Personal Information

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:** / /

Last Name:

Address: | **Date of Birth:** / / | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: ( ) - | **Home Phone #:** ( ) - | **E-mail Address:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse Name: | **Contact Phone #:** ( ) -

Emergency Contact *(if different from spouse)* | **Contact Phone #:** ( ) -

Employment Status: ☐ Full-Time ☐ Part-time ☐ Unemployed ☐ Retired ☐ Student

Employer Name: | **Work Phone #:** ( ) -

Family Physician *(if applies)* **:** | **Contact Phone #:** ( ) -

Person Responsible for Bills *(if different from personal information)*

First Name: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss | **MI:** | **Today's Date:** / /

Last Name:

Address: | **Date of Birth:** / / | **Age:**

City: | **State:** | **Zip:** | **Gender:** ☐ Male ☐ Female

Cell Phone #: ( ) - | **Home Phone #:** ( ) - | **E-mail Address:**

Employer Name: | **Work Phone #:** ( ) -

Reason for Your Visit to Our Office

☐ Auto Accident ☐ Independent Personal Health Reasons ☐ Personal Accident (slip & fall)

How Did You Hear About Us

Friend Refered Me (please write down their name):

☐ Internet/Website ☐ Doctor Refered ☐ Insurance Agent Refered ☐ Lawyer Refered

Complaint History

Patient Name _____ **Date** _____

Current Health Complaint: ***(Give a brief, detailed description of the problem you are currently experiencing)***

When did this problem start (date)? | How did it start?

How often do you feel it? ☐ 0-25% of the time (intermittent), ☐ 26-50% of the time (occastional), ☐ 51-75% of the time (frequently), ☐ 76-100% of the time (constantly)

What does it feel like? *(Please check all that apply):*

☐ Achy ☐ Burning ☐ Congestion ☐ Cramping ☐ Crawling ☐ Dull ☐ Electric-like ☐ Fatigue ☐ Itchy ☐ Nagging ☐ Numb
☐ Pounding ☐ Pressure ☐ Pulling ☐ Sharp ☐ Shooting ☐ Sore ☐ Spasm ☐ Stabbing ☐ Stiff ☐ Stressed ☐ Tight ☐ Tingling
☐ Throbbing ☐ Weakness ☐ Sharp with motion ☐ Shooting with motion ☐ Stabbing with motion ☐ Electric-like with motion

Does it radiate to anywhere? *(please describe)* :

On a Scale of 0 to 10 - where 0 is no pain and 10 is the worst pain ever - please circle the numbers that apply:
Level you feel the most: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the best: 0 1 2 3 4 5 6 7 8 9 10, Level when it feels the worst: 0 1 2 3 4 5 6 7 8 9 10

Does anything make it feel worse? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Twisting right ☐ Twisting left
☐ Climbing stairs ☐ Coughing ☐ Driving ☐ Exercising ☐ Kneeling ☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side
☐ Carrying ☐ Lifting ☐ Pushing ☐ Pulling ☐ Running ☐ Sleeping ☐ Sneezing ☐ Sitting ☐ Standing ☐ Straining ☐ Stretching
☐ Walking ☐ Work duties ☐ Feels worse in the A.M. ☐ Feels worse in the P.M. ☐ Nothing specific makes it feel worse
☐ Other *(please describe)* :

Does anything make it feel better? *(Please check all that apply):*

☐ Bending forward ☐ Bending backward ☐ Bending or leaning right ☐ Bending or leaning left ☐ Resting ☐ Sleeping
☐ Laying on your back ☐ Laying on your (R) side ☐ Laying on your (L) side ☐ Massage ☐ Moving around ☐ Sitting ☐ Standing ☐ Walking
☐ Stretching ☐ Icing the symptomatic area ☐ Heat on the symptomatic area ☐ OTC Medication ☐ Prescription medication
☐ Feels better in the A.M. ☐ Feels better in the P.M. ☐ Nothing specific makes it feel better
☐ Other *(please describe)* :

Have you received **previous treatment** for this condition? From who? ☐ Yes, ☐ No
☐ Medical Doctor ☐ Chiropractor ☐ Physical Therapist ☐ Other:

Did the treatment help?
☐ It improved ☐ Got Worse ☐ There was no change

Activites of Daily Living *(Please mark a number, as described below, for all the problems you are experiencing)*

0 = Not a Problem, 1 = Mild difficulty (can do it but with pain), 2 = Moderate difficulty (have pain and it really hurts), 3 = Significant difficulty (unable to perform without agonizing pain)

Hygiene: ___ Bathing ___ Showering ___ Washing your hair ___ Drying your hair ___ Combing your hair ___ Washing your face ___ Brushing your teeth
___ Using the toilet ___ Putting on make-up ___ Shaving your legs ___ Shaving your face

Self Care: ___ Cleaning dishes ___ Eating ___ Preparing meals ___ Putting on a shirt ___ Hooking your Bra ___ Putting on pants ___ Putting on shoes
___ Tying your shoes ___ Cleaning your home ___ Doing laundry ___ Making your bed ___ Getting normal, restful sleep at night
___ Participating in desired sexual activity

Work: ___ Concentrating ___ Using a keyboard ___ Writing ___ Performing work Duties

Activities: ___ Climbing ___ Driving ___ Golfing ___ Jogging ___ Personal hobbies ___ Playing sports ___ Running ___ Walking ___ Weightlifting
___ Exercising ___ Exercising upper body ___ Exercising lower body ___ Exercising arms ___ Exercising legs

Movement: ___ Carrying your purse ___ Carrying small objects ___ Carrying large objects ___ Climbing Stairs ___ Climbing inclines ___ Grasping objects
___ Lifting ___ Pushing ___ Pulling ___ Reaching ___ Reclining ___ Kneeling ___ Sitting ___ Standing
___ Bending forward ___ Bending Back ___ Bending/Leaning right ___ Bending/Leaning left ___ Twisting right ___ Twisting left
___ kneeling for long periods ___ Sitting for long periods ___ Standing for long periods ___ Walking for long periods

Other *(please describe)* **:**

Health History

ALL INFORMATION IS CONFIDENTIAL

Patient Name _____ **Date** _____

Circle "C" for Current problems or Mark the box with a check ☑ next to the conditions you've had in the past

General Health Conditions:

C ☐ Alcoholism C ☐ Allergies C ☐ Anemia C ☐ Anxiety C ☐ Bi-polar disorder C ☐ Cancer C ☐ Chicken pox
C ☐ Cold sores C ☐ Depression C ☐ Diabetes C ☐ Dizziness C ☐ Edema (Swelling) C ☐ Endometriosis C ☐ Epilepsy
C ☐ Fainting C ☐ Fatigue C ☐ Goiter C ☐ Headaches C ☐ Hepititis C ☐ Herpes C ☐ High cholesterol
C ☐ HIV/ AIDS C ☐ Malaria infection C ☐ Measles C ☐ Miscarrage C ☐ Multiple sclerosis C ☐ Mumps C ☐ Nervousness
C ☐ Osteoporosis C ☐ Pace maker C ☐ Polio C ☐ Rhumatic fever C ☐ Stroke C ☐ Tremors C ☐ Thyroid disease
C ☐ Tuberculosis C ☐ Unexplained weight loss C ☐ Unexplained weight gain

