KLEPZIG
natural healing clinic

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FEES FOR SERVICES RENDERED AT OUR CLINIC ARE AS FOLLOWS

New Patient Examination/Consultation	$85
Nutritional Consultation/Interpretation	15 minutes $40
	30 minutes $55
Acupuncture	$55
Nutritional Supplements	Prices Vary

CONSENT TO EXAMINATION AND TREATMENT

I hereby give permission to the doctor to administer treatment and perform such general procedures, as he may deem necessary in the diagnosis and treatment of my condition. I have read and agree to the above statements.

PATIENT SIGNATURE _____ DATE _____

NOTICE OF PRIVACY PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health research, and law enforcement activities. Any other disclosures for the purpose of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures. This provision does not apply to the transfer of medical records for treatment. Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure.

We maintain a history of protected health information disclosures that is accessible to you. You may inspect and receive copies of your records within 30 days of a request to do so. There may be a reasonable cost-based fee for photocopying, postage, and preparation.

In the future we may contact you by mail, email, or telephone for appointment reminders or announcements. Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

PATIENT SIGNATURE _____ DATE _____

KLEPZIG
natural healing clinic

35 Circle Dr., Charleston, IL 61920
Mon + Wed 8a-5p, Fri 10a-5p | Tel 217.345.1416

2902 Crossing Ct., Suite D, Champaign, IL 61821
Tue + Thur 10a-5p | Tel 217.359.7400

Fax 217.345.1460
KlepzigNaturalHealingClinic.com

PERSONAL INFORMATION

Date _____

Name _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____

PREFERRED FORM OF CONTACT ☐ HOME ☐ WORK ☐ CELL ☐ EMAIL

Date of Birth _____

Marital Status _____ Sex _____ Age _____

Occupation _____ Referred By _____

Emergency Contact Name/Phone _____

FINANCIAL AGREEMENT

I understand that all services are rendered on a cash, check, or credit card basis. Unless other arrangements have been made and approved, I agree to pay for each appointment at the time of the appointment. I understand that I am responsible for any debts incurred at this office.

_____

PATIENT'S SIGNATURE DATE

AUTHORIZATION TO RELEASE INFORMATION FOR INSURANCE PUPROSES

I understand that Klepzig Natural Healing Clinic does not accept or bill insurance. I hereby authorize Klepzig Natural Healing Clinic to release any information required in a the course of my examination or treatment to satisfy medical insurance claims that I have submitted for reimbursement.

_____

PATIENT'S SIGNATURE DATE

CURRENT HEALTH CONDITION

Purpose of this appointment _____

Today's condition started when? _____

Please list all medical diagnosis/conditions you are currently being treated for: _____

_____

Other doctors seen for this condition _____

Type of treatment _____ Results _____

Please list medications _____

Please list vitamins, herbs, and supplements _____

Please check symptoms that apply to you, and circle severity of symptoms where it's requested.

YOUR LIFESTYLE

___Alcohol
___Tobacco
___Marijuana
___Drugs
___Stress
___Occupational hazards
___Regular exercise
___Type_____Frequency _____
___Type_____Frequency _____
___Type_____Frequency _____

FEMALES, PLEASE COMPLETE

___Pregnant
___Planning pregnancy
___Menstrual flow regular/irregular/pain
___Days of flow
___Length of cycle
___First day of your last period
___Pain/Bleeding during or after sex
Number of:
Pregnancies _____
Abortions _____
Miscarriages _____
Live births _____
Bird control method _____
Birth control pill name _____
___Flushing/Menopause
Date of last PAP test _____
___Normal
___Abnormal
Date of last mammogram _____
___Normal
___Abnormal

HOSPITALIZATIONS

Date _____
Reason _____

Date _____
Reason _____

Date _____
Reason _____

Date _____
Reason _____

MEDICAL HISTORY

___Ringing in ear
___Frequent ear infections
___Dizziness/Fainting
___Failing vision
___Eye infections
___Nose bleeds
___Sinus trouble
___Frequent sore throats
___Hayfever/Allergies
___Pneumonia
___Bronchitis/Chronic cough
___Asthma/Wheezing
___Chest pain
___High blood pressure
___Heart murmur
___Swollen ankles
___Leg pain (walking)
___Varicose veins/phlebitis
___Loss of appetite
___Difficulty swallowing
___Indigestion/Heartburn
___Persistent nausea/vomiting
___Peptic ulcers
___Chronic abdominal pain
___Gall bladder trouble
___Jaundice/Hepatitis
___Change in bowel habits
___Diarrhea
___Constipation
___Diverticulosis
___Crohn's/Colitis
___Bloody/Tarry stools
___Hemorrhoids
___Hernia
___Frequent urine infections
___Blood in urine
___Urinate overnight more than twice
___Painful urination
___Loss of control of urination
___Decrease in force/flow of urination
___Kidney stones
___Venereal disease
___Chronic fatique
___Recent weight loss
___Anemia
___Bruise easily
___Cancer
___Diabetes
___Thyroid disease
___Convulsions/Seizures
___Stroke
___Tremor/Hands shaking
___Muscle weakness
___Numbness/Tingling sensations
___Frequent headaches
___Arthritis/Rheumatism
___Osteoporosis
___Recurrent back pain
___Bone fracture/join injury
___Gout
___Foot Pain
___Cold numb feet
___Rashes/Hives
___Psoriasis
___Eczema
___Nervousness
___Depression
___Memory loss
___Excessive moodiness
___Mental illness
___Phobias
___Lactose intolerance
___Prostate disease
___Sexual/Menstrual dysfunction
___Frequent infections
___Diphtheria
___Tetanus
___Chicken pox
___Polo
___Mumps
___Measels
___Rubella
___Rheumatic fever
___Scarlet fever
___Tuberculosis
___Herpes
___Other _____

