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 $500.00
-Follow-up Appointments: $200an 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

EmergencyContact 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 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, thefullfeewill be charged to the credit card we have onfile.

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

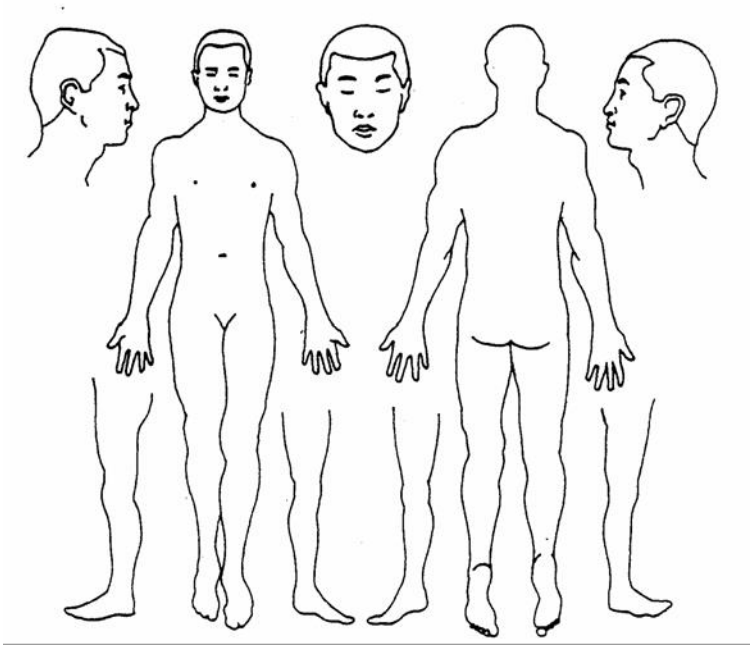
1. __ _____

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 Women:

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

2. Indicate number ofoccurrences:
LiveBirths_____Pregnancies_____Miscarriages_____Abortions _____

3. Age:Firstperiod_____Menopause (if applicable) _____

4. Date: Last PapSmear_____/_____LastMammogram_____/ _____

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

6. Isyourmensescycleregular?[]Yes [

]NoAveragenumberofdaysofflow_____
The flow is: [ ] Normal [ ] Heavy [ ] Light
The color is: [ ] Normal [ ] Dark [ ] Purple [ ] Light Brown [ ] Brown

7. Doyouhavethefollowingmenstruationrelatedsigns/symptoms?

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

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

[ ]BloodClots [ ]BreastDistention [ ] VaginalDischarge

III.MedicalHistory

Please Check allthatapply	***DateDiagnosed***		***DateDiagnosed***
Diabetes	___/____/ ____	HighCholesterol	___/____/ ____
HighBloodPressure	___/____/ ____	HighBloodPressure	___/____/ ____
ThyroidDisease	___/____/ ____	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

Symptom Checklist for WOMEN

Useeachofthefollowingchecklisttodeterminesigns&symptomsofhormoneimbalanceandhelpyouchoosetheappropriateprofile.

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

_____Hotflashes	_____Mood swings(PMS)	_____Urinaryincontinence	_____Nightsweats
_____Heartpalpitations	_____Cysticovaries	_____Vaginaldryness	_____Acne
_____Heavymenses	_____Foggythinking	_____Weightgain	_____Depressedmood
_____Fibrocystic breasts	_____Irritability	_____Increasedbody/facial	
_____Lowlibido/decreased sexualfunction	_____Uterinefibroids	_____Headacheshair	

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

_____Aches andpains	_____Weightgain	_____ Morning fatigue	_____ Food cravings
_____Sleepdisturbances	_____Depression	_____ Anxiety	_____ Susceptibility to infections
_____Chronichealth problems	_____Eveningfatigue	_____ Allergies	_____ Autoimmune diseases
_____Low bloodsugar	_____History of steroidusage	_____ Bone loss	_____ Diabetes/prediabetes

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

_____Aches andpains	_____Anxiety	_____Brittle nails	_____Depression
_____Dryskin	_____Cold hands and feet	_____Headaches	_____Infertility
_____Fatigue	_____Foggythinking	_____Weightgain	_____Feeling cold all thetime
_____Heartpalpitations	_____Low libido	_____Inability tolose 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.

_____Historyofsmoking	_____Weightgain	_____Heart disease or family history of heartdisease
_____High blood sugar	_____Sugar cravings	_____Diabetes or family history ofdiabetes
_____Highbloodpressure	_____Fatigue	_____Waist size greater than 35inches
	_____Lowphysicalactivity	_____Elevatedtriglycerides

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/BloodSpot) andCardioMetabolicProfile(BloodSpot)

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/BloodSpot)

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/BloodSpot)

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**ComprehensiveElementsThyroidProfile(BloodSpot/ DriedUrine)plusFemale/MaleSalivaProfileIII(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				