Muscle & Joint Conditions:

C ☐ Arthritis (Joint pain) C ☐ General muscle pain C ☐ Neck pain C ☐ Mid-back pain C ☐ Low-back pain C ☐ Shoulder pain C ☐ Elbow pain
C ☐ Wrist/Hand pain C ☐ Hip pain C ☐ Knee pain C ☐ Ankle pain C ☐ Foot pain C ☐ Bursitis C ☐ Gout

Skin Conditions:

C ☐ Boils C ☐ Bruise easliy C ☐ Dryness C ☐ Eczema C ☐ Hives C ☐ Itching C ☐ Jaundice C ☐ Rash C ☐ Shingles C ☐ Varicose veins

Eyes, Ears, Nose & Throat Conditions:

C ☐ Deafness C ☐ Ear aches C ☐ Eye pain C ☐ Gum disease C ☐ Hoarseness C ☐ Nasal obstruction C ☐ Nose bleeds
C ☐ Ringing in ears C ☐ Sinus infection C ☐ Sore throat C ☐ Tonsilitis C ☐ Vision problems

Respiratory Conditions:

C ☐ Asthma C ☐ Bronchitis C ☐ Chronic cough C ☐ COPD C ☐ Coughing up phlem C ☐ Emphysema C ☐ Pneumonia
C ☐ Spitting up blood C ☐ Wheezing C ☐ Pain with breathing C ☐ Shortness of Breath

Cardiovascular Conditions:

C ☐ Arteriosclerosis C ☐ Heart disease C ☐ Hypertension C ☐ Hypotension C ☐ Irregular pulse C ☐ Pain over heart C ☐ Palpatations
C ☐ Poor circulation C ☐ Bradycardia C ☐ Tachycardia C ☐ Swelling in ankles

Gastrointestinal Conditions:

C ☐ Abdominal pain C ☐ Appendicitis C ☐ Bloated abdomen C ☐ Black stool C ☐ Bloody stool C ☐ Celiac Disease C ☐ Cirrhosis of liver
C ☐ Colitis C ☐ Crohn's disease C ☐ Constipation C ☐ Diarrhea C ☐ Difficult digestion C ☐ Diverticulitis C ☐ Excess gas
C ☐ Gall stones C ☐ Gastric reflux C ☐ Hernia C ☐ Hemorrhoids C ☐ Intestinal worms C ☐ Irritable Bowel C ☐ Leaky Gut Syndrome
C ☐ Nausea C ☐ Painful defication C ☐ Poor appetite C ☐ Stomach pain C ☐ Vomiting C ☐ Ulcers

Genitourinary Conditions:

C ☐ Bladder infections C ☐ Blood in urine C ☐ Impotence C ☐ Kidney infection C ☐ Kidney stones C ☐ Stress incontinence
C ☐ Bed wetting C ☐ Decreased flow or force C ☐ Painful urination

Male Specifc:

Date of last prostate exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a prostate exam

Female Specifc:

Date of last PAP exam: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a PAP exam

Date of last Mamogram: _____ / Findings: ☐ Negative *(nothing found)* ☐ Positive *(an abnormality was discovered)* ☐ Never had a Mamogram

Are you taking Birth Control medication? ☐ Yes ☐ No / If *Yes*, please indicate the name in the medication section on the next page

Are you Pregnant? ☐ Yes ☐ No / If *Yes*, how many months: _____

Menstrual Flow: ☐ Regular ☐ Regular with pain and/or camping ☐ Irregular ☐ Irregular with pain and/or camping

Patient Name _____ **Date** _____

Allergies *(please list all known allergies)* **:**

☐ Animal dander ☐ Animal hair ☐ Beef ☐ Corn ☐ Dairy ☐ Eggs ☐ Fish ☐ Fungus
☐ Latex ☐ Legumes ☐ Mold ☐ Nuts ☐ Peanuts ☐ Penicillin ☐ Pollen ☐ Ragweed
☐ Shellfish ☐ Soy ☐ Strawberries ☐ Wheat ☐ Other *(please describe)* :

Medication *(please list all medications that you are currently using)* **:**

Over-the-counter:
☐ Advil ☐ Alieve ☐ Acetaminophen ☐ Aspirin ☐ Ibuprophen ☐ Motrin ☐ Naproxen Sodium ☐ Tylenol

Prescribed Medication:
☐ Alendronate ☐ Chantix ☐ Crestor ☐ Cymbalta ☐ Darvocet ☐ Daytrana ☐ Estrogen ☐ Flexeril
☐ Hydrocodone ☐ Levoxyl ☐ Lipitor ☐ Morphine ☐ Norco ☐ Oxycontin ☐ Percocet
☐ Testosterone ☐ Ultram ☐ Valium ☐ Wellbutrin ☐ Zanaflex ☐ Zocor ☐ Zoloft

☐ Other *(please describe)* :

Vitamins, Minerals & Herbs *(please list all that you are currently using)* **:**

☐ Multivitamin ☐ Vitamin B ☐ Vitamin C ☐ Vitamin D ☐ Vitamin E

☐ Other *(please describe)* :

Surgeries & Hospitalization *(please list any surgeries and the years performed, the years you gave birth, any other reason for being hospitalized and the year)* **:**

Surgery: _____

_____

Births *(years)* : _____

Hospitalization: _____

_____

Injuries *(please list any previous auto accidents and the year, bone fractures and the year, sprains/strains and the year)* **:**

Injuries: _____

_____

Family History *(Please circle the family member "symbol" for any of the applicable diseases or illnesses)* **:**

F = Father / **M** = Mother / **B** = Brother / **S** = Sister / **PGF** = Paternal Grandfather / **PGM** = Paternal Grandmother / **MGF** = Maternal Grandfather / **MGM** = Maternal Grandmother

Alcoholism	F	M	B	S	PGF	PGM	MGF	MGM	Epilepsy	F	M	B	S	PGF	PGM	MGF	MGM
Anemia	F	M	B	S	PGF	PGM	MGF	MGM	Glaucoma	F	M	B	S	PGF	PGM	MGF	MGM
Arteriosclerosis	F	M	B	S	PGF	PGM	MGF	MGM	Heart disease	F	M	B	S	PGF	PGM	MGF	MGM
Arthritis	F	M	B	S	PGF	PGM	MGF	MGM	High blood presure	F	M	B	S	PGF	PGM	MGF	MGM
Asthma	F	M	B	S	PGF	PGM	MGF	MGM	High cholesterol	F	M	B	S	PGF	PGM	MGF	MGM
Bleed easily	F	M	B	S	PGF	PGM	MGF	MGM	Multiple Sclerosis	F	M	B	S	PGF	PGM	MGF	MGM
Cancer	F	M	B	S	PGF	PGM	MGF	MGM	Osteoporsis	F	M	B	S	PGF	PGM	MGF	MGM
Diabetes	F	M	B	S	PGF	PGM	MGF	MGM	Stroke	F	M	B	S	PGF	PGM	MGF	MGM
Emphysema	F	M	B	S	PGF	PGM	MGF	MGM	Thyroid disease	F	M	B	S	PGF	PGM	MGF	MGM

