Dr. Christina Joy Mackie
Naturopathic Doctor/Acupuncturist

728 W. Douglas Ave.
Wichita, KS 67203

(p) 316-259-6409
(f) 316-267-2554
cjoymackie@hotmail.com

Step 1. Please print off the new patient intake forms, fill out & bring to office visit.

Step 2: Please complete an 8 day food log diet diary, exercise, & bowel movements. The log is attached with paperwork and bring to office visit.

Step 3: Please bring bottles of supplements, medications, recent lab work done within the last year, & any imaging pertinent to your chief concern(s).

Step 4: Cost of Service:

Form of Payments: Cash, Check, or prior approval flex spending account

(Depending on complexity of the case at the discretion of Dr. Mackie)

Naturopathic Care with or without Acupuncture Intake

-New Patient **Child**: 1.5 hour $250
-New Patient **Adult**: 2 hours $400.00
-Follow-up Appointments: $160 an hour
-Additional 15 minutes added as needed $40

Acupuncture Care Only

-New Patient: 1 hour $160.00
-Follow-up: 30 minutes $60
-Additional 15 minutes added $30.00

Step 5: 24 HOUR CANCELLATION POLICY

In "JOY" Wellness Clinic takes pride in the quality of care she offers her patients. In order to do this she has a strict cancellation policy. Dr. Mackie requires a 24-hour cancellation notice prior to your appointment. Please call Dr. Mackie at 316-259-6409 to cancel.

Looking forward to meeting and serving you in the future. God Bless You!

Dr. Christina Joy Mackie (Dr. CJoy) Naturopathic Doctor/Certified Acupuncturist

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PATIENT INFORMATION FORM

Please Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name M.I. Last Name

Address City State Zip

Home Phone ( ) Cell ( ) Work ( )

SS# Age DOB

Drivers License # Male ☐ Female ☐

Employer Occupation

Married ☐ Single ☐ Divorced ☐ Name of Spouse

Emergency Contact Telephone ( )

Referred by Friend ☐ Relative ☐ Insurance ☐ Other ☐

PRIMARYINSURANCE Cash ☐ Group ☐ Work/Comp ☐ Auto ☐ Other ☐

Name of Insurance Co. ID#. Group#

Name of Insured Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

Secondary Insurance Name of Insured

I understand that this is a quotation of benefits and is NOT a guarantee of payment, and the agreement is between the Insurance Carrier and me. I authorize any and all payment from my insurance carrier directly to this office with the understand that all monies be credit to my account upon receipt. Any denial of payment becomes my responsibility (patient).

Patient Name (print) Patient Signature Date

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

_____takes pride in the quality of care he offers his patients. In order to do this he has a strict cancellation policy. Dr. _____ requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, the full fee will be charged to the credit card we have on file.

I,_____authorize Dr._____to charge the credit card given below, for cancellation fees, insurance co-payments and related charges.

_____-_____-_____-_____Ex_____/_____ Visa ☐ / MC ☐

Patient Name (print) Patient Signature Date

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NAME_____ **DATE**_____

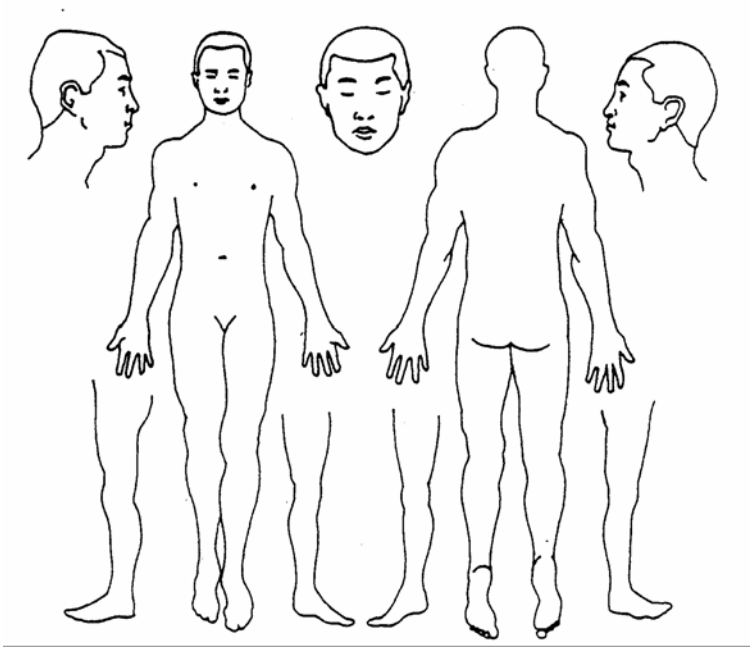
I. Goals: What would you most like to achieve through your work at the In Joy Wellness Clinic, P.A.?

