

Today's Date: _____

Confidential Patient Intake Form

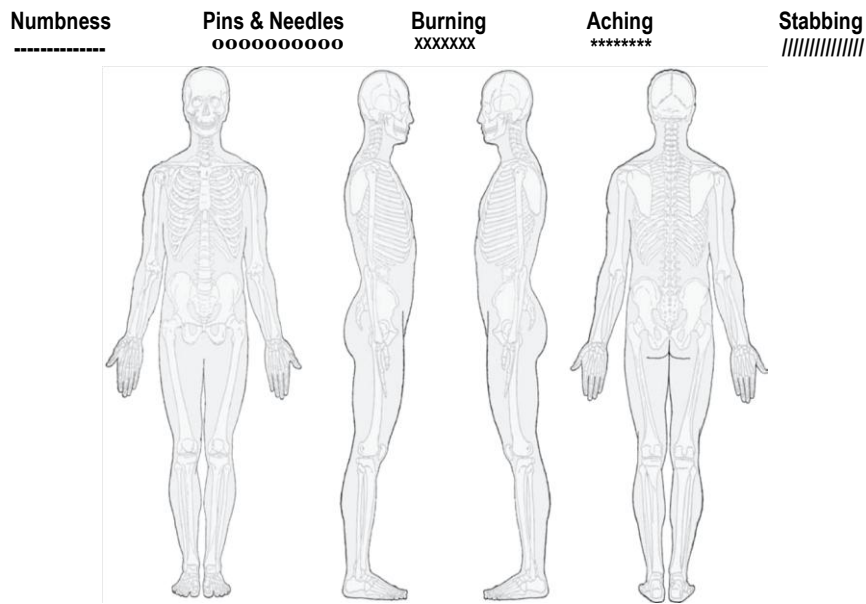
Information contained in this form is considered strictly confidential. Your responses are important to better understand the health issues you face and ensure the delivery of the best possible treatment.

Name: _____ Date of Birth: _____ Age: _____ Male Female
 What would you prefer to be called in our office? _____
 Address: _____ City/ State: _____ Zip: _____
 Home Phone: _____ Work: _____ Cell: _____
 Email: _____ Occupation: _____ Employer: _____
 Marital Status: S M D W Social Security #: _____
 Emergency Contact: Name: _____ Relationship: _____ Phone: _____
 How did you hear about us? _____ May we send you our online newsletter? Yes No

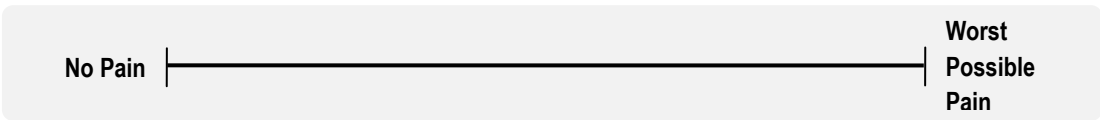
Give a brief detailed description of the problem you are currently experiencing: _____

 What seemed to be the initial cause? _____
 When did this condition begin? _____ Is this condition: Getting Worse Better Same
 Is this condition interfering with: Work Sleep Daily Routine Other: _____
 Have you had this or similar conditions in the past? Yes No, comments: _____
 What seems to make this problem better? _____ worse? _____
 Other issues you would like addressed: _____

Please indicate your area/s and type/s of pain on the figure below:



Please place a mark at the level of your pain on the scale below:



Other doctors or therapists that have treated *this* condition: _____

Have you been given a diagnosis? Yes No; if yes, what was it? _____

Family physician's name (if you have one): _____ Date of Last Physical Exam: _____

Was this a result of a work related or auto injury? Yes No, comments: _____

Review of Health History

Name: _____

Please check the corresponding boxes if you have the condition now or have had it in the past:

General	Now	Past	Neck	Now	Past	Genitourinary	Now	Past
01. Weakness	<input type="checkbox"/>	<input type="checkbox"/>	49. Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	98. Urgency	<input type="checkbox"/>	<input type="checkbox"/>
02. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	50. Soreness	<input type="checkbox"/>	<input type="checkbox"/>	99. Bed-Wetting	<input type="checkbox"/>	<input type="checkbox"/>
03. Fever	<input type="checkbox"/>	<input type="checkbox"/>	51. Enlargement	<input type="checkbox"/>	<input type="checkbox"/>	100. Incontinence	<input type="checkbox"/>	<input type="checkbox"/>
04. Chills	<input type="checkbox"/>	<input type="checkbox"/>	52. Lumps / Masses	<input type="checkbox"/>	<input type="checkbox"/>	101. Frequent Voiding	<input type="checkbox"/>	<input type="checkbox"/>
05. Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory			102. Bladder Infection	<input type="checkbox"/>	<input type="checkbox"/>
06. Fainting	<input type="checkbox"/>	<input type="checkbox"/>	53. Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	103. Kidney Infection	<input type="checkbox"/>	<input type="checkbox"/>
Skin			54. Phlegm	<input type="checkbox"/>	<input type="checkbox"/>	104. Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>
07. Color Changes	<input type="checkbox"/>	<input type="checkbox"/>	55. Cough Up Blood	<input type="checkbox"/>	<input type="checkbox"/>	105. Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>
08. Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	56. Short of Breath	<input type="checkbox"/>	<input type="checkbox"/>	106. Discharge	<input type="checkbox"/>	<input type="checkbox"/>
09. Hair Changes	<input type="checkbox"/>	<input type="checkbox"/>	57. Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	107. Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>
10. Moles	<input type="checkbox"/>	<input type="checkbox"/>	58. Difficult Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Women Only		
11. Rashes	<input type="checkbox"/>	<input type="checkbox"/>	59. Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	108. Lumps in Breast	<input type="checkbox"/>	<input type="checkbox"/>
12. Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Cardiovascular			109. Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
13. Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	60. Murmur	<input type="checkbox"/>	<input type="checkbox"/>	110. Menopause	<input type="checkbox"/>	<input type="checkbox"/>
14. Acne	<input type="checkbox"/>	<input type="checkbox"/>	61. Palpitation	<input type="checkbox"/>	<input type="checkbox"/>	111. Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>
Head			62. Rapid Pulse	<input type="checkbox"/>	<input type="checkbox"/>	112. Vaginal Itching	<input type="checkbox"/>	<input type="checkbox"/>
15. Headache	<input type="checkbox"/>	<input type="checkbox"/>	63. Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	113. PMS	<input type="checkbox"/>	<input type="checkbox"/>
16. Injuries	<input type="checkbox"/>	<input type="checkbox"/>	64. Cold Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>	114. Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>
17. Bumps	<input type="checkbox"/>	<input type="checkbox"/>	65. Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	115. Spotting	<input type="checkbox"/>	<input type="checkbox"/>
18. TMJ Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	66. Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	116. Uterine Fibroids	<input type="checkbox"/>	<input type="checkbox"/>
Eyes			67. Blue Hands/Feet	<input type="checkbox"/>	<input type="checkbox"/>	117. Age at First Menses: _____		
19. Last Eye Exam _____			68. High BP	<input type="checkbox"/>	<input type="checkbox"/>	118. Length of Cycle: _____		
20. Glasses	<input type="checkbox"/>	<input type="checkbox"/>	69. Low BP	<input type="checkbox"/>	<input type="checkbox"/>	119. Days of Flow: _____		
21. Contact Lenses	<input type="checkbox"/>	<input type="checkbox"/>	Blood			120. Color: bright red/ dark red/pale red/brown		
22. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	70. Anemia	<input type="checkbox"/>	<input type="checkbox"/>	121. Clots: <input type="checkbox"/> yes <input type="checkbox"/> no		
23. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	71. Low Iron	<input type="checkbox"/>	<input type="checkbox"/>	122. Birth Control Type: _____		
24. Change in Vision	<input type="checkbox"/>	<input type="checkbox"/>	72. Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	123. # of Pregnancies: _____		