Personal Habbits *(please mark the appropriate options)* **:**

Alcohol	☐ Don't drink it	☐ 1-2 times per month	☐ drink 1-3 per week	☐ drink 1 per day	☐ drink 2 or more per day
Coffee	☐ Don't drink it	☐ drink 1-4 cups per week	☐ drink 1-3 cups per day	☐ drink 3 or more cups per day	
Tobacco	☐ Don't use it	☐ use light amounts	☐ use moderate amounts	☐ use heavy amounts	
Sleep	☐ Don't get regular sleep	☐ sleep 4-6 hours per night	☐ sleep 6-7 hours per night	☐ sleep 8 or more hours per night	
Soda	☐ Don't drink it	☐ drink 1-4 per week	☐ drink 1-2 per day	☐ drink 2-4 a day	☐ drink 4 or more a day
Water	☐ Don't drink it	☐ drink 1-3 cups per day	☐ drink 3-6 per day	☐ drink 6 or more cups a day	
Sugar	☐ Don't eat it	☐ eat light amounts	☐ eat moderat amounts	☐ eat heavy amounts	
Exercise	☐ Don't exercise	☐ engage in light exercise every week	☐ engage in moderate exercise every week	☐ engage in heavy exercise every week	

INFORMED CONSENT

(Please Read Carefully Before Signing.)

As will all things physical, when you engage in the treatment of soft (muscles, ligaments, etc.) and osseous (bone) tissues, there are risks in making changes to those tissues since they have been in a state of dysfunction for an undetermined amount of time. At Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic, we strive to provide the greatest physical health care available. Our methods and techniques allow us greater flexibility in our treatments and minimize the risks that can be found in traditional healthcare facilities. However, there are always risks in any treatment you decide to receive. This document outlines the possible risks of the type of care that we provide in this office. Please read all the information in this document before signing and accepting care.

- **The chiropractic adjustment:**
  The doctor will use his hands or a mechanical adjusting instrument, upon your body, in such a way, as to move your joints when necessary. This may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may also feel or sense a movement of the joint. It is not uncommon to feel some stiffness and/or soreness in the adjusted areas following the first few days of treatment.

- **The material risks inherent in chiropractic adjustment:**
  There are certain complications which may arise during chiropractic manipulation. Those complications include: fractures, disc injuries, dislocations, muscle strain, diaphragmatic paralysis, cervical myelopathy, costovertebral strains and/or separations and/or rib fractures. In rare instances, some types of manipulation of the neck have been associated with injuries to the arteries (known as vertebral artery dissection) in the neck leading to or contributing to serious health complications including (but not limited to) stroke.

- **The probability of risks occurring:**
  Receiving a fracture from treatment is an extremely rare occurrence and generally results from some underlying pathological weakness of the bones. The different causes of stroke have been the subject of tremendous disagreement within the medical community for decades. One prominent authority claims that there is at most a one-in-a-million chance of such an outcome while utilizing the chiropractic adjustment in the cervical spine. As a policy, to reduce your risk, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury. The possibility of having the other complications that are list above in the *material risks section* also generally described as occurring "rarely."

- **Ancillary (Modality) treatments:**
  In addition to chiropractic adjustments, we use the following treatments which have been listed with their known risks:
  - ***Needle acupuncture*** - infection is rare but possible. We use single use, sterile needles to reduce this risk.
  - ***Electrical stimulation*** - Skin burns and soft tissue irritation.
  - ***Infrared heat (moxa) therapy*** - Skin burns.
  - ***Physiotherapy*** - Used to rehabilitate fascia, muscles, ligaments and nerves. Possible side effects are:
    - Muscle strain and/or reinjury of presented complaint(s)
    - Ligamentous strain, sprain or reinjury
    - Possible reinjury of presented complaint(s)
  - ***Manual therapy*** - Used to release muscle tension, skeletal subluxation and toxic metabolites. This can cause muscle stiffness and aches as well as headaches and/or **bruising of the soft tissues**. Drinking plenty of water should aid in a quick recovery if these symptoms arise.
  - ***Neuromuscular Therapy*** - Findings are similar to Manual Therapy.

- **The availability and nature of other treatment options:**
  Other treatment options for your condition include:
  - Self-administered, over-the-counter analgesics and rest or exercise, etc.
  - Prescription drugs such as anti-inflammatory, muscle relaxants and painkillers recommended and provided by your MD.
  - Surgery

- **The material risks inherent in such options and the probability of such risks occurring include:**
  - Overuse of over-the-counter medications can produce undesirable side effects. If complete recovery is impractical, premature return to work and household chores may aggravate the condition and extend the recovery time. The probability of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance and self-discipline in not abusing the medicine. Available (online) literature describes the highly undesirable effects from long term use of over-the-counter medicines.
  - Prescription muscle relaxants and painkillers can produce undesirable side effects and patient dependence. The risk of such complications arising is dependent upon the patient's general health, severity of the patient's discomfort, his pain tolerance, self-discipline in not abusing the medicine and proper professional supervision. Such medications generally entail very significant risks - some with rather high probabilities.
  - Hospitalization in conjunction with other care bears the additional risk of exposure to communicable disease, iatrogenic (doctor induced) mishap and expense. The probability of iatrogenic mishap is remote, expense is certain; exposure to communicable disease is likely with adverse result from such exposure dependent upon unknown variables.
  - The risks inherent in surgery include adverse reaction to anesthesia, iatrogenic (doctor induced) mishap, all those of hospitalization and an extended convalescent period. The probability of those risks occurring varies according to many factors. Additionally, there is no guarantee of outcome with surgery.

- **The risks and dangers attendant to remaining untreated:**
  Remaining untreated allows the formation of adhesions, a continual increase of soft tissue inflammation and reduces mobility which sets up a pain reaction further reducing mobility. Over time, this process may complicate treatment making it more difficult to treat and less effective the longer it is postponed. The probability that non-treatment will complicate a later rehabilitation is very high.

- **Treatment Outcome Possibilities:**
  The treatments provided in this clinic have proven to be effective in relieving a variety of illnesses and health problems. The outcome of treatments provided have the following possibilities: *the symptoms or illness you have sought care for may improve, may remain unchanged, or have the possibility of getting worse.* We strive to ensure that your care is complete and that you will be satisfied with your outcome.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE INFORMATION PRESENTED ABOVE.
By signing this informed consent, you agree that you have read ALL (in its entirety) or that someone has read to you ALL (in its entirety) the above explanation(s) of the nature of any treatments provided and possible risks with undergoing and/or receiving chiropractic treatment and modality treatments. By signing below, you are stating that you also understand the inherent risks of refusing chiropractic treatment and modality treatments provided by the staff and/or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
By signing below, I state that I have weighed the risks involved in undergoing and/or receiving treatment and assume the risk in receiving any and all chiropractic treatment and/or all modality therapies and I have decided it is in my best interest to undergo and/or receive any and/or all said treatment as well as any or all other treatments and services offered and provided by the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic.
Having been informed of the risks, I hereby give my consent and assume any and/or all the risks of receiving any and/or all treatment deemed necessary the staff and or business entities which operate in the office of the Arbor Creek Health & Wellness, aka. Arbor Creek Chiropractic for any reason. I understand that if I have any questions regarding treatment and/or services, I may ask the doctor and/or staff at any time for an explanation for reasons and purposes of treatment or services provided.

