensions Wellness Inc.** to provide, facilitate and include physical therapy, performance exercise, biomechanic evaluation, infrared sauna, phototherapy, acupuncture, hyperbaric chambers, chiropractic, supportive, naturopathic care for myself or my minor child. Naturopathic services use natural means and remedies to further health and wellness, including assessment and patient education and counseling about nutritional interventions; herbal and homeopathic remedies; lifestyle modifications; mind-body supportive counseling; and a range of other natural interventions/consultation.

I understand that there are risks involved with my participation at **New Dimensions Wellness, Inc.** I hereby authorize **New Dimensions Wellness, Inc**. to act for me according to their best judgment in any emergency requiring medical care. I hereby waive and release **New Dimensions Wellness, Inc.** and any clinician, staff member,and/or any representative or contracted worker of **New Dimensions Wellness, Inc.** from all liability and agree to accept all medical expenses incurred. I know of no physical or mental problem, which was not described on the **New Dimensions Wellness** history questionnaire, which will affect my ability to safely participate at **New Dimensions Wellness, Inc.**

I am aware that playing, practicing, training, and/or other involvement in any sport or exercise can be a dangerous activity involving **MANY RISKS OF INJURY**, including, but not limited to catastrophic injury or death. Further, I voluntarily and knowingly accept the dangers and risks of playing, practicing, or training in any athletic activity or exercise including, but no limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the neuromuscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Furthermore, I understand and accept the risk of injury, catastrophic injury, and/or death.

Permission is granted for me to receive emergency medical treatment if needed. I hereby release and forever discharge **New Dimensions Wellness**, and all their agents, employees and affiliated entities from any and all liability, claims, demands, and causes of action for personal injury or death, negligence, property damage, and/or other loss suffered in connection with my participation. I acknowledge and accept that this Release and Waiver is intended to be binding on my family, estate, heirs, executors, administrators and assigns. I further acknowledge and accept the this Release and Waiver is intended to be as broad and inclusive as permitted by the laws of the state in which **New Dimensions Wellness, Inc.** practice is taking place and agree that if any portion of this release and waiver is invalid, the remainder will continue to be in full force and effect. I agree that this Release and Waiver binds me to all of its terms.

I waive and release **New Dimensions Wellness, Inc**. and their heirs, assigns or successors in interest of any and each of them from any and all liability which may result or arise from either my participation or any medical treatment I may receive. Management retains the right to use any photography, images, video, etc. for promotion and/or other purposes. I acknowledge and accept the conditions above with my signature below.

*Supplement Purchases:* I understand I am not obligated to purchase nutritional or herbal products recommended by **New Dimensions,** from this office or from any specific vendor, and I will be given the same level of attention without regard to my purchases.

*Privacy Policy:* My privacy is important and my records will be held confidential unless I request in writing that they be released to myself or to other caregivers.

*Important Insurance and Payment Notices:* **New Dimensions Wellness Inc.** services are, with few exceptions, not reimbursed by insurance or Medicare. Payment in full is required at each visit. I understand I am responsible for payment even if I submit and am denied reimbursement or even if my insurer determines that services are not medically necessary.

**New Dimensions Wellness Inc. requests 24-hours notice for canceling or rescheduling appointments. For any visits canceled with less than 24-hours notice, the patient will be charged half the amount of the original visit fee except in the case of family or medical emergency. Any no call or no show will be charged the full amount of service. This charge will be billed directly to the client. Late arrivals will not receive an extension of scheduled service times and will be responsible for full service fee. In the event legal action is required to collect payment, I agree to be responsible for attorney fees and costs.**

*Informed Consent for Naturopathic Consultation and Conditions of Admission*
I hereby authorize naturopathic assessment and consultation and certify that I understand the nature of this health care method. I understand that no recommendations are being made to me to discontinue any treatment being provided by any other health care professional. I understand that New Dimensions Wellness and all its employees/ does not function as a primary care or medical physician and that they offer their services as a complement to other services I receive. I have been adequately informed, and questions I have asked have been satisfactorily answered. I represent that I am seeking assessment and consultation in order to further my own health and for no other reason and do not represent a third party. I hereby request and authorize the staff of New Dimensions Wellness Inc. to provide me with treatment and to perform any procedures now contemplated an/or such any additional procedures deemed reasonable and necessary. The agencies and their staff are hereby relieved of any and all liability occurring from the performance of before mentioned treatments

Signature: ______________________________________________ Date: __________________

## Assignment of Benefits Form Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service, unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

### Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to New Dimensions Wellness and Education Inc. rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

### Authorization to Release Information

I hereby authorize New Dimensions Wellness and Education Inc. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from New Dimensions Wellness and Education Inc. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature: ________________________________________________ Date: ___________________

Witness Signature: _________________________________________ Date: ___________________