Ears			73. Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	124. # of Births: _____ Miscarriages: _____		
25. Deafness	<input type="checkbox"/>	<input type="checkbox"/>	74. Swollen Nodes	<input type="checkbox"/>	<input type="checkbox"/>	125. Date of Last Period: _____		
26. Ringing	<input type="checkbox"/>	<input type="checkbox"/>	75. Tender Nodes	<input type="checkbox"/>	<input type="checkbox"/>	126. Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no		
27. Discharge	<input type="checkbox"/>	<input type="checkbox"/>	76. High Blood Sugar	<input type="checkbox"/>	<input type="checkbox"/>	127. Trying to get pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no		
28. Ear ache	<input type="checkbox"/>	<input type="checkbox"/>	77. Red Spots	<input type="checkbox"/>	<input type="checkbox"/>	128. Date of Last PAP: _____		
29. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal			<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
30. Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	78. Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	129. Date of Last Mammogram: _____		
Nose			79. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
31. Decreased Smell	<input type="checkbox"/>	<input type="checkbox"/>	80. Bloating	<input type="checkbox"/>	<input type="checkbox"/>	Men Only		
32. Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	81. Belching	<input type="checkbox"/>	<input type="checkbox"/>	130. Testicular Mass	<input type="checkbox"/>	<input type="checkbox"/>
33. Pain	<input type="checkbox"/>	<input type="checkbox"/>	82. Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	131. Date of Last Prostate Exam: _____		
34. Discharge	<input type="checkbox"/>	<input type="checkbox"/>	83. Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> normal <input type="checkbox"/> abnormal		
35. Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	84. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Neurological		
36. Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	85. Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	132. Seizures	<input type="checkbox"/>	<input type="checkbox"/>
37. Sinus Congestion	<input type="checkbox"/>	<input type="checkbox"/>	86. Undigested Food	<input type="checkbox"/>	<input type="checkbox"/>	133. Tremors	<input type="checkbox"/>	<input type="checkbox"/>
Mouth			87. Gas	<input type="checkbox"/>	<input type="checkbox"/>	134. Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>
38. Bleeding Gums	<input type="checkbox"/>	<input type="checkbox"/>	88. Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	135. Incoordination	<input type="checkbox"/>	<input type="checkbox"/>
39. Sores	<input type="checkbox"/>	<input type="checkbox"/>	89. Poor Appetite	<input type="checkbox"/>	<input type="checkbox"/>	136. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
40. Dental Problems	<input type="checkbox"/>	<input type="checkbox"/>	90. Food Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	137. Numbness	<input type="checkbox"/>	<input type="checkbox"/>
41. Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>	91. Bloody Stool	<input type="checkbox"/>	<input type="checkbox"/>	138. Tingling	<input type="checkbox"/>	<input type="checkbox"/>
42. Loss of Taste	<input type="checkbox"/>	<input type="checkbox"/>	92. Black/ Tarry Stool	<input type="checkbox"/>	<input type="checkbox"/>	139. Loss of Memory	<input type="checkbox"/>	<input type="checkbox"/>
43. Dry Mouth	<input type="checkbox"/>	<input type="checkbox"/>	93. Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine		
Throat			94. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	140. Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
44. Soreness	<input type="checkbox"/>	<input type="checkbox"/>	95. Vomiting Blood	<input type="checkbox"/>	<input type="checkbox"/>	141. Weight Gain	<input type="checkbox"/>	<input type="checkbox"/>
45. Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	96. Colitis/ Crohn's	<input type="checkbox"/>	<input type="checkbox"/>	142. Heat Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
46. Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	97. Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	143. Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>
47. Trouble Swallowing	<input type="checkbox"/>	<input type="checkbox"/>				144. Hyperthyroidism	<input type="checkbox"/>	<input type="checkbox"/>
48. Recurrent Infection	<input type="checkbox"/>	<input type="checkbox"/>				145. Hypothyroidism	<input type="checkbox"/>	<input type="checkbox"/>