_____ _____
Patient Printed Name Date

_____
Patient Signature

_____
(Signature of Parent or Guardian or Responsible Party)

Financial Policy & Assignment of Benefits

The following form represents our financial policy. You are required to read and sign this agreement prior to receiving any treatment and/or services. You will not be admitted for care without it.

Financial Policy:
PLEASE READ CAREFULLY (before signing)

Some (and/or perhaps all) of the services provided in our office may (or can) be considered, by your insurance provider, as non-covered (or non-essential) services and may not be considered "reasonable and/or necessary". Your insurance policy is a contract between you and your insurance company. We bill them for services provided. They remit or deny payment based on the provisions in that contract. There is never any guaranty of payment provided by your insurance carrier. **It is your responsibility to pay for any deductible amount, co-insurance, co-pay, or any other balance not paid or covered by your insurance. You are financially responsible for all charges for services rendered regardless of any applicable insurance or benefit payments. We will bill you for these charges and if not paid will be sent to a collections recovery agency or law firm.**

Insurance does NOT cover maintenance care and/or nutritional supplements. Maintenance care is considered medically unnecessary by all insurance companies. Federal plans (Medicare and Medicaid) explicitly exclude maintenance-type care from coverage. Therefore, you are responsible for all charges incurred for maintenance care.

Participating Insurance Plans:

Please note that most insurance plans have a deductible. YOU MUST PAY THE FULL DEDUCTIBLE BEFORE THE INSURANCE WILL PAY THE COST OF YOUR CARE. This is not negotiable.

For those plans with which we are participating providers, it is our policy to collect all co-pays, co-insurance or any deductibles that are due at the time of service. In order to properly bill your insurance company and avoid untimely delays, we require that you provide us with accurate insurance information and allow us to maintain a copy of your insurance card and driver's license on file. In the event that your insurance coverage changes to a plan with which we do not participate, refer to the paragraph below for information regarding coverage. For minors, the adult accompanying a minor and the parent (or guardian(s) of the minor) are considered guarantors for the minor's account. For an unaccompanied minor; by law, all care will be denied unless the office or provider has been pre-authorized to treat and therefore charge for treatment with an approved credit plan or insurance plan.

Non-Participating Insurance Plans:

We do not accept assignment (payment) of insurance benefits, nor bill your insurance company if we are not a participating provider. Full payment (at the Self-Pay rate) is expected at time of service. If you want to use your insurance, and if we are not providers with that insurance carrier, we suggest you find a provider in your network. *Review the next page for the Fee Schedule for Self-Pay Patients.*

Assignment of Benefits:

Authorization to Pay Benefits to Physician/Office (Statement):

I hereby assign payment directly to the Office for any and all procedures and treatments provided, if any, otherwise payable to me for services provided at the Office, but not to exceed the indebtedness to the Office for those services. *I understand that I am financially responsible for charges not covered by my insurance.*

Authorization to Release Information (Statement):
I hereby authorize the Office to release any information acquired in the course of my examination and/or treatment(s) to my referring practitioner and/or my insurance company.

Acknowledgement of Financial Policy and Assignment of Benefits (Statement):

I have read and understand and agree to comply with the above Financial Policy and Assignment of Benefits provisions and agree to all provisions outlined therein.

X_____ _____
(Signature of Patient, Parent/Guardian or Responsible Party) **Date**

Fee Schedule for Self-Pay Patients:

This is the fee structure for Self-pay and/or Non-insured patients and/or patients with whom the doctor(s) will not accept assignment. You must confirm with your individual practitioner which insurance plans he participates with. If he is not in-network with your insurance carrier he will not accept insurance coverage from your insurance carrier. Self-pay (time-of-service) visits are billed primarily by time but also by services provided. Fees are listed as follows:

Service (time-of-service rates only)*	**Time allotted**	**Discount fees**	**Regular fees**
First exam (only)	1-30 minutes	$120	$125-280
First exam + first treatment	1-60 minutes	$165	$180-320
Bundled (all) services (with or without chiropractic)	1-20 minutes	$75	$120
Bundled (all) services (with or without chiropractic)	21-30 minutes	$100	$135-200
Bundled (all) services (with or without chiropractic)	31-40 minutes	$140	$210-285
Bundled (all) services (with or without chiropractic)	41-60 minutes	$200	$285-395
Chiropractic (adjustment) only	1-10 minutes	$50	$75

Acknowledgement of Financial Policy for Self-Pay and non-insured patients (Statement):

I have read and understand and agree to comply with the Financial Policy as stated in this document. Additionally, I hereby declare that I am unable to pay for the standard service fees at Arbor Creek Health & Wellness (i.e. Tim Bhakta, P.A., aka. Arbor Creek Chiropractic.) and/or waive the right to use insurance for any and all services rendered as they may or may not be covered by my insurance carrier, regardless of whether the service(s) rendered and office staff and facility are listed as providers in any or all insurance networks. I agree to pay for all services as listed in the Fee Schedule for Self-pay Patients section of the Financial Policy. I understand that additional costs may/will apply for unrelated charges of the fee schedule. I acknowledge that the fee schedule can change without notice and new fees will apply with or without being provided with notice of changes.

X_____ _____
(Signature of Patient, Parent/Guardian or Responsible Party) **Date**

(Arbor Creek Health & Wellness, Tim Bahkta, PA, aka Arbor Creek Chiropractic)

24 Hour Cancellation & "No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice (24-hours advanced notice), another patient is prevented from receiving care. Therefore, Arbor Creek Health & Wellness, Tim Bhakta, PA (AKA Arbor Creek Chiropractic) reserve the right to charge a fee of $70.00 for all missed appointments ("no shows") regardless of reason, and appointments which are not cancelled with a 24-hour advance notice.

"No Show" fees will be billed to the patient or guardian of the patient. This fee is NOT covered by insurance, and must be paid on the day of or prior to your next appointment. Multiple "no shows" in any 12 month period may result in termination from either practice. Thank you for your understanding and cooperation as we strive to serve the needs of all of our patients.

Release from Care Assumption (If the Fee is not Paid):
As per the "No Show" policy; if the fee is not paid within 60 days of this notice, it is assumed that there is no intention, desire, or will, on the part of the patient, to remit the required fee. It is also assumed that the patient *does* have the intention, desire and will to be released from any and all future care. This will mean that the patient will not be able to make/schedule any new/future appointments and the patient will be permanently released from care. Please be advised that promissory notes, notes payable, IOU's, or any other negotiable instruments will not be accepted in lieu of fee payment.

By signing below, you acknowledge that you have received this notice and understand this policy.

Patient or Guardian Signature **Date**

HIPPA PRIVACY NOTIFICATION & PRACTICE REQUIREMENTS

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.

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

Uses and Disclosures of Protected Health Information

Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purposes of providing health care services to you, pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment

We will use and disclose your PHI to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third-party. For example, we would disclose your PHI, as necessary, to a home health agency that provides care to you. For example, your PHI 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.

Payment

Your PHI will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant PHI be disclosed to the health plan to obtain prior approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your PHI 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, licensing, and conducting or arranging for other business activities. For example, we may disclose your PHI to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to

sign your name and indicate your physician. We may also call you by name in the waiting room when your physician in ready to see you. We may use or disclose your PHI as necessary to contact you to remind you of your appointment.

