Office Use ONLY	#
Demographics	
Day 0	
Day 1	
Letter	
Call Slip	

Confidential Patient Health Record

Date:_____

Name_____ Date of Birth _____ Age _____

Address_____City_____ State_____ Zip_____

SS#_____-_____-_____ Male / Female Email Address _____

Home #_____ Cell #_____

Occupation_____ Employer_____ Work # _____

Employer's Address_____

City_____ State_____ Zip Code_____

Marital Status_____ Spouse's Name_____

Spouse's Occupation_____ Spouse's DOB_____

How Many Children Do You Have?_____ Children's Ages_____

Emergency contact name_____ Phone #_____

Whom may we thank for referring you to our office? _____

Name and location of Primary Care Physician? _____

What Medications Are You Currently Taking?_____

_____

What Surgeries Have You Had? _____

_____

List any accidents or falls_____

Date and location of most recent X-rays? _____

Date of most recent bloodwork? _____

PRIMARY HEALTH CONCERN

What Is Your Primary health concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

SECONDARY HEALTH CONCERN

What Is Your Primary health concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

ADDITIONAL HEALTH CONCERN

What Is Your Primary health concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It at It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

ADDITIONAL HEALTH CONCERN

What Is Your Secondary health concern? _____

How Long Have You Been Experiencing This Problem?_____

On A Scale of 1 to 10, How Severe Is It At It's Worst? 1 2 3 4 5 6 7 8 9 10

What Percent of Time Do You Experience This? 0 10 20 30 40 50 60 70 80 90 100%

What Makes it Feel Better?_____ Feel Worse?_____

When Do You Notice It Most? (Circle) Morning Afternoon Evening While Sleeping

I Have ☐Been Hospitalized ☐Been Seen By Another Doctor ☐Never Received Treatment For This Problem

Please check to indicate if you are currently or have ever experiencing any of the following conditions:

- ❑ Alcoholism
- ❑ Allergies
- ❑ Allergy Shots
- ❑ Anemia
- ❑ Ankle Swelling
- ❑ Anorexia
- ❑ Appendicitis
- ❑ Arm/Hand Pain
- ❑ Arthritis
- ❑ Asthma
- ❑ Asthma
- ❑ Back Pain/Stiffness
- ❑ Bleeding Disorders
- ❑ Blurred Vision
- ❑ Bowel/Bladder Changes
- ❑ Breast Lump
- ❑ Bronchitis
- ❑ Bulimia
- ❑ Cancer
- ❑ Cataracts
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Chicken Pox
- ❑ Cold Feet/Hands
- ❑ Cold Sores
- ❑ Cold Sweats
- ❑ Constipation
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting
- ❑ Fatigue
- ❑ Fractures
- ❑ Glaucoma
- ❑ Goiter
- ❑ Gout
- ❑ Hair Loss
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herniated Disc
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Jaw Problems
- ❑ Kidney Disease
- ❑ Leg/Knee Pain
- ❑ Light Bothers Eyes
- ❑ Liver Disease
- ❑ Loss of Memory
- ❑ Loss of Smell
- ❑ Loss of Taste
- ❑ Low Body Temp
- ❑ Measles
- ❑ Migraines
- ❑ Miscarriage
- ❑ Mononucleosis
- ❑ Mumps
- ❑ Nausea
- ❑ Neck Pain/Stiffness
- ❑ Nervousness
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Pinched Nerve
- ❑ Pins/Needles in Arms
- ❑ Pins/Needles in Legs
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problems
- ❑ Prosthesis
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Rheumatoid Arthritis
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Sinus
- ❑ Skin Rashes
- ❑ Sleeping Difficulties
- ❑ Stomach Problems
- ❑ Strep Throat
- ❑ Stroke
- ❑ Sudden Weight Loss
- ❑ Suicide Attempt
- ❑ Tension
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tubes in Ears
- ❑ Tumors/Growths
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Varicose Veins
- ❑ Venereal Disease
- ❑ Whooping Cough
- ❑ Other _____

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

❑ Arthritis _____
❑ Autoimmune _____
❑ Cancer _____
❑ Diabetes _____
❑ Heart Disease _____
❑ Neurological Diseases_____
❑ Other _____

Received A Diagnosis For ANY Condition By Another Health Care Provider? Y N

If Yes, What Was The Diagnosis?
_____

Who Provided the
Diagnosis?_____

Medication Name	Dosage	Reason

Supplement Name/Brand	Dosage	Reason

Please list any allergies: _____

Lifestyle History

Do you exercise?
❑ Frequently ❑ Moderately ❑ Occasionally ❑ None

Does your work activity mostly involve?
❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:
Caffeine _____ cups/day Alcohol ___ drinks/week
Cigarettes ____packs/day

Have you ever been exposed to mold? Yes _____ No _____

Have you ever been exposed to chemicals (work, pesticides, etc.)? Yes _____ No ____

Sleep/Rest:

Average number of hours you sleep: _____ more than 10 _____ 8 to 10 _____ 6 to 8 _____ less than 6

Do you have trouble sleeping? Yes_____ No _____

Do you have problems falling asleep? Yes_____ No _____

Do you have problems staying asleep Yes_____ No _____

Do you feel rested upon awakening? Yes_____ No_____

Do you have problems with insomnia? Yes _____ No _____

Do you snore? Yes_____ No _____

Do you use sleeping aids? Yes _____ No _____

Dental History:

Do you have (or had) any non-tooth colored fillings (ie silver or gold colored fillings)?