Review of Health History (continued)

Name: _____

Please check the corresponding boxes if you have the condition now or have had it in the past:

Musculoskeletal	Now	Past	Musculoskeletal	Now	Past	Psychiatric	Now	Past
146. Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	154. Low Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	165. Hyperventilation	<input type="checkbox"/>	<input type="checkbox"/>
147. Muscle Cramps	<input type="checkbox"/>	<input type="checkbox"/>	155. Middle Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	166. Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>
148. Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	156. Neck Pain	<input type="checkbox"/>	<input type="checkbox"/>	167. Depression	<input type="checkbox"/>	<input type="checkbox"/>
149. Muscle Twitching	<input type="checkbox"/>	<input type="checkbox"/>	157. Hand Pain	<input type="checkbox"/>	<input type="checkbox"/>	168. Irritability	<input type="checkbox"/>	<input type="checkbox"/>
150. Joint Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	158. Wrist Pain	<input type="checkbox"/>	<input type="checkbox"/>	169. Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
151. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	159. Elbow Pain	<input type="checkbox"/>	<input type="checkbox"/>	170. Nervousness	<input type="checkbox"/>	<input type="checkbox"/>
Type: _____			160. Shoulder Pain	<input type="checkbox"/>	<input type="checkbox"/>	171. Extreme Worry	<input type="checkbox"/>	<input type="checkbox"/>
152. Bursitis	<input type="checkbox"/>	<input type="checkbox"/>	161. Foot Pain	<input type="checkbox"/>	<input type="checkbox"/>	172. Hallucinations	<input type="checkbox"/>	<input type="checkbox"/>
153. Foot Trouble	<input type="checkbox"/>	<input type="checkbox"/>	162. Ankle Pain	<input type="checkbox"/>	<input type="checkbox"/>	173. Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Explain: _____			163. Knee Pain	<input type="checkbox"/>	<input type="checkbox"/>	174. Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>
			164. Hip Pain	<input type="checkbox"/>	<input type="checkbox"/>	175. Sexual Problems	<input type="checkbox"/>	<input type="checkbox"/>

Please check the corresponding box if you have had any of the following conditions:

176. Measles	<input type="checkbox"/> yes	188. COPD	<input type="checkbox"/> yes	200. Diabetes	<input type="checkbox"/> yes
177. Mumps	<input type="checkbox"/> yes	189. Asthma	<input type="checkbox"/> yes	201. Appendicitis	<input type="checkbox"/> yes
178. Rheumatic Fever	<input type="checkbox"/> yes	190. Pneumonia	<input type="checkbox"/> yes	202. Multiple Sclerosis	<input type="checkbox"/> yes
179. Chicken Pox	<input type="checkbox"/> yes	191. Tuberculosis	<input type="checkbox"/> yes	203. Osteoporosis	<input type="checkbox"/> yes
180. Cancer	<input type="checkbox"/> yes	192. Liver Trouble	<input type="checkbox"/> yes	204. Epilepsy	<input type="checkbox"/> yes
181. Tumor	<input type="checkbox"/> yes	193. Hepatitis	<input type="checkbox"/> yes	205. Mental Illness	<input type="checkbox"/> yes
182. Angina	<input type="checkbox"/> yes	194. Gall Stones	<input type="checkbox"/> yes	206. Migraine	<input type="checkbox"/> yes
183. Heart Disease	<input type="checkbox"/> yes	195. Parasites	<input type="checkbox"/> yes	207. Syphilis	<input type="checkbox"/> yes
184. Stroke	<input type="checkbox"/> yes	196. Malaria	<input type="checkbox"/> yes	208. Gonorrhea	<input type="checkbox"/> yes
185. Arteriosclerosis	<input type="checkbox"/> yes	197. Blood Disease	<input type="checkbox"/> yes	209. Herpes	<input type="checkbox"/> yes
186. High Cholesterol	<input type="checkbox"/> yes	198. Gout	<input type="checkbox"/> yes	210. HIV / AIDS	<input type="checkbox"/> yes
187. Emphasema	<input type="checkbox"/> yes	199. Goiter	<input type="checkbox"/> yes		