We may use or disclose your PHI in the following situation without your authorization. These situations include: as Required by Law, Public Health issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroner, Funeral Directors, and Organ Donation, Research, Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures, Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization, or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights. Following is a statement of your rights with respect to your PHI.

You have the right to inspect and copy your PHI. 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 PHI that is subject to law that prohibits access to PHI.

You have the right to request a restriction on your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your dare or for notification purposes as described in this Notice of Privacy Practices. Your 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 the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your PHI. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. We reserve the right to change the terms of this Notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this Notice.

Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This Notice was published and becomes effective on/before April 1, 2019.

We are required by law to maintain the privacy of, and provide individuals with, this Notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Clicking "Agree" below is only acknowledgment that you have received this Notice of our Privacy Practices.

PATIENT ACKNOWLEDGEMENT:
By subscribing my name below, I acknowledge having read the Notice; I understand it and agree to its terms.

Signature of Patient, Parent/Guardian or Responsible Party	**Date**

SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT_____ AGE_____ DOCTOR_____ DATE_____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank**.
Circle either: **(1)** for **MILD** symptoms (occurs rarely), **(2)** for **MODERATE** symptoms (occurs several times a month), or **(3)** for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

1 – 1 2 3 Acid foods upset
2 – 1 2 3 Get chilled, often
3 – 1 2 3 "Lump" in throat
4 – 1 2 3 Dry mouth-eyes-nose
5 – 1 2 3 Pulse speeds after meal
6 – 1 2 3 Keyed up - fail to calm
7 – 1 2 3 Cuts heal slowly
8 – 1 2 3 Gag Easily
9 – 1 2 3 Unable to relax, startles easily
10 – 1 2 3 Extremities cold, clammy
11 – 1 2 3 Strong light irritates
12 – 1 2 3 Urine amount reduced
13 – 1 2 3 Heart pounds after retiring
14 – 1 2 3 "Nervous" stomach
15 – 1 2 3 Appetite reduced
16 – 1 2 3 Cold sweats often
17 – 1 2 3 Fever easily raised
18 – 1 2 3 Neuralgia-like pains
19 – 1 2 3 Staring, blinks little
20 – 1 2 3 Sour stomach frequent

GROUP TWO

21 – 1 2 3 Joint stiffness after arising
22 – 1 2 3 Muscle-leg-toe cramps at night
23 – 1 2 3 "Butterfly" stomach, cramps
24 – 1 2 3 Eyes or nose watery
25 – 1 2 3 Eyes blink often
26 – 1 2 3 Eyelids swollen, puffy
27 – 1 2 3 Indigestion soon after meals
28 – 1 2 3 Always seem hungry; feels "lightheaded" often
29 – 1 2 3 Digestion rapid
30 – 1 2 3 Vomiting frequent
31 – 1 2 3 Hoarseness frequent
32 – 1 2 3 Breathing irregular
33 – 1 2 3 Pulse slow; feels "irregular"
34 – 1 2 3 Gagging reflex slow
35 – 1 2 3 Difficulty swallowing
36 – 1 2 3 Constipation, diarrhea alternating
37 – 1 2 3 "Slow starter"
38 – 1 2 3 Get "chilled" infrequently
39 – 1 2 3 Perspire easily
40 – 1 2 3 Circulation poor, sensitive to cold
41 – 1 2 3 Subject to colds, asthma, bronchitis

GROUP THREE

42 – 1 2 3 Eat when nervous
43 – 1 2 3 Excessive appetite
44 – 1 2 3 Hungry between meals
45 – 1 2 3 Irritable before meals
46 – 1 2 3 Get "shaky" if hungry
47 – 1 2 3 Fatigue, eating relieves
48 – 1 2 3 "Lightheaded" if meals delayed
49 – 1 2 3 Heart palpitates if meals missed or delayed
50 – 1 2 3 Afternoon headaches
51 – 1 2 3 Overeating sweets upsets
52 – 1 2 3 Awaken after few hours sleep - hard to get back to sleep
53 – 1 2 3 Crave candy or coffee in afternoons
54 – 1 2 3 Moods of depression - "blues" or melancholy
55 – 1 2 3 Abnormal craving for sweets or snacks

GROUP FOUR

56 – 1 2 3 Hands and feet go to sleep easily, numbness
57 – 1 2 3 Sigh frequently, "air hunger"
58 – 1 2 3 Aware of "breathing heavily"
59 – 1 2 3 High altitude discomfort
60 – 1 2 3 Opens windows in closed room
61 – 1 2 3 Susceptible to colds and fevers
62 – 1 2 3 Afternoon "yawner"
63 – 1 2 3 Get "drowsy" often
64 – 1 2 3 Swollen ankles worse at night
65 – 1 2 3 Muscle cramps, worse during exercise; get "charley horses"
66 – 1 2 3 Shortness of breath on exertion
67 – 1 2 3 Dull pain in chest or radiating into left arm, worse on exertion
68 – 1 2 3 Bruise easily, "black and blue" spots
69 – 1 2 3 Tendency to anemia
70 – 1 2 3 "Nose bleeds" frequent
71 – 1 2 3 Noises in head, or "ringing in ears"
72 – 1 2 3 Tension under the breastbone, or feeling of "tightness", worse on exertion

GROUP FIVE

73 – 1 2 3 Dizziness
74 – 1 2 3 Dry skin
75 – 1 2 3 Burning feet
76 – 1 2 3 Blurred vision
77 – 1 2 3 Itching skin and feet
78 – 1 2 3 Excessive falling hair
79 – 1 2 3 Frequent skin rashes
80 – 1 2 3 Bitter, metallic taste in mouth in mornings
81 – 1 2 3 Bowel movements painful or difficult
82 – 1 2 3 Worrier, feels insecure
83 – 1 2 3 Feeling queasy; headache over eyes
84 – 1 2 3 Greasy foods upset
85 – 1 2 3 Stools light-colored
86 – 1 2 3 Skin peels on foot soles
87 – 1 2 3 Pain between shoulder blades
88 – 1 2 3 Use laxatives
89 – 1 2 3 Stools alternate from soft to watery
90 – 1 2 3 History of gallbladder attacks or gallstones
91 – 1 2 3 Sneezing attacks
92 – 1 2 3 Dreaming, nightmare type bad dreams
93 – 1 2 3 Bad breath (halitosis)
94 – 1 2 3 Milk products cause distress
95 – 1 2 3 Sensitive to hot weather
96 – 1 2 3 Burning or itching anus
97 – 1 2 3 Crave sweets

GROUP SIX

98 – 1 2 3 Loss of taste for meat
99 – 1 2 3 Lower bowel gas several hours after eating
100 – 1 2 3 Burning stomach sensations, eating relieves
101 – 1 2 3 Coated tongue
102 – 1 2 3 Pass large amounts of foul-smelling gas
103 – 1 2 3 Indigestion 1/2 - 1 hour after
104 – 1 2 3 Mucous colitis or "irritable bowel"
105 – 1 2 3 Gas shortly after eating
106 – 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can't gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can't work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
130 – 1 2 3 Mental sluggishness
131 – 1 2 3 Hair coarse, falls out
132 – 1 2 3 Headaches upon arising wear off during day
133 – 1 2 3 Slow pulse, below 65
134 – 1 2 3 Frequency of urination
135 – 1 2 3 Impaired hearing
136 – 1 2 3 Reduced initiative

