

Today's Date: \_\_\_\_\_

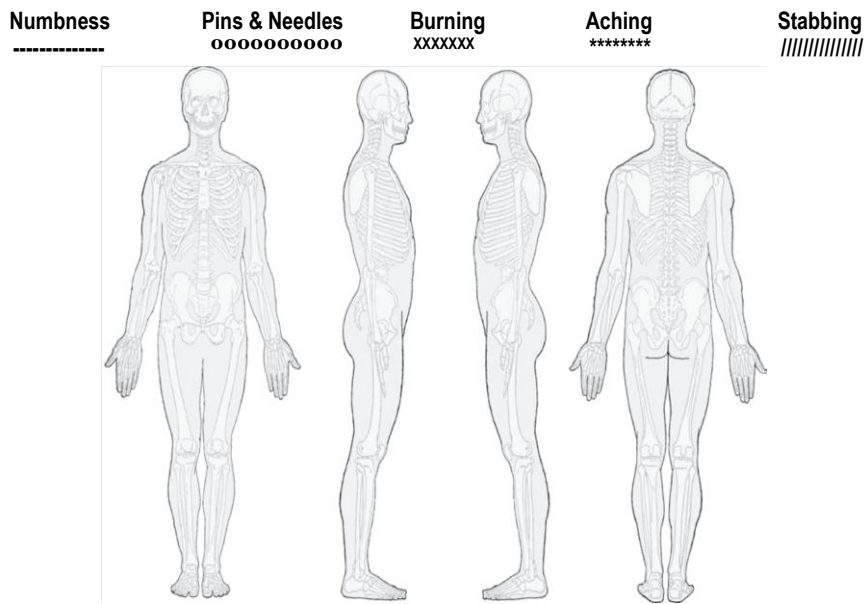
### Confidential Patient Intake Form

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"/>	<b>Respiratory</b>			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"/>
<b>Skin</b>			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"/>	<b>Women Only</b>		
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"/>	<b>Cardiovascular</b>			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"/>
<b>Head</b>			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"/>
<b>Eyes</b>			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"/>	<b>Blood</b>			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: _____		
<b>Ears</b>			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"/>	<b>Gastrointestinal</b>			<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: _____		
<b>Nose</b>			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"/>	<b>Men Only</b>		
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"/>	<b>Neurological</b>		
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"/>
<b>Mouth</b>			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"/>	<b>Endocrine</b>		
<b>Throat</b>			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

Coffee: \_\_\_\_\_ cups per day/week (circle)

Tea: \_\_\_\_\_ cups per day/week (circle)

Alcohol: \_\_\_\_\_ drinks per day/week (circle)

Type:  beer  wine  liquor

Soft Drinks: \_\_\_\_\_ per day/week  regular  diet

Juice: \_\_\_\_\_ per day/week (circle)

Sweets: \_\_\_\_\_ per day/week (circle)

Cigarettes: \_\_\_\_\_ packs/day for \_\_\_\_\_ years

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 / Achesness / 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/ Stingy 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: Flexible Spending and Health Savings Accounts**

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. You can also use these accounts for chiropractic services.\*\*\* 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.

\*\*\*NOTE: If you use a credit card to pay for any services in our office, we are not permitted to offer refunds to transfer payments to an HSA or FSA account. We can however provide receipts for reimbursement, and for future purchases you may switch to using your HSA or FSA at any time.

**Return Policy**

Any unopened and unexpired products may be returned for a credit on your account to be used towards future purchases. We do not offer credit card refunds unless you choose to discontinue treatment, in which case a refund may be applied to your credit card.

**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](http://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, **Laura Harry** at **(980) 355-0842** for further information about the complaint process.

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