Surgeries/Injuries/Serious Illnesses: _____

Medications / Vitamins / Supplements (include dosages):

Allergies:

Immunizations/ Vaccinations	Blood Type
DPT	<input type="checkbox"/> A+
MMR	<input type="checkbox"/> A-
Smallpox	<input type="checkbox"/> B+
Typhoid	<input type="checkbox"/> B-
Meningitis	<input type="checkbox"/> AB+
Influenza	<input type="checkbox"/> AB-
Polio	<input type="checkbox"/> O+
Hepatitis	<input type="checkbox"/> O-

Review of Health History (continued)

Name: _____

Family History: please fill in the following information

Relative	Age (If Living)	Age at Death	Cause of Death	Illnesses
Father				
Mother				
Sibling				
Sibling				
Sibling				
Sibling				
Maternal Grandfather				
Maternal Grandmother				
Paternal Grandfather				
Paternal Grandmother				

Social History: please check the box that most accurately represents you or fill in the blanks

Mental Work: <input type="checkbox"/> none <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy Physical Work: <input type="checkbox"/> none <input type="checkbox"/> light <input type="checkbox"/> moderate <input type="checkbox"/> heavy Exercise: days per week: _____ Type/s: _____ _____	Sleep: hours per night: _____ Quality: <input type="checkbox"/> poor <input type="checkbox"/> fair <input type="checkbox"/> good <input type="checkbox"/> excellent Difficulty Falling Asleep? <input type="checkbox"/> yes <input type="checkbox"/> no Frequent Waking? <input type="checkbox"/> yes <input type="checkbox"/> no, if so what time/s? _____ Dream-Disturbed? <input type="checkbox"/> yes <input type="checkbox"/> no
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Past Occupational History:

Please indicate usage per day or per week of the following:

Water: _____ glasses per day room temp. cold Soft Drinks: _____ per day/week regular diet

Coffee: _____ cups per day/week (circle) Juice: _____ per day/week (circle)

Tea: _____ cups per day/week (circle) Sweets: _____ per day/week (circle)

Alcohol: _____ drinks per day/week (circle) Cigarettes: _____ packs/day for _____ years

Type: beer wine liquor Have you ever smoked in the past? yes no

Please describe your average daily diet. Be specific.

Morning: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Please describe your energy levels:

How is your energy? (Please circle) **Low** 0 1 2 3 4 5 6 7 8 9 10 **High**

What time of day is your energy *highest*? 6am – 12pm 1pm – 5pm 6pm – 12am

What time of day is your energy *lowest*? 6am – 12pm 1pm – 5pm 6pm – 12am

Patient's Signature _____

Date _____

consistency taking supplements _____ %

7 PILLARS OF HEALTH SURVEY OF YOUR BODY'S SYSTEMS

Rate 1-10 severity of any symptom you have experienced in last 6 MONTHS.