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, "splitting or rendering" type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Apprehension
174 – 1 2 3 Irritability
175 – 1 2 3 Morbid fears
176 – 1 2 3 Never seems to get well
177 – 1 2 3 Forgetfulness
178 – 1 2 3 Indigestion
179 – 1 2 3 Poor appetite
180 – 1 2 3 Craving for sweets
181 – 1 2 3 Muscular soreness
182 – 1 2 3 Depression; feelings of dread
183 – 1 2 3 Noise sensitivity
184 – 1 2 3 Acoustic hallucinations
185 – 1 2 3 Tendency to cry without reason
186 – 1 2 3 Hair is coarse and/or thinning
187 – 1 2 3 Weakness
188 – 1 2 3 Fatigue
189 – 1 2 3 Skin sensitive to touch
190 – 1 2 3 Tendency toward hives
191 – 1 2 3 Nervousness
192 – 1 2 3 Headache
193 – 1 2 3 Insomnia
194 – 1 2 3 Anxiety
195 – 1 2 3 Anorexia
196 – 1 2 3 Inability to concentrate; confusion
197 – 1 2 3 Frequent stuffy nose; sinus infections
198 – 1 2 3 Allergy to some foods
199 – 1 2 3 Loose joints

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. _____
2. _____
3. _____
4. _____
5. _____

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month
FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.
MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date:_____Temperature: _____
Date:_____Temperature: _____
Date:_____Temperature: _____
Date:_____Temperature: _____
Date:_____Temperature: _____
Date:_____Temperature: _____
Date:_____Temperature: _____

BP SIT_____ BP STAND _____
PULSE SIT _____ PULSE STAND _____
SALIVA PH _____ BLOOD TYPE _____

CASE RECORD

Name_____Date _____Telephone _____

Address _____City_____State _____Zip _____

Age_____Weight_____Height_____Sex_____

Occupation_____Married_____

History of Illness and Treatment: _____

_____

Operations, Accidents or Injuries: _____

_____

_____

Present Illness or Complaints: _____

_____

_____

Diagnostic Summary: _____

_____

_____

Treatment, Recommendations and Progress: _____

_____

_____

_____

_____

_____

_____

Female Intake Questionnaire

General Information

Name_____ Age_____ Today's Date _____

Date of Birth _____ Email _____

Address _____ City_____ State ____ Zip_____

Phone (Home)_____ (Cell)_____ (Work) _____

Genetic Background: ☐ African American ☐ Hispanic ☐ Mediterranean ☐ Asian
☐ Native American ☐ Caucasian ☐ Northern European
☐ Other _____

When, where and from whom did you last receive medical or health care? _____

_____

Emergency Contact: _____ Relationship _____

Phone (Home)_____ (Cell)_____ (Work) _____

How did you hear about our practice?

☐ Clinic website ☐ IFM website ☐ Referral from doctor ☐ Referral from friend/family member
☐ Social media ☐ Other_____

Current Health Concerns

Please rank current and ongoing health concerns in order of priority

Describe Problem	Severity	Mild	Moderate	Severe	Prior Treatment/Approach	Success	Excellent	Good	Fair
Example: Post Nasal Drip		*X*			*Elimination Diet*		*X*		
1.									
2.									
3.									
4.									
5.									
7.									
8.									
9.									
9.									
10.									

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Lifestyle Review

Sleep

How many hours of sleep do you get each night on average?_____

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No
Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No
Do you feel rested upon awakening? ☐ Yes ☐ No
Do you use sleeping aids? ☐ Yes ☐ No
If yes, explain:_____

Exercise

Current Exercise Program:

Activity	Type	# of Times Per Week	Time/Duration (Minutes)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g., golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No
Are there any problems that limit exercise? ☐ Yes ☐ No
If yes, explain:_____
Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No
If yes, explain:_____

Nutrition

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb ☐ High Protein
☐ Blood Type ☐ Low sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free
☐ Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No
If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, explain: _____

Do you adversely react to: *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite–containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No
If yes, what foods? _____

Do you eat 3 meals a day? ☐ Yes ☐ No If no, how many _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No

How many meals do you eat out per week? ☐ 0–1 ☐ 1–3 ☐ 3–5 ☐ >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

☐ Fast eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like healthy foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship to food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc.)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

Diet

Please record what you eat in a typical day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Fluids _____

How many servings do you eat in a typical week of these foods:

Fruits (not juice)_____ Vegetables (not including white potatoes) _____

Legumes (beans, peas, etc) _____ Red meat _____ Fish _____

Dairy/Alternatives _____ Nuts & Seeds _____ Fats & Oils _____

Cans of soda (regular or diet) _____ Sweets (candy, cookies, cake, ice cream, etc.) _____

Do you drink caffeinated beverages? ☐ Yes ☐ No If yes, check amounts:

Coffee (cups per day) ☐ 1 ☐ 2-4 ☐ >4 Tea (cups per day) ☐ 1 ☐ 2-4 ☐ >4

Caffeinated sodas—regular or diet (cans per day) ☐ 1 ☐ 2-4 ☐ >4

Do you have adverse reactions to caffeine? ☐ Yes ☐ No

If yes, explain: _____

When you drink caffeine do you feel: ☐ Irritable or wired ☐ Aches or pains

Smoking

Do you smoke currently? ☐ Yes ☐ No Packs per day: _____ Number of years _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quit? ☐ Yes ☐ No

If yes, using what methods: _____

If you smoked previously: Packs per day: _____ Number of years _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

Alcohol

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1–3 ☐ 4–6 ☐ 7–10 ☐ >10 ☐ None

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

Other Substances

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

Stress

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle the stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

Work ____ Family ____ Social ____ Finances ____ Health ____ Other____

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

☐ Meditation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other: _____

Have you ever sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: _____

Have you ever been abused, a victim of crime, or experienced a significant trauma? ☐ Yes ☐ No

What are your hobbies or leisure activities?_____

Relationships

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation: _____

Previous occupations:_____

Do you have resources for emotional support? ☐ Yes ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other:_____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? _____

How well have things been going for you? *(Mark on scale of 1–10, or N/A if not applicable)*

	N/A	Poorly									Very Well
Overall	☐	1	2	3	4	5	6	7	8	9	10
At school	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10
In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	☐	1	2	3	4	5	6	7	8	9	10
With your children	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With your spouse	☐	1	2	3	4	5	6	7	8	9	10

History

Patient's Birth/Childhood History:

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No
If yes, explain:_____

You were: ☐ Breast-fed/How long? _____ ☐ Bottle-fed/Type of formula:_____ ☐ Don't know

Age of introduction of: Solid food: _____ Wheat _____ Dairy _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No
If yes, what foods and what symptoms? (Example: milk—gas and diarrhea)

_____

_____

Did you eat a lot of sugar or candy as a child? ☐ Yes ☐ No

Dental History:

Check if you have any of the following, and provide number if applicable:

☐ Silver mercury fillings ____ ☐ Gold fillings ____ ☐ Root canals ____ ☐ Implants ____
☐ Caps/Crowns ____ ☐ Tooth pain____ ☐ Bleeding gums____ ☐ Gingivitis_____
☐ Problems with chewing____ ☐ Other dental concerns (explain):_____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when: _____

How many fillings did you have as a kid? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