FAMILY HISTORY (Have any blood relatives had the following illnesses? If so, please indicate relationship.)

Illness	**Family Member**
Diabetes	
Cancer	
Blood disease	
Glaucoma	
Epilepsy	
Rheumatoid Arthritis	
Tuberculosis	
Gout	
High blood pressure	
Heart disease	
Back Problems	

Name Date

7 PILLARS OF HEALTH: SURVEY OF YOUR BODY'S SYSTEM V3.1

Please check symptoms that apply to you, and circle severity of symptoms where it's requested.

NEURO-HORMONAL/ENDOCRINE PILLAR #1

Adrenals

___Energy low/variable/normal/high
___Difficulty falling asleep
___Difficulty staying asleep
___Slow to start in the morning
___Energy Crash at _____ am/pm
___Dizzy when standing quickly
___Light bothers your eyes
___Weak nails
___Perspire easily or excessively
___Other _____

Pituitary

___Sex drive flat/low/normal/high
___Menstrual disorders
___Splitting headaches
___Other

Thyroid

___Tired/Sluggish throughout the day
___Chills/Cold hands, feet, body
___Require excessive sleep
___Increase in weight unexplained
___Difficult/Infrequent bowel movements
___Depression or lack of motivation
___Hair loss/thinning
___Thinning of outer third of eyebrow
___Dryness of scalp
___Heart palpitations, skip/flutter
___Inward trembling
___Increase pulse at rest
___Insomnia/Cannot sleep
___Night sweats
___Other _____

Uterus (Women Only)

Last menstrual period _____
Length of menses _____
___Regular cycle
___Irregular cylce
___Early (less than 28 days)
___Late (more than 28 days)
___Skip cycles
___Flow heavy/moderate/light
___Cramps mild/moderate/severe
___Clotting/Spotting
___Headhache side of head
___Other _____

Ovaries (Women Only)

___Sex Drive flat/low/normal/high
___Low abdominal puffiness
___Fluid retention Face/Hands/Feet
___Mood swings/irritable/depression
___Tired during cycle
___Ovarian pain
___Breast tenderness around cycle
___Acne around cycle pre/mid/post
___Birth control pill/patch
___Menopausal natural/surgical
___Hot flashes
___Facial hair growth
___Dark nipple hair
___Hair growing up towards belly button
___Skin crawling
___Breast discharge
___Breasts shrinking
___Breast feeding
___Breast surgery
___Other _____

Vagina (Women Only)

___Burn
___Itch
___Dry
___Dischage clear/white/yellow/green/brown
___Pain with intercourse
___Other _____

Testes (Men Only)

___Sex drive flat/low/normal/high
___Decreased morning erections
___Decreased fullness of erections
___Inability to concentrate
___Episodes of depression
___Decreased physical stamina
___Sweating attacks
___More emotional than past
___Unexplained weight gain
___Other _____

Sleep

___Quality poor/fair/good/great
___Hours in bed
___Hours asleep
___Interrupted per night
___Awaken suddenly (jolt)
___Other _____

Emotions

___Stress
___Sad
___Grief
___Depression
___Moodiness
___Frustrated
___Irritable
___Angry
___Worrisome
___Nervous
___Anxiety
___Panic
___Cry
___Fear
___Shame
___Guilt
___Other _____

Brain

___Forget names
___Forget numbers
___Forget words
___Forget actions
___Difficulty focusing/concentrating
___Other _____

GLYCEMIC MANAGEMENT PILLAR #2

Pancreas

___Crave sweets
___Irritable when you skip meals
___Light headed when you skip meals
___Eating relieves fatique
___Bouts of blurred vision
___Fatique after meals
___Frequent urination
___Increased thirst
___Difficulty losing weight
___Other _____

Appetite/Diet

___Appetite low/normal/high
___Eat animal protein /per day
___Eat starch pasta/bread/potatoes/rice
___Eat sweets cakes/cookies/candy
___Eat chocolate /per week

Appetite/Diet Continued

___Eat spicy foods /per week
___Eat ice cream /per week
___Coffee cups/week
___Caffeinated tea cups/week
___Juice /per week
___Soda /per week
___Beer /per week
___Wine /per week
___Liquor /per week
___Artifical sweeteners yes/no
___Trans fats yes/no
___Food allergens yes/no
___Special diet? _____