Neuro-hormonal/ Endocrine Pillar #1

Adrenals

- ___ Energy Low /Normal/ High
- ___ Difficulty falling asleep
- ___ Difficulty staying asleep
- ___ Slow to Start in Morning
- ___ Energy Crash _____ am/pm
- ___ Dizzy when stand quickly
- ___ Light Bothers Eyes
- ___ Weak Nails
- ___ Perspire easily or excessively
- ___ Orgasm Quality (poor/ good/ great)
- ___ Other _____

Pituitary

- ___ Sex Drive Low/ Normal/ High
- ___ Menstrual Disorders
- ___ Splitting Headaches
- ___ Other _____

Thyroid

- ___ Tired/Sluggish
- ___ Chills, Feel Cold hands, feet, body
- ___ Require Excessive Sleep
- ___ Increase in weight unexplained
- ___ Difficult infrequent bowel movements
- ___ Depression Lack of Motivation
- ___ Hair Loss and Thinning
- ___ Thinning of Outer Third of Eyebrow
- ___ Dryness of Scalp
- ___ Mental Sluggishness
- ___ 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 cycle
- ___ Early (less than 28 days)
- ___ Late (more than 28 days)
- ___ Skip cycle
- ___ Flow (heavy/ moderate/ light)
- ___ Cramps (mild/ mod/ severe)
- ___ Clotting/ Spotting
- ___ Headache side of head
- ___ Other _____

Ovaries (women only)

- ___ Sex drive Flat / Low/ Normal
- ___ Low Abdominal Puffiness
- ___ Fluid Retention Face / Hands / Feet
- ___ mood swings/irritable/depression
- ___ Tired during cycle
- ___ Ovarian pain
- ___ Breast Tender 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
- ___ Discharge-clear white yellow green brown
- ___ Pain with Intercourse
- ___ Other _____

Testes (Men)

- ___ Sex drive Flat / Low/ Normal
- ___ Decreased morning erections
- ___ Decreased fullness 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 Focus/ Concentrating
- ___ Other _____

Exercise

- ___ Cardiovascular _____ times/ week
- ___ Weight Train _____ times/per week

Glycemic Management Pillar #2

Pancreas

- ___ Crave Sweets
- ___ Irritable when skip meals
- ___ Light headed skip meals
- ___ Eating relieves fatigue
- ___ Bouts of blurred vision
- ___ Fatigue after meals
- ___ Frequent Urination
- ___ Increased Thirst
- ___ Difficulty losing weight
- ___ Other _____

Appetite / Diet

- ___ Appetite (Low, Norm, High)
- ___ Eat Animal Protein _____/per day
- ___ Eat Starch (pasta/bread/potatoes/rice)
- ___ Eat Sweets (cakes, cookies, candy)
- ___ Eat Chocolate _____/per week
- ___ 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
- ___ Avoid Artificial Sweeteners _____ %
- ___ Avoid Trans Fats _____ %
- ___ Avoid Food Allergens _____ %
- ___ Special Diet? _____

Bioterrain/ Mineral Pillar #3

- ___ Twitching around eyes
- ___ Difficulty falling asleep
- ___ Restlessness
- ___ Don't Remember Dreams
- ___ Nails 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 morning
- ___ Floaters
- ___ Stye
- ___ Itchy Eyes
- ___ Eye Ache
- ___ Vision blurry
- ___ Tired
- ___ Spots
- ___ Puffy
- ___ Dark Circles

Ears

- ___ Ear Noise (Ring/Hiss/Pound)
- ___ Ear Plugged
- ___ Ear Popping
- ___ Ear Ache / Infections
- ___ Ears Itch internally
- ___ Ear Drainage
- ___ Hearing Loss
- ___ Excessive Ear Wax
- ___ Dizziness/ Vertigo

Sinus

- ___ Frontal headache
- ___ Sinus dry
- ___ Sinus drain
- ___ Sinus stuffy
- ___ Sneeze frequent
- ___ Smell / Taste Loss
- ___ Post nasal drip
- ___ mucous: clear/white/yellow/green/brown

Lungs

- ___ Chest Congestion
- ___ Pain on Breastbone
- ___ Breath short on exertion
- ___ Wheezing
- ___ Asthma
- ___ Emphysema
- ___ Bronchitis

