



The Pain and Brain Healing Center

Dr. Greg Fors, DC, Board-certified Neurologist (IBCN)

1400 131st Ave NE Blaine, MN 55449- 763.862.7100

Dear Prospective Patient,

Thank you for contacting Pain and Brain Healing Center. We are dedicated to providing the best in innovative Functional Medicine care. As such, we are selective in the patients we accept for our care programs.

The Pain and Brain Healing Center provides a natural Functional Medicine approach which asks “Why”. Why do you, at this time, present with these health issues. Functional Medicine then gets at the cause through a thorough review of your health history, comprehensive examination, and extensive investigatory lab testing such as: multiple blood tests of metabolism, disease and nutritional deficiencies, salivary hormone testing, GI comprehensive stool testing, food allergy testing, leaky gut, and SIBO breath testing – to name a few. Based on this data Functional Medicine then addresses the underlying causes through diet, nutritional support and lifestyle modifications to provide real healing, not symptom cover-up. Some refer to this as Personalized Lifestyle Medicine (PLM).

Read the following policies and sign below that you understand and agree with these policies, and that you would like to proceed with a Free Consultation.

1. Pain and Brain Healing Center does not bill or accept any insurance; this is a cash-based practice.
2. You are provided a Free Consultation: 10 minutes with the doctor’s assistant, and 10 minutes with Dr. Fors to review your case.
3. Then a second follow-up visit with the doctor’s assistant is provided – at no charge. At this time your Care Program will be explained to you: options, costs, and time involved.
4. Your Care Program will be designed for you with specific number of visits to be used during a specific timeframe.
5. Your Care Program is to be paid in full when you begin care, i.e., on the day of your comprehensive exam. The funds are put into an escrow account that is drawn on as you are seen for care.
6. The cost depends upon the complexity and chronicity of your health issues; as an example, Care Programs can average about \$3000 to \$4000 for a 2-to-4-month program.
7. Labs utilized are dependent upon a patient’s health issues and vary from patient to patient. Lab costs are separate from the Care Program. Some insurances may cover some lab tests.
8. All of this will be specified and delineated on your in your documented Care Program.

I have read the above clinic policies. I understand and agree with stated clinic policies. Therefore, I request a FREE Consultation.

Signed _____ Date _____

Bring this signed clinic policy form along with your intake form – filled out completely – to your FREE consultation. If possible, return it prior to your appointment.



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Functional Medicine Patient Intake Form

Dear patient,

This form is to be filled out by those individuals seeking care **from the Pain and Brain Healing Center**. For those individuals with complex chronic disorder (e.g. wide spread pain syndrome, fibromyalgia, depression, digestive disorders, metabolic syndrome, etc.) please take the time to fill this questionnaire out thoroughly. If you have any questions please ask our staff or call us. The first four pages are your health history questionnaire, the six pages to follow are our office policies and procedures please read carefully.

PERSONAL INFORMATION:

First Name: _____ Last Name: _____ Middle Initial: _____
Home Address: _____ City/State/Zip: _____
Phones: (Home) _____ (Cell) _____
(Work) _____ Email for doctor communications: _____
Age: ___ Birth Date: ___/___/___ Female / Male Occupation: _____
Place of Birth: _____ Race/National/Ethnic Roots: _____
Height: _____ Weight: _____ lbs ___ Right Handed / Left Handed / Mixed Dominance

HEALTH INSURANCE INFORMATION: Please note → generally we do not take health insurance. We will provide you with a super bill to submit to your insurance for reimbursement. *

Primary Health Insurance: _____ ID/Group #: _____
Secondary Health Insurance: _____

GENERAL:

Who can we thank for referred you? _____
What do you hope to get from today's visit?