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

II. Major Symptoms: Please list in order of importance what symptoms are of concern to you.
(most concerning to least, along with the duration of the symptom)

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

Use the following illustration to indicate painful or distressed areas:



Are you experiencing pain/discomfort in any area of your body? **Y / N**

If yes, using the models to the left, please indicate the location of the discomfort by using the symbol that best describes the feeling:

X X X Sharp/stabbing
P P P Pins & Needles
D D D Dull/Aching
N N N Numbness

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For Women:

1. Are you pregnant now? [ ]Yes [ ]No [ ]Unsure

2. Indicate number of occurrences:
Live Births_____Pregnancies_____Miscarriages_____Abortions _____

3. Age: First period_____Menopause (if applicable) _____

4. Date: Last Pap Smear_____/_____Last Mammogram_____/ _____

5. Any History of an Abnormal Pap Smear? [ ] Yes [ ] No If so, what / when? _____

6. Is your menses cycle regular? [ ] Yes [ ] No

Average number of days of flow _____
The flow is: [ ] Normal [ ] Heavy [ ] Light
The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Do you have the following menstruation related signs/symptoms?

[ ] Difficulty with Orgasm [ ] Cramps [ ] PMS [ ] Heavy Vaginal Discharge Between Periods

[ ] Pain with Intercourse [ ] Nausea [ ] Bleeding Between Periods

[ ] Blood Clots [ ] Breast Distention [ ] Vaginal Discharge

III. Medical History

Please Check all that apply	***Date Diagnosed***		***Date Diagnosed***
Diabetes	___ /____/ ____	High Cholesterol	___/____/ ____
High Blood Pressure	___/____/ ____	High Blood Pressure	___/____/ ____
Thyroid Disease	___/____/ ____	Seizures	___/____/ ____
Cancer	___/____/ ____	Hepatitis	___/____/ ____
HIV	___/____/ ____	Others	___/____/ ____

IV. Surgical History

_____ Date _____
_____ Date _____
_____ Date _____

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V. Family History

Please check all that apply and state how you are related to the family member with that condition.

Condition	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent
Heart disease					
Cancer					
Hypertension					
Stroke					
Asthma					
Allergies					
Migraines					
Depression					
Other mental illness					
Substance abuse					
Osteoporosis					
Diabetes					
Glaucoma					

VI. Medications / Supplements

Medications you are currently taking (please include prescription medicine, supplement, herbal supplements and over the counter medicines you take on a regular basis, along with dosages and brands if known)

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

Allergies (to medications, chemicals or foods):

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

VIII. Nutrition

1. Do you follow a special diet? [ ] Yes [ ] No If yes, how would you describe the diet?
(ie Vegetarian, Vegan, Low Carb, etc.)