Mouth/ Throat/ Immune

- ___ Blisters
- ___ Canker Sore
- ___ Bad Breath
- ___ Bleeding gums
- ___ Receding gums
- ___ Teeth Health Problems
- ___ Dry Mouth
- ___ Swelling of Glands
- ___ Difficulty Swallowing
- ___ Sore Throat
- ___ Hoarseness
- ___ Fever
- ___ Cough (dry/productive)
- ___ Frequent Colds/ Flu
- ___ Environmental Allergies
- ___ Nightmares

Bladder

- ___ Urinate _____ times per day awake
- ___ Urinate at night _____ per night
- ___ Urination urgency
- ___ Burning /Pain urination
- ___ Cloudy urine
- ___ Odor urine
- ___ Spasm urinate
- ___ Urinary Tract Infection
- ___ Kidney Pain or Infections
- ___ Other _____

Skin

- ___ Skin Rash
- ___ Acne
- ___ Itchy Skin
- ___ Cellulite
- ___ Nail fungus (mild/mod/severe)

Breasts

- ___ Breast fibrosis
- ___ Breast Lumps
- ___ Other _____

Prostate (Men)

- ___ Urination difficulty
- ___ Frequent urination
- ___ Urination Burn / Achiness / Pain
- ___ Urination Dribbling /Emission/ Swelling
- ___ Pain inside of legs or heels
- ___ Leg twitching at night
- ___ Urination Dribbling /Emission/ Swelling
- ___ Headache 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
- ___ Sleep Apnea
- ___ Mitral Valve Prolapse
- ___ Murmur
- ___ Other _____

Digestion Pillar #6

Stomach

- ___ Heartburn
- ___ Indigestion
- ___ Stomach Aches
- ___ Stomach Cramps
- ___ Nausea/ Queasy
- ___ Bloat after Eat
- ___ 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 skin look different
- ___ Yellow cast to eyes
- ___ Stool color clay colored
- ___ History of gallbladder attacks
- ___ Excessively foul smelling sweat
- ___ Hormonal imbalances

Hemorrhoids

- ___ Swollen/ Distended / Bloody Anus
- ___ Burning Anus
- ___ Itchy/ Stinging Anus
- ___ Achy Anus

List Your Primary Concerns

in order of importance to you:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Bowels

- ___ Bowel Movements _____ Per day
- ___ Regular
- ___ Incomplete
- ___ Skip days _____ per (week/month)
- ___ Sluggish bowels every _____ days
- ___ Cramps in Abdomen
- ___ Taking Laxatives
- ___ Using Suppositories
- ___ Enemas
- ___ Colonics
- ___ Pain with Bowel Movements
- ___ Irritable Bowel Syndrome
- ___ Chrons
- ___ Colitis
- ___ Other _____

Fecal Consistency

- ___ Color faces light or 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 lean body

PAIN/ STIFFNESS/ SWELLING/ ACHE/ NUMBNESS/ 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 _____

For Doctor's Use

- ___ Luna Fingernails Rt 1 2 3 4 5 Lt 1 2 3 4 5
- ___ Splinter Hemorrhages
- ___ Ear Creases (Rt/ Lt) mild/mod/severe
- ___ Cherry Hemangiomas
- ___ Frenular Cyst
- ___ Color Tongue _____
- ___ Coated Tongue (mild/mod/severe)
- ___ Cracks in Tongue-midline/ all over
- ___ Swollen Tongue
- ___ Dark Veins under Tongue
- ___ Allergy Patches Tongue
- ___ Red Spots Tongue
- ___ Geographic Tongue
- ___ Height _____
- ___ Weight _____ (+/- lbs) overall(+/- _____)
- ___ Pulse _____ BP:(_____ / _____)
- ___ saliva pH _____ Urine pH _____
- ___ Allergies _____
- ___ Current Meds: _____

NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term “DRUG” is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although, a Vitamin, a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

I have read and understand the above:

Patient's Name (Please Print)

Signature of Patient/ Legal Guardian

Date

Relationship (if not signed by patient)

Signature of Witness to Above Signature

Date

Nicole Fodel, D.C., MSOM, LAc
Stuart White, D.C.