PLEASE DESCRIBE YOUR PRIMARY HEALTH CONCERNS

Is the condition due to injury or sickness arising out of employment? _____

Is the condition due to injury or sickness arising out of an auto or other type of accident? _____

Number of days lost from work _____ Date symptoms appeared or accident happened _____

1. What are the primary problems you are experiencing? _____

2. In the past have you ever had the same or a similar condition? ___yes ___no If yes, please describe: _____

3. Has it changed recently? ___Better ___Worse ___Same What types of treatment have you tried? _____

What makes it better? _____

Worse? _____

4. How frequent is the condition? _____ How long does it last? _____

5. Is this affecting your sleep? ___Yes ___No If yes, please describe: _____

6. Is this affecting your ability to perform your job or daily activities? ___Yes ___ No If yes, please describe: _____

7. Are there any other symptoms that may be related to these concerns, which you have not listed? ___Yes ___No

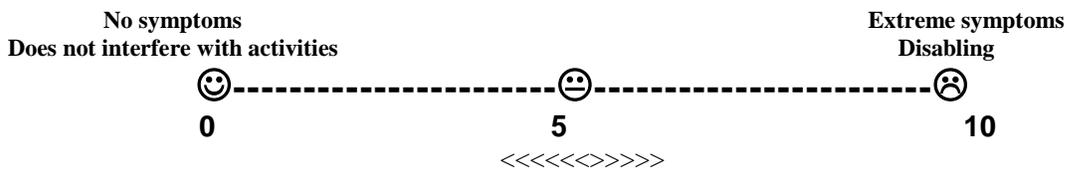
If yes, please describe:

Please list all doctors you have seen related to you current concern, also please include any chiropractors or family medical doctors. If possible list the approximate date of the last visit and their city and telephone number.

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

Please describe any previous tests (X-ray, MRI, EKG, blood work, etc.) to investigate your current problems.

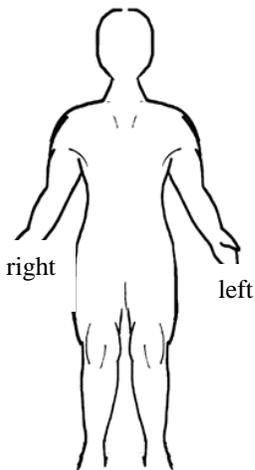
Please mark an "X" on the line to indicate the severity of your condition:



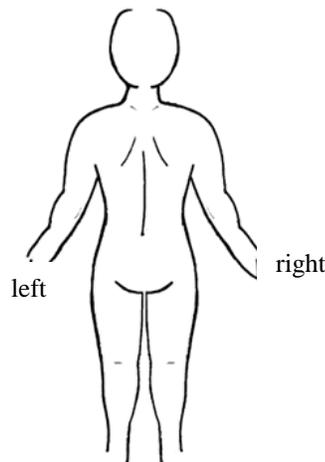
Please mark any areas of concern on the diagrams below. N – Numbness P- pins & needles B- burning A- aching S-stabbing. Indicate any other problems as best you can.



right side



front



back



left side

List In Order Major Health Problems with Brief Description	DATE OF ONSET	FREQUENCY (Daily, weekly...)	SEVERITY (mild, mod or severe)
1.			
2.			
3.			
4.			

OTC & Prescription MEDICATIONS What drugs are you taking

DRUG NAME	DOSAGE and # per day	Good Response	No Response	Bad Response	Bad then Good

PAST MEDICAL HISTORY

Include any chronic/recurring disorder or previous problems/diseases which no longer affect you

CONDITION	PAST TREATMENTS	CURRENT TREATMENTS	APPROXIMATE DATE (S) of TREATMENT

DIETARY HISTORY

Check the most appropriate description below of my diet:

- _____ Mostly carbohydrates (bread, pasta, etc.)
_____ Mostly dairy (milk, cheese, etc.)
_____ Mostly meat
_____ Mostly vegetarian (vegetables, fruits, grains, etc.)

Other Describe: _____

Are you on a Gluten Free Diet ___Yes ___No

Are you on a Dairy Free Diet ___Yes ___No

Have you benefited by being on this diet? _____

Are you on a Low Carbohydrate Diet? _____

Are you on high Omega 3 fatty acid supplementation? ___Yes ___No. Any benefits? _____

Please list the foods and beverages normally consumed by you for three typical days:

DAY 1

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DAY 2

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DAY 3

Breakfast: _____

Morning snack(s): _____

Lunch: _____

Afternoon snack(s): _____

Dinner: _____

Other _____

DIGESTIVE HEALTH

Do you have periodic loose stools/diarrhea ___ Yes ___ No Offensive Gas ___ Yes ___ No

Undigested Food in Stools ___ Yes ___ No Offensive Breath ___ Yes ___ No

Do you suffer with acid reflux/heartburn ___ Yes ___ No

Are you currently taking an acid-blocking medication such as Tagamet, Pepcid, etc. ___ Yes ___ No

Do your digestive problems occur more with stress ___ Yes ___ No ___ Unsure

Do you produce well formed stools ___ Yes ___ No

Have you ever produced formed stools ___ Yes ___ No

ANTIBIOTIC HISTORY

How many courses of antibiotics have you received in lifetime (approx): ___ 0 ___ 1-5 ___ 5-10

___ 10-15 ___ 15-20 ___ 20+

Main reason for antibiotic use: ___ Ear Infections ___ Bronchitis ___ Pneumonia ___ Sinus Infection

___ Intestinal Infection ___ Other (please explain) _____

Have you ever been treated for a yeast infection following antibiotic use _____

Survey of Your Health History

Please circle all that apply. Indicate whether this is a Current (C) or Past (P) concern also provide an approximate date for past concerns. Indicate severity with 1 mild, 2 moderate, 3 severe.

1. General

- Fever
- Night sweats
- Nervous ness
- Bleeding
- Diabetes
- Thyroid
- Headache
- Fainting
- Depression
- Memory loss
- Chills
- Fatigue
- Weight loss/gain
- Anemia
- Cancer
- Substance abuse
- Dizziness
- Seizures
- Phobias
- Waking in night
- Problems falling asleep
- Explain any surgeries or hospitalizations: _____
- _____
- Any broken bones, car accidents or other injuries? _____
- _____

2. Gastrointestinal

- belching/gas
- vomiting
- bloody stools
- hernia
- constipation
- diarrhea
- abdominal pain
- nausea
- liver problems
- other _____

3. Respiratory

- breathing problems
- spitting phlegm/blood
- allergies
- asthma
- shortness of breath
- chronic cough
- pneumonia
- other _____

4. Cardiovascular

- irregular heartbeat
- racing heart
- chest pain
- high blood pressure
- swelling
- prior heart problem
- pacemaker
- stroke
- other _____

5. Musculoskeletal

- stiffness
- pain
- swelling
- spinal curve
- arthritis
- weakness
- twitching
- tremors
- numbness
- other _____

6. Skin

- rashes
- mole changes
- itching
- nail changes
- redness
- other _____

7. EENT

- blurry vision
- double vision
- eye pain
- jaw pain
- hearing loss
- ringing in ears
- ear infection
- sinus problems
- nosebleeds
- throat problems
- speech problems
- Glasses or contacts? _____

8. Genitourinary

- frequent/painful urination
- incontinence
- blood in urine or stool
- urinary infection
- venereal infection
- other _____

9. Women Only

- difficult periods
- hot flashes
- irregular cycles
- breast pain
- lump in breast
- difficulty becoming pregnant
- complications of pregnancy
- other _____
- Date last period ended _____
- Date last gynecologic exam _____

10. Men Only

- testicular pain
- prostate problems
- difficult erection
- low sperm count

11. Exercise

- none
- 1-2 per week
- 3-4 per week
- 5-7 per week
- What type? _____

12. Habits

- Smoke(____packs/day, years?____)
- Alcohol (____ drinks per wk)
- Caffeine (____ cups per day)
- Recreational drug use _____

13. Family

- Are your parents living? _____
- If so do you consider them to be in good health? _____
- Ages: Mother _____ Father _____

Circle any below that apply to your parents, siblings or children:

- Diabetes
- Stroke
- Hypertension
- Cancer
- Seizures
- Tremors
- Brain disorder
- Heart disease
- Lung disease
- Arthritis
- Scoliosis

I, the undersigned, understand that I am financially responsible for all charges. I consent to proceed with the interview and examination. I understand that any treatment will be explained to me and my verbal consent will be requested before any care is rendered.

Signature _____ Date _____