Yes _____ No _____ How many _____

Have you had any fillings removed? Yes _____ No _____

Do you have any root canals? Yes _____ No _____ How many?_____

Other dental fixtures? Yes_____ No_____
Describe_____

Have you had any dental work in the last 12 months? Please describe.

_____
_____
_____
_____

Is there anything else you would like our providers to know?

I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) _____ DATE _____

CONSENT TO CARE

A patient coming to the doctor gives him/ her permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare cases underlying physical defects, deformities or pathologies, may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/ she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I agree to settle any claim or dispute I may have against or with any of these persons or entities, whether related to the prescribed care or otherwise, will be resolved by binding arbitration under the current malpractice terms which can be obtained by written request.

I have read and understand the foregoing.

_____ _____

Patient's Signature Date

Consent to treat a minor

Patient Name: _____ Date _____

Authorized Signature: _____ Date _____

X-ray Questionnaire:

- □ I do **NOT** have any non-visible piercings that the doctor should be aware of.
- □ I do have piercings that are not visible to the naked eye that the doctors should be aware of.

  Specify: _____

For women only

Our consultation and examination may indicate that x-rays are necessary to accurately diagnose and analyze your condition. Should x-rays be necessary we would like to confirm that you are not pregnant at this time.

Name: _____

- □ There is a possibility that I a may be pregnant at this time.
- □ Yes, I am definitely pregnant
- □ No, I am definitely not pregnant at this time

I request that x-ray films not be taken because:_____
_____

INSURANCE INFORMATION

Primary Insured Name: _____ Relationship w/ Patient: _____

Insurance Company Name: _____ ***If you have a secondary insurance***

Address: _____ ***please ask for another form and***

_____ ***complete just this section***

Insurance Co. Phone: (_____) _____ Insured Employer: _____

Policy #: _____ Group:_____ Insured SSN #: _____ /____ /_____

Insured DOB: _____ / _____ / _____

I hereby authorize the release of any medical information necessary to process my insurance claims. I permit a copy of this authorization to be used in place of the original. I understand and agree that health and accident insurance policies are an arrangement between my insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature_____

Date_____

Consent to Treat a Minor_____

Date_____

Guardian or Spouse's Signature Authorizing Care_____

Date_____

INFORMED CONSENT

1. SERVICES: My health care provider has recommended functional, nutritional, and lifestyle evaluation, testing, consulting, and care, including dietary supplements. I understand and are informed that products and services are not provided by medical physicians and do not include prescription of legend drugs, surgery, or other conventional allopathic medical treatments. I further understand that consultations, evaluations, supplementation, lifestyle consultation, testing, recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, modalities, or other nutrients pertain to the functional health/whole body concept.

2. NO GUARANTEE: I have been informed that the methods of functional/nutritional evaluation or testing made available to me are not intended to diagnose disease from an allopathic model of medicine. Rather, they are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor progress in achieving goals. I further understand that any recommendations are supportive in nature allowing the body to return to improved health. Like all other health care, results are not guaranteed and there is no promise to cure. Accordingly, I understand that payment(s) for services are not conditional on my response to care. Prorated fees for unused, prepaid services, however, will be refunded if I wish to cancel. No refunds will be available for any products purchased and opened.

3. RISKS: I understand the functional/nutritional supplements, vitamins, minerals, food grade herbs, modalities, and other nutrients that may be recommended are generally considered safe. However, some functional/nutritional supplements, vitamins, minerals, food grade herbs, modalities and other nutrients may be toxic in large doses. I also understand that functional/nutritional supplements, vitamins, minerals, food grade herbs, modalities, and other nutrients may interact with some legend drugs. Accordingly, I agree to consult with my prescribing physician about any legend drugs I am taking and the impact of supplements, vitamins, minerals, food grade herbs, modalities and other nutrients on such drugs. I will inform my health practitioner if I experience gastrointestinal upset (nausea, gas, stomachache, vomiting), allergic reactions (hives, rashes, itching, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, modalities, and other nutrients.

4. PREGNANCY: I understand that some functional/nutritional supplements, vitamins, minerals, food grade herbs, modalities, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner if I am or become pregnant.

5. ALTERNATIVES: I understand that the alternatives to the recommendations include doing nothing and/or seeking additional allopathic medical care.

6. QUESTIONS AND ANSWERS: I have read and fully understand this consent form, and understand that I should not sign this form if all items, including all my questions, have not been explained or answered to my satisfaction or if I do not understand any of the terms or words contained in this consent form.

DO NOT SIGN UNLESS YOU HAVE READ AND FULLY UNDERSTAND THIS FORM!

I have read and fully understand this consent. All items have been explained, I have had sufficient time to evaluate the information, and my questions have been answered. Knowing the alternatives and risks, I consent to the services.

Signature _____ Date _____

Name (printed)_____