OFFICE FINANCIAL POLICY

Our policy is designed to provide you the convenience of allowing you to assign your insurance benefits directly to us. Our policy reduces your out-of-pocket expenses and allows us to place you under our care.

For Chiropractic Care

1. If You Do Not Have Health Insurance: All payments will be due at the time of service/s, or according to the payment schedule based on an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated, unless you have made prior arrangements for a payment plan. Payment plans are available to make treatment an affordable part of your budget.

2. If You Have Health Insurance: All payments will be due at the time of service/s, or according to the payment schedule based on an authorized payment plan. Synergy Holistic Health is not a participating provider with any insurance companies, however you may request documentation to file through your insurance independently. Your personal balance may not exceed \$100 at any time or care may be terminated, unless you have made prior arrangements for a payment plan. Payment plans are available to make treatment an affordable part of your budget.

For Nutrition Services

Nutrition services are not covered by any insurance provider; however, you can use a Flex Spending Account (FSA) or Health Savings Account (HSA) to pay for the office visits and supplement purchases. For these types of accounts you may need an itemized receipt or a Letter of Medical Necessity to submit to your insurance company. Our office will provide these upon request.

Cancellation Policy

All appointment cancellations or changes must be requested at least 24 hours before your scheduled appointment time. These changes must be made within our regular operating hours, and therefore cannot be requested on the weekend. For instance, if you have an appointment on a Monday at 9:00am, you must change or cancel the appointment by the Friday before at 9:00am. Any appointment changes with less than a 24 hour notice will result in a \$25 cancellation fee.

If you are a "no show" for your appointment the same \$25 fee applies. If you "no show" a second time then you will not be permitted to reschedule in our office.

Check Sales:

We accept VISA, Mastercard, American Express, and Discover, along with cash and check. There will be a \$25 fee for returned checks. We also reserve the right to no longer accept checks from your account if a check is returned.

*Signing below also acknowledges receipt of our *Privacy Notice*, which can also be accessed on www.synergycharlotte.com.

Patient's Name (Please Print)

Signature of Patient/ Legal Guardian

Date

Relationship (if not signed by patient)

Signature of Witness to Above Signature

Date

Synergy Holistic Health
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact our Privacy Officer who is Laura Harry

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail, or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes recording your current healthcare information in a file so in the future we can see your medical history to help in diagnosis and treatment, or to determine how you are responding to treatment. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. The information disclosed may include information that identifies you and your diagnosis, as well as services rendered, procedures performed, and/or supplies used. For example, if obtaining approval for a hospital stay it may be required that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, and licensing.

We may share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

Treatment Options: We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Appointment Reminders: We may use and disclose information in your medical record to contact you as a reminder that you have an appointment at Synergy Chiropractic & Acupuncture. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems,

biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object

We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgment, determine whether the disclosure is in your best interest.

Facility Directories: Unless you object, we will use and disclose in our facility directory your name, the location at which you are receiving care, your general condition (such as fair or stable).

Others Involved in Your Health Care or Payment for your Care: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

2. **YOUR RIGHTS**

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory results that are subject to law that prohibits access to protected health information.

We may deny your request to inspect and copy in certain limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed. A licensed healthcare professional who was not directly involved in the denial of your request will conduct the review. We will comply with the outcome of the review. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. A written request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means that if you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You may make a request in writing for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. A written request is required and must state a time period which may not be longer than six years. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to receive a notice of a breach. We are required by law to notify you of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no longer than 60 days following the discovery of the breach. “Unsecured Protected Health Information” is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

If you believe your privacy rights have been violated by us you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave., S.W., Washington, D.C. 20201. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Dr. Nicole Fodel** at **(980) 355-0842** for further information about the complaint process.

This notice was published and becomes effective on **November 22, 2010.**