Environmental/Detoxification History

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: _____

In your work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold ☐ Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation
☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers
☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals
☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other _____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No
If yes: Chemical name, length of exposure, date:_____

Do you have any pets or farm animals? ☐ Yes ☐ No
If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

Women's History

Obstetric History: *(Check box and provide number if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____
☐ Vaginal deliveries_____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature birth_____

Birth weight of largest baby_____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain _____

Menstrual History:

Age at first period _____ Date of last menstrual period _____
Length of cycle _____ Time between cycles _____

Cramping? ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No
If yes, please describe:_____

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring
☐ Other_____ How Long _____

Any problems with hormonal birth control? ☐ Yes ☐ No
If yes, explain _____

Use of other contraception? ☐ Yes ☐ No ☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age at last period:_____

Was it surgical menopause? ☐ Yes ☐ No If yes, explain surgery:_____

_____

Do you currently have symptomatic problems with menopause? *(Check all that apply)*

☐ Hot flashes ☐ Mood swings ☐ Concentration/memory problems ☐ Headaches ☐ Joint pain
☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido ☐ Loss of control of urine ☐ Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No
If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?_____

_____

Other Gynecological Symptoms: *(Check if applicable)*

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe) _____

_____

Gynecological Screening/Procedures: *(If applicable, provide date)*

Last Pap test: _____ ☐ Normal ☐ Abnormal
Last mammogram: _____ ☐ Normal ☐ Abnormal
Last bone density: _____ Results: ☐ High ☐ Low ☐ Within Normal Range
Other tests/procedures (list type and dates)_____

_____

Family History:

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autoimmune disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Medical History: Illnesses/Conditions

Check YES = a condition you currently have, **Check PAST** = a condition you've had in the past.

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Medical History *(cont.)*

Diagnostic Studies	Date	Comments
Bone density		
CT scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Other X-rays		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalizations	**Date**	**Reason**

Symptom Review

Please check if these symptoms occur presently or have occurred in the last 6 months

General	Mild	Moderate	Severe
Cold hands and feet	☐	☐	☐
Cold intolerance	☐	☐	☐
Daytime sleepiness	☐	☐	☐
Difficulty falling asleep	☐	☐	☐
Early waking	☐	☐	☐
Fatigue	☐	☐	☐
Fever	☐	☐	☐
Flushing	☐	☐	☐
Heat intolerance	☐	☐	☐
Night waking	☐	☐	☐
Nightmares	☐	☐	☐
Can't remember dreams	☐	☐	☐
Low body temperature	☐	☐	☐
Head, Eyes, and Ears			
Conjunctivitis	☐	☐	☐
Distorted sense of smell	☐	☐	☐
Distorted taste	☐	☐	☐
Ear fullness	☐	☐	☐
Ear ringing/buzzing	☐	☐	☐
Eye crusting	☐	☐	☐
Eye pain	☐	☐	☐
Eyelid margin redness	☐	☐	☐
Headache	☐	☐	☐
Hearing loss	☐	☐	☐
Hearing problems	☐	☐	☐
Migraine	☐	☐	☐
Sensitivity to loud noises	☐	☐	☐
Vision problems	☐	☐	☐
Musculoskeletal			
Back muscle spasm	☐	☐	☐
Calf cramps	☐	☐	☐
Chest tightness	☐	☐	☐
Foot cramps	☐	☐	☐
Joint deformity	☐	☐	☐
Joint pain	☐	☐	☐
Joint redness	☐	☐	☐
Joint stiffness	☐	☐	☐
Muscle pain	☐	☐	☐
Muscle spasms	☐	☐	☐
Muscle stiffness	☐	☐	☐
Muscle twitches:	☐	☐	☐
Around eyes	☐	☐	☐
Arms or legs	☐	☐	☐
Muscle weakness	☐	☐	☐

Musculoskeletal *(cont.)*	Mild	Moderate	Severe
Neck muscle spasm	☐	☐	☐
Tendonitis	☐	☐	☐
Tension headache	☐	☐	☐
TMJ problems	☐	☐	☐
Mood/Nerves			
Agoraphobia	☐	☐	☐
Anxiety	☐	☐	☐
Auditory hallucinations	☐	☐	☐
Blackouts	☐	☐	☐
Depression	☐	☐	☐
Difficulty:	☐	☐	☐
Concentrating	☐	☐	☐
With balance	☐	☐	☐
With thinking	☐	☐	☐
With judgment	☐	☐	☐
With speech	☐	☐	☐
With memory	☐	☐	☐
Dizziness (spinning)	☐	☐	☐
Fainting	☐	☐	☐
Fearfulness	☐	☐	☐
Irritability	☐	☐	☐
Light-headedness	☐	☐	☐
Numbness	☐	☐	☐
Other phobias	☐	☐	☐
Panic attacks	☐	☐	☐
Paranoia	☐	☐	☐
Seizures	☐	☐	☐
Suicidal thoughts	☐	☐	☐
Tingling	☐	☐	☐
Tremor/trembling	☐	☐	☐
Visual hallucinations	☐	☐	☐
Cardiovascular			
Angina/chest pain	☐	☐	☐
Breathlessness	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
High blood pressure	☐	☐	☐
Irregular pulse	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Palpitations	☐	☐	☐
Phlebitis	☐	☐	☐
Swollen ankles/feet	☐	☐	☐
Varicose veins	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Urinary	Mild	Moderate	Severe
Bed wetting	☐	☐	☐
Hesitancy	☐	☐	☐
Infection	☐	☐	☐
Kidney disease	☐	☐	☐
Kidney stone	☐	☐	☐
Leaking/incontinence	☐	☐	☐
Pain/burning	☐	☐	☐
Urgency	☐	☐	☐
Digestion			
Anal spasms	☐	☐	☐
Bad teeth	☐	☐	☐
Bleeding gums	☐	☐	☐
Bloating of:	☐	☐	☐
Lower abdomen	☐	☐	☐
Whole abdomen	☐	☐	☐
Bloating after meals	☐	☐	☐
Blood in stools	☐	☐	☐
Burping	☐	☐	☐
Canker sores	☐	☐	☐
Cold sores	☐	☐	☐
Constipation	☐	☐	☐
Cracking at corner of lips	☐	☐	☐
Dentures w/poor chewing	☐	☐	☐
Diarrhea	☐	☐	☐
Difficulty swallowing	☐	☐	☐
Dry mouth	☐	☐	☐
Farting	☐	☐	☐
Fissures	☐	☐	☐
Foods "repeat" (reflux)	☐	☐	☐
Heartburn	☐	☐	☐
Hemorrhoids	☐	☐	☐
Intolerance to:	☐	☐	☐
Lactose	☐	☐	☐
All dairy products	☐	☐	☐
Gluten (wheat)	☐	☐	☐
Corn	☐	☐	☐
Eggs	☐	☐	☐
Fatty foods	☐	☐	☐
Yeast	☐	☐	☐
Liver disease/jaundice	☐	☐	☐
(yellow eyes or skin)			
Lower abdominal pain	☐	☐	☐
Mucus in stools	☐	☐	☐

