InJOY Wellness Clinic, P.A.

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 $300
-New Patient **Adult**: 2 hours $500
-Follow-up Appointments: $200 an hour
-Additional 15 minutes added as needed $50

Acupuncture Care Only

-New Patient: 1 hour $200.00
-Follow-up: 30 minutes $65
-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. LastName

Address City State Zip

Home Phone ( ) Cell( ) Work( )

SS# Age DOB

Drivers License # Male ☐ Female ☐

Employer Occupation

Married☐ Single☐ Divorced☐ Name ofSpouse

Emergency Contact Telephone( )

Referredby Friend☐ Relative☐ Insurance☐ Other☐

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

Name ofInsuranceCo. ID#. Group#

NameofInsured Relationship to Patient: Self☐ Spouse☐ Parent☐

SecondaryInsurance Name ofInsured

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).

PatientName(print) PatientSignature Date

24 HOUR CANCELLATION POLICY & CREDIT AUTHORIZATION RELEASE

__________takes pride in the quality of care she offers his patients. In order to do thisshe has a strict cancellation policy.Dr. __________requires a 24-hour cancellation notice prior to your appointment time. If sufficient time is not given, thefullfeewill be charged to the credit card we have onfile.

I,_____________________________________authorize Dr.__________to charge the credit card givenbelow,forcancellation fees, insurance co-payments and relatedcharges.

____________-_____________-______________-________________Ex______/_______ Visa ☐ / MC ☐

PatientName(print)	PatientSignature	Date

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NAME_________________________________ **DATE**__________________________

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

1.____

2.____

3.____

4.____

5.___ ________ _ _______ _ _______ _ _______ _ _______ _ _______ _ _______ _ _ _ _

II. MajorSymptoms: Pleaselistinorderofimportancewhatsymptomsareofconcerntoyou.
(most concerning to least, along with the duration of the symptom)

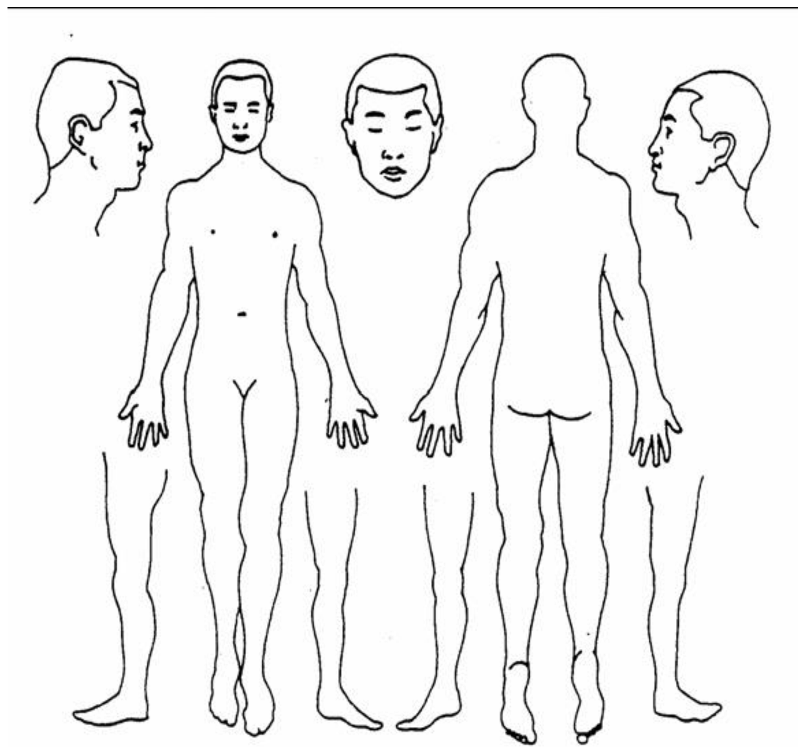
1.__ _______ _ _______ _ _______ _ _______ _ _______ _ _______ _ _______ _ _______ _ __

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 locationof the discomfort by using the symbol that best describes the feeling:

XXX Sharp/stabbing
PPP Pins&Needles
DDD Dull/Aching
NNN Numbness

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For Men:

1. Doyouhaveanybothersomeurinarysymptoms?[]Yes [ ]No

Describe:____

2. Checkallthatapply:

[ ] Erectiledysfunction
[ ] Impotence
[ ] Difficultywithorgasm
[ ]Prematureejaculation
[ ] Pain/Subtly of testicles
[ ] Pain or swelling ofthe testicles
[ ] Feeling of coldnessor numbness in genitalia
[ ] Frequent need to urinate at night

3. Doyougetupatnighttourinate?[]Yes [ ]No Howoften?______________________________

4. Towhatextentdotheseconditionsinterferewithyourdailyactivities(work,sleep,socializing,sex,etc.)?

____

5. HaveyousoughtMedicalinterventionfortheseproblems?Ifso,when?______________________________

____

6. Whattreatmentshaveyoutriedfortheseproblemsandhowsuccessfulhavetheybeen?

____

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. SurgicalHistory

____ Date ______________
____ Date ______________
____ Date ______________

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V. FamilyHistory

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 tocrave: ____

f) Foods youdislike: ____

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IX. SocialHistory

1. How much per day do you use of thefollowing?

a) Coffee, tea, softdrinks: ____________________
b) Alcohol:____________________
c) Cigarettes, cigars, othertobacco:____________________
d) Otherdrugs: ____________________

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 andwhen?

____

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 noticedsymptoms?

____

____

7. In the past year, how many days have been significantly affected by yourhealth?__________

8. How many days did you feel generallypoor? __________

9. How many times were you in thehospital?__________

10. Please describe your current exerciseregimen:
Hoursperweek:________Activities:____________________[ ] NoExercise

11. How many hours of sleep do you usually get per night during theweek? __________

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 toyou)

X. OtherInformation

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 THATAPPLY)

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
[]	[ ]	Blurredvision
[ ]	[ ]	Visual changes
[ ]	[ ]	Poor night vision
[ ]	[ ]	Spots
[ ]	[]	Cataracts
[ ]	[]	Glasses /contacts
[ ]	[ ]	Eyeinflammation
[ ]	[ ]	Other:________________

NOSE, THROAT, MOUTH

Past	Current	Condition
[ ]	[ ]	Nosebleeds
[ ]	[ ]	Sinusinfections
[ ]	[ ]	Hay feverorallergies [
[ ]	]	Recurringsorethroats
[ ]	[ ]	Grindingteeth
[ ]	[ ]	Difficultyswallowing

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

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Symptom Checklist for MEN

Useeachofthefollowingchecklists todeterminesigns&symptomsofhormoneimbalanceandhelpyouchoosetheappropriateprofile.

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

_____Burned outfeeling
_____Hotflashes
_____Weight gainwaist
_____Decreasedlibido
_____Decreasederections
_____Nightsweats
_____Irritable
_____Erectiledysfunction
_____Prostateproblems
_____Decreasedmentals harpness
_____Insomnia
_____Increasedurinaryurge
_____Infertility problems
_____Oily skin
_____Apathy
_____Decreased urineflow
_____Decreasedstamina
_____Sleep disturbances
_____Decreased muscle mass

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

_____Aches andpains
_____Sleepdisturbances
_____Chronichealth problems
_____Stress
_____Depression
_____Lack ofmotivation
_____Prostateproblems
_____Eveningfatigue
_____ Morning fatigue
_____ Anxiety
_____ Allergies
_____ Weight gain waist
_____ Decreased erections
_____ Bone loss
_____ Low blood sugar
_____ Autoimmune disease
_____ Fibromyalgia
_____ Susceptibility to infections

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

_____Low libido
_____Foggy thinking
_____Constipation
_____Elevated cholesterol
_____Depression
_____Infertility
_____Fatigue
_____Dry skin
_____Feelingcold
_____Headaches
_____Lack ofmotivation
_____Heartpalpitations
_____Decreasederections
_____Sleepdisturbances
_____Inability to loseweight
_____Brittlenails

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

_____History ofsmoking
_____High bloodsugar
_____High bloodpressure
_____Low physicalactivity
_____Weightgain
_____Sugarcravings
_____Fatigue
_____Elevatedtriglycerides
_____Heart disease or family history of heartdisease
_____Diabetes or family history ofdiabetes
_____Waist size greater than 40inches

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

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

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

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

If you checked symptoms ONLY in Category 4, 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				