_____

2. What do you eat on a "typical" day? _____
a) Breakfast _____
b) Lunch _____
c) Dinner _____
d) Snacks _____
e) Foods you tend to crave: _____
f) Foods you dislike: _____

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IX. Social History

1. How much per day do you use of the following?

a) Coffee, tea, soft drinks: _____

b) Alcohol: _____

c) Cigarettes, cigars, other tobacco: _____

d) Other drugs: _____

2. Have you ever had a problem with *alcohol* or *alcoholism*? [ ] Yes [ ] No

3. Have you ever had a problem with *dependency* on other drugs? [ ] Yes [ ] No

4. If yes which and when?

_____

5. Do you have a known history of any exposure to *toxic* substances? [ ] Yes [ ] No

6. If so, please list which and when you first noticed symptoms?

_____

_____

7. In the past year, how many days have been significantly affected by your health? _____

8. How many days did you feel generally poor? _____

9. How many times were you in the hospital? _____

10. Please describe your current exercise regimen:
Hours per week:_____Activities:_____[ ] No Exercise

11. How many hours of sleep do you usually get per night during the week? _____

12. Do you awake feeling rested? [ ] Yes [ ] No Do you feel you sleep well at night? [ ] Yes [ ] No

13. Who would you describe as your source of primary social support? (relationship to you)

X. Other Information

Please list and briefly describe the most significant events in your life:

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

Have you been treated for emotional issues? [ ] Yes [ ] No

Have you ever considered or attempted suicide? [ ] Yes [ ] No

Do you have any other neurological or psychological problem? [ ] Yes [ ] No

Please provide us with any other information that you think is relevant for us to know:

_____

_____

_____

_____

_____

_____

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HEALTH: (CHECK ALL THAT APPLY)

GENERAL

Past	*Current*	*Condition*
[ ]	[ ]	Poor appetite
[ ]	[ ]	Excessive appetite
[ ]	[ ]	Insomnia
[ ]	[ ]	Fatigue
[ ]	[ ]	Fevers
[ ]	[ ]	Night sweats
[ ]	[ ]	Sweat easily
[ ]	[ ]	Chills
[ ]	[ ]	Localized weakness
[ ]	[ ]	Poor coordination
[ ]	[ ]	Bleed or bruise easily
[ ]	[ ]	Catch cold easily
[ ]	[ ]	Change in appetite
[ ]	[ ]	Strong thirst
[ ]	[ ]	Other: _____

SKIN & HAIR

Past	*Current*	*Condition*
[ ]	[ ]	Rashes
[ ]	[ ]	Hives
[ ]	[ ]	Itching
[ ]	[ ]	Eczema
[ ]	[ ]	Pimples
[ ]	[ ]	Dryness
[ ]	[ ]	Tumors, lumps

HECK & NECK

Past	*Current*	*Condition*
[ ]	[ ]	Dizziness
[ ]	[ ]	Fainting
[ ]	[ ]	Neck stiffness
[ ]	[ ]	Enlarged lymph glands
[ ]	[ ]	Headaches
[ ]	[ ]	Concussions
[ ]	[ ]	Other: _____

EARS

Past	Current	Condition
[ ]	[ ]	Infection
[ ]	[ ]	Ringing
[ ]	[ ]	Decreased hearing
[ ]	[ ]	Other: _____

EYES

Past	*Current*	*Condition*
[ ]	[ ]	Blurred vision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[ ]	Cataracts
[ ]	[ ]	Glasses / contacts
[ ]	[ ]	Eye inflammation
[ ]	[ ]	Other: _____

NOSE, THROAT, MOUTH

Past	*Current*	*Condition*
[ ]	[ ]	Nose bleeds
[ ]	[ ]	Sinus infections
[ ]	[ ]	Hay fever or allergies
[ ]	[ ]	Recurring sore throats
[ ]	[ ]	Grinding teeth
[ ]	[ ]	Difficulty swallowing

CARDIOVASCULAR

Past	*Current*	*Condition*
[ ]	[ ]	High blood pressure
[ ]	[ ]	Low blood pressure
[ ]	[ ]	Blood clots
[ ]	[ ]	Palpitations
[ ]	[ ]	Phlebitis
[ ]	[ ]	Chest pain
[ ]	[ ]	Irregular heart beat
[ ]	[ ]	Cold hands / feet
[ ]	[ ]	Fainting
[ ]	[ ]	Difficult breathing
[ ]	[ ]	Swelling of hands / feet
[ ]	[ ]	Other: _____