BIOTERRAIN/MINERAL PILLAR #3

___Twitching around eyes
___Difficulty falling asleep
___Restlessness
___Don't remember dreams
___Nail spots or weakness
___Air hunger/frequent sighs
___Cramps legs/feet/arms/hands
___Aches legs/feet/arms/hands
___Restless legs/feet/arms/hands
___Frequent thirst
___Shallow rapid breathing
___Poor muscle endurance
___Swelling in ankles and wrists
___Uterine cramps (women)
___Urination leakage
___Other _____

INFLAMMATORY/IMMUNE PILLAR #4

Eyes

___Burn/red/dry
___Tears
___Eye film/crust in the morning
___Floaters
___Stye
___Itchy eyes
___Eye ache
___Vision blurry
___Tired
___Spots
___Puffy
___Dark circles
___Other _____

Ears

___Ear noise rings/hiss/pound
___Ear plugged
___Ear popping
___Ear ache/infections
___Ear itch internally
___Ear drainage
___Hearing loss
___Excessive ear wax
___Dizziness/Vertigo
___Other _____

Sinus

___Frontal headache
___Sinus dry
___Sinus drain
___Sinus stuffy or pressure
___Sneeze frequently
___Smell/Taste loss
___Post nasal drip
___Mucous clear/white/yellow/green/brown
___Other _____

Lungs

___Chest congestion
___Pain on breastbone
___Shortness of breath upon exertion
___Frequent sighs
___Wheezing
___Asthma
___Emphysema
___Bronchitis
___Other _____

Mouth/Throat/Immune

___Blisters
___Canker sore(s)
___Bad breath
___Dry mouth
___Bleeding gums
___Receding gums
___Teeth health problems
___Swelling of glands
___Cough dry/productive
___Sore throat
___Hoarseness
___Fever
___Frequent colds/flu
___Environmental allergies
___Nail fungus mild/moderate/severe
___Nightmares
___Other _____

Bladder

___Urinate times/day (awake)
___Urinate times/night (asleep)
___Urination urgency
___Burn/Pain urinating
___Cloudy urine
___Odorous urine
___Spasm urinating
___Urinary tract infection (UTI)
___Kidney pain or infections
___Other _____

Skin

___Skin rash
___Acne
___Itchy skin
___Cellulite
___Other _____

Breasts (Women Only)

___Breast fibrosis
___Breast lumps
___Other _____

Prostate (Men Only)

___Urination difficulty
___Frequent urination
___Urination burn/achiness/pain
___Urination dribbling/emission/swelling
___Pain inside of legs or heels
___Headaches side of head
___Other _____

CARDIOVASCULAR PILLAR #5

___Chest tension/tight/pressure
___Chest heaviness
___Chest heart pain
___Heart palpitations skip/flutter
___Heart racing
___Heart slowing down
___Constant shortness of breath
___Sleep apnea
___Mitral valve prolapse
___Murmur
___Bruise easily
___Other _____

DIGESTION PILLAR #6

Stomach

___Heartburn
___Indigestion
___Stomach aches
___Nausea/Queasy
___Bloat after eating
___Gas/Flatulence
___Belching
___Ulcer
___Hiatal Hernia
___Other _____

Liver/Gallbladder

___Headaches at base of skull
___Greasy high fat foods cause distress
___Difficulty losing weight
___Dry or itchy skin
___Patches of skin look different
___Yellow cast to eyes
___Stool color clay colored
___History of gallbladder attacks
___Excessively foul smelling sweat
___Hormonal imbalances
___Difficulty swallowing
___Wake up between 11pm-3am
___Other _____

Hemorrhoids

___Swollen/Distended/Bloody anus
___Burning anus
___Itchy/Stingy anus
___Achy anus
___Other _____

Bowels

___Bowel movements _____ /per day
___Regular
___Incomplete
___Skip days _____ /per week
___Sluggish bowels every ____ days
___Cramps in abdomen
___Taking laxatives
___Using suppositories
___Enemas
___Colonics
___Pain with bowl movements
___Irritable bowel syndrome (IBS)
___Chrohns
___Colitis
___Other _____

Fecal Consistency

___Color of feces is light/dark
___Normal
___Soft
___Hard
___Pebbles
___Dry
___Ribbon-like
___Bulky
___Mucous
___Diarrhea
___Constipation
___Other _____

CELLULAR VITALITY PILLAR #7

___Fatigue constant
___Dehydrated
___Slow to heal
___Low stamina
___Sluggish memory
___Inability to achieve a lean body
___Other _____

PAIN/STIFFNESS/SWELLING/TINGLING

___Head
___Facial
___Neck
___Trapezius
___Upper back
___Shoulders
___Arms
___Elbows
___Wrist
___Hand
___Mid back
___Low back
___Sacral iliac
___Hips
___Buttocks
___Legs
___Knees
___Ankles
___Feet
___Other _____

LIST YOUR PRIMARY CONCERNS IN ORDER

1. _____
2. _____
3. _____
4. _____
5. _____