Digestion *(cont.)*	Mild	Moderate	Severe
Nausea	☐	☐	☐
Periodontal disease	☐	☐	☐
Sore tongue	☐	☐	☐
Strong stool odor	☐	☐	☐
Undigested food in stools	☐	☐	☐
Upper abdominal pain	☐	☐	☐
Vomiting	☐	☐	☐
Eating			
Binge eating	☐	☐	☐
Bulimia	☐	☐	☐
Can't gain weight	☐	☐	☐
Can't lose weight	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Carbohydrate intolerance	☐	☐	☐
Poor appetite	☐	☐	☐
Salt cravings	☐	☐	☐
Frequent dieting	☐	☐	☐
Sweet cravings	☐	☐	☐
Caffeine dependency	☐	☐	☐
Respiratory			
Bad breath	☐	☐	☐
Bad odor in nose	☐	☐	☐
Cough – dry	☐	☐	☐
Cough – productive	☐	☐	☐
Hayfever:	☐	☐	☐
Spring	☐	☐	☐
Summer	☐	☐	☐
Fall	☐	☐	☐
Change of season	☐	☐	☐
Hoarseness	☐	☐	☐
Nasal stuffiness	☐	☐	☐
Nose bleeds	☐	☐	☐
Post nasal drip	☐	☐	☐
Sinus fullness	☐	☐	☐
Sinus infection	☐	☐	☐
Snoring	☐	☐	☐
Sore throat	☐	☐	☐
Wheezing	☐	☐	☐
Winter stuffiness	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Nails	Mild	Moderate	Severe
Bitten	☐	☐	☐
Brittle	☐	☐	☐
Curve up	☐	☐	☐
Frayed	☐	☐	☐
Fungus – fingers	☐	☐	☐
Fungus – toes	☐	☐	☐
Pitting	☐	☐	☐
Ragged cuticles	☐	☐	☐
Ridges	☐	☐	☐
Soft	☐	☐	☐
Thickening of:	☐	☐	☐
Finger nails	☐	☐	☐
Toenails	☐	☐	☐
White spots/lines	☐	☐	☐
Lymph Nodes			
Enlarged/neck	☐	☐	☐
Tender/neck	☐	☐	☐
Other enlarged/tender	☐	☐	☐
lymph nodes			
Skin, Dryness of			
Eyes	☐	☐	☐
Feet	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Hair	☐	☐	☐
And unmanageable?	☐	☐	☐
Hands	☐	☐	☐
Any cracking?	☐	☐	☐
Any peeling?	☐	☐	☐
Mouth/throat	☐	☐	☐
Scalp	☐	☐	☐
Any dandruff?	☐	☐	☐
Skin in general	☐	☐	☐
Skin Problems			
Acne on back	☐	☐	☐
Acne on chest	☐	☐	☐
Acne on face	☐	☐	☐
Acne on shoulders	☐	☐	☐
Athlete's foot	☐	☐	☐
Bumps on back of upper arms	☐	☐	☐
Cellulite	☐	☐	☐
Dark circles under eyes	☐	☐	☐

Skin Problems *(cont.)*	Mild	Moderate	Severe
Ears get red	☐	☐	☐
Easy bruising	☐	☐	☐
Eczema	☐	☐	☐
Herpes – genital	☐	☐	☐
Hives	☐	☐	☐
Jock itch	☐	☐	☐
Lackluster skin	☐	☐	☐
Moles w color/size change	☐	☐	☐
Oily skin	☐	☐	☐
Pale skin	☐	☐	☐
Patchy dullness	☐	☐	☐
Psoriasis	☐	☐	☐
Rash	☐	☐	☐
Red face	☐	☐	☐
Sensitive to bites	☐	☐	☐
Sensitive to poison ivy/oak	☐	☐	☐
Shingles	☐	☐	☐
Skin cancer	☐	☐	☐
Skin darkening	☐	☐	☐
Strong body odor	☐	☐	☐
Thick calluses	☐	☐	☐
Vitiligo	☐	☐	☐
Itching Skin			
Anus	☐	☐	☐
Arms	☐	☐	☐
Ear canals	☐	☐	☐
Eyes	☐	☐	☐
Feet	☐	☐	☐
Hands	☐	☐	☐
Legs	☐	☐	☐
Nipples	☐	☐	☐
Nose	☐	☐	☐
Genitals	☐	☐	☐
Roof of mouth	☐	☐	☐
Scalp	☐	☐	☐
Skin in general	☐	☐	☐
Throat	☐	☐	☐

Symptom Review *(cont.)*

Please check if these symptoms occur presently or have occurred in the last 6 months

Female Reproductive	Mild	Moderate	Severe
Breast cysts	☐	☐	☐
Breast lumps	☐	☐	☐
Breast tenderness	☐	☐	☐
Ovarian cyst	☐	☐	☐
Poor libido (sex drive)	☐	☐	☐
Endometriosis	☐	☐	☐
Fibroids	☐	☐	☐
Infertility	☐	☐	☐
Vaginal discharge	☐	☐	☐
Vaginal odor	☐	☐	☐
Vaginal itch	☐	☐	☐
Vaginal pain	☐	☐	☐
Premenstrual:	☐	☐	☐
Bloating	☐	☐	☐
Breast tenderness	☐	☐	☐
Carbohydrate craving	☐	☐	☐
Chocolate craving	☐	☐	☐
Constipation	☐	☐	☐
Decreased sleep	☐	☐	☐
Diarrhea	☐	☐	☐
Fatigue	☐	☐	☐
Increased sleep	☐	☐	☐
Irritability	☐	☐	☐
Menstrual:	☐	☐	☐
Cramps	☐	☐	☐
Heavy periods	☐	☐	☐
Irregular periods	☐	☐	☐
No periods	☐	☐	☐
Scanty periods	☐	☐	☐
Spotting between	☐	☐	☐

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDs (Advil, Aleve, etc.), Motrin, Aspirin? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid-blocking drugs (Zantac, Prilosec, Nexium, etc.)? ☐ Yes ☐ No

How many times have you taken antibiotics?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Have you ever taken long term antibiotics? ☐ Yes ☐ No

If yes, explain: _____

How often have you taken oral steroids (e.g., cortisone, prednisone, etc.)?

	< 5	> 5	Reason for Use
Infancy/Childhood			
Teen			
Adulthood			

Readiness Assessment and Health Goals

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing):

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Take several nutritional supplements each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Keep a record of everything you eat each day	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Modify your lifestyle (e.g., work demands, sleep habits)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Practice a relaxation technique	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
Engage in regular exercise	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Rate on a scale of 5 (very confident) to 1 (not confident at all):

How confident are you of your ability to organize and follow through on the above health-related activities? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to follow through? _____

_____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):

How much ongoing support (e.g., telephone consults, email correspondence) from our professional staff would be helpful to you as you implement your personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments _____

_____

Health Goals

What do you hope to achieve in your visit with us? _____

_____

_____

When was the last time you felt well? _____

_____

_____

Did something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

THE INSTITUTE FOR FUNCTIONAL MEDICINE®

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

Point Scale

0 – ***Never or almost never*** have the symptom
1 – ***Occasionally*** have it, effect is ***not severe***
2 – ***Occasionally*** have it, effect is ***severe***
3 – ***Frequently*** have it, effect is ***not severe***
4 – ***Frequently*** have it, effect is ***severe***

HEAD

_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia

Total _____

EYES

_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision
(Does not include near or far-sightedness)

Total _____