RESPIRATORY

Past	*Current*	*Condition*
[ ]	[ ]	Asthma
[ ]	[ ]	Bronchitis
[ ]	[ ]	Frequent colds
[ ]	[ ]	Chronic obstructive
[ ]	[ ]	Pulmonary disease
[ ]	[ ]	Pneumonia
[ ]	[ ]	Cough
[ ]	[ ]	Coughing blood
[ ]	[ ]	Production of phlegm
[ ]	[ ]	Other: _____

GASTRO-INTESTINAL

Past	*Current*	*Condition*
[ ]	[ ]	Nausea
[ ]	[ ]	Vomiting
[ ]	[ ]	Diarrhea
[ ]	[ ]	Belching
[ ]	[ ]	Blood in stools/black
[ ]	[ ]	Stools
[ ]	[ ]	Bad breath
[ ]	[ ]	Rectal pain
[ ]	[ ]	Hemorrhoids
[ ]	[ ]	Constipation
[ ]	[ ]	Pain or cramps
[ ]	[ ]	Indigestion
[ ]	[ ]	Gall bladder disorder
[ ]	[ ]	Gas
[ ]	[ ]	Other: _____

GENITO-URINARY

Past	*Current*	*Condition*
[ ]	[ ]	Kidney stones
[ ]	[ ]	Pain or urination
[ ]	[ ]	Frequent urination
[ ]	[ ]	Blood in urine
[ ]	[ ]	Urgency to urinate
[ ]	[ ]	Unable to hold urine
[ ]	[ ]	Other: _____

MALE

Past	*Current*	*Condition*
[ ]	[ ]	Pain / itching genitalia
[ ]	[ ]	Genital lesions/ discharge
[ ]	[ ]	Impotence
[ ]	[ ]	Weak urinary stream
[ ]	[ ]	Lumps in testicles
[ ]	[ ]	Other: _____

FEMALE

Past	*Current*	*Condition*
[ ]	[ ]	Frequent urinary tract infections
[ ]	[ ]	Frequent vaginal infections
[ ]	[ ]	Pain / itching of genitalia
[ ]	[ ]	Genital lesions / discharge
[ ]	[ ]	Pelvic inflammatory disease
[ ]	[ ]	Abnormal pap smear
[ ]	[ ]	Irregular menstrual periods
[ ]	[ ]	Painful menstrual periods
[ ]	[ ]	Premenstrual syndrome
[ ]	[ ]	Abnormal bleeding
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Breast lumps
[ ]	[ ]	Hot flashes
[ ]	[ ]	Menopausal syndrome
[ ]	[ ]	Other: _____

NEUROLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Seizures
[ ]	[ ]	Tremors
[ ]	[ ]	Numbness/tingling of limbs
[ ]	[ ]	Concussion
[ ]	[ ]	Pain
[ ]	[ ]	Paralysis
[ ]	[ ]	Other: _____

PSYCHOLOGICAL

Past	*Current*	*Condition*
[ ]	[ ]	Depression
[ ]	[ ]	Anxiety / stress
[ ]	[ ]	Irritability
[ ]	[ ]	Treated for emotional or
[ ]	[ ]	Psychological problems
[ ]	[ ]	Other: _____

INFECTION SCREENING

Past	*Current*	*Condition*
[ ]	[ ]	HIV
[ ]	[ ]	TB
[ ]	[ ]	Hepatitis
[ ]	[ ]	Gonorrhea
[ ]	[ ]	Chlamydia
[ ]	[ ]	Syphilis
[ ]	[ ]	Genital warts
[ ]	[ ]	Herpes: oral
[ ]	[ ]	Herpes: genital

MUSCULAR-SKELETAL

Past	*Current*	*Condition*
[ ]	[ ]	Stiff neck / shoulders
[ ]	[ ]	Low back pain
[ ]	[ ]	Back pain
[ ]	[ ]	Muscle spasm, twitching, cramps
[ ]	[ ]	Sore, cold or weak knees
[ ]	[ ]	Joint pain

Symptom Checklist for WOMEN

Use each of the following checklists to determine signs & symptoms of hormone imbalance and help you choose the appropriate profile.

Category 1: Basic Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

_____ Hot flashes	_____ Mood swings (PMS)	_____ Urinary incontinence	_____Night sweats
_____ Heart palpitations	_____ Cystic ovaries	_____ Vaginal dryness	_____Acne
_____ Heavy menses	_____ Foggy thinking	_____ Weight gain	_____Depressed mood
_____ Fibrocystic breasts	_____ Irritability	_____ Increased body/facial hair	_____Headaches
_____ Low libido/decreased sexual function	_____ Uterine fibroids		_____Bone loss

Category 2: Adrenal Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

_____ Aches and pains	_____ Weight gain	_____ Morning fatigue	_____ Food cravings
_____ Sleep disturbances	_____ Depression	_____ Anxiety	_____ Susceptibility to infections
_____ Chronic health problems	_____ Evening fatigue	_____ Allergies	_____ Autoimmune diseases
_____ Low blood sugar	_____ History of steroid usage	_____ Bone loss	_____ Diabetes/prediabetes

Category 3: Thyroid Hormone Imbalance
Mark which of the following factors/symptoms are present and/or persist over time.

_____ Aches and pains	_____ Anxiety	_____Brittle nails	_____Depression
_____ Dry skin	_____ Cold hands and feet	_____Headaches	_____Infertility
_____ Fatigue	_____ Foggy thinking	_____Weight gain	_____Feeling cold all the time
_____ Heart palpitations	_____ Low libido	_____Inability to lose weight	_____Sleep disturbances
_____ Constipation	_____ Thinning hair	_____Menstrual irregularities	_____Elevated cholesterol

Category 4: Cardiometabolic Risk
Mark which of the following factors/symptoms are present and/or persist over time.

_____ History of smoking	_____Weight gain	_____Heart disease or family history of heart disease
_____ High blood sugar	_____Sugar cravings	_____Diabetes or family history of diabetes
_____ High blood pressure	_____Fatigue	_____Waist size greater than 35 inches
	_____ Low physical activity	_____Elevated triglycerides

If you checked symptoms in <u>all four categories</u>, the suggested test profiles are:
MINIMUM: Female Blood Profile II (Blood Spot)
PREFERRED: Comprehensive Female Profile I or II (Saliva/Blood Spot) and CardioMetabolic Profile (Blood Spot)

If you checked symptoms <u>ONLY in Category 1</u>, the suggested test profiles are:
MINIMUM: Female Blood Profile I (Blood Spot) or Female/Male Saliva Profile I (Saliva)
PREFERRED: Comprehensive Female Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 2</u>, the suggested test profiles are:
MINIMUM: Adrenal Stress Profile (Saliva)
PREFERRED: Comprehensive Female Profile I or II (Saliva/Blood Spot)

If you checked symptoms <u>ONLY in Category 3</u>, the suggested test profiles are:
MINIMUM: Essential Thyroid Profile (Blood Spot)
PREFERRED: Comprehensive Female Profile I or II (Saliva/Blood Spot); **OR** Comprehensive Elements Thyroid Profile (Blood Spot/ Dried Urine) plus Female/Male Saliva Profile III (Saliva)

If you checked symptoms <u>ONLY in Category 4</u>, the suggested test profiles are:
MINIMUM: CardioMetabolic Profile (Blood Spot)
PREFERRED: CardioMetabolic Profile (Blood Spot) plus Female/ Male Saliva Profile III (Saliva)

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BREAKFAST Times	LUNCH Times	SUPPER Times	EXERCISE Time	Bowel Movement Time(s)
Day 1				
Day 2				
Day 3				
Day 4				

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BREAKFAST Times	LUNCH Times	SUPPER Times	EXERCISE Time	Bowel Movement Time(s)
Day 5				
Day 6				
Day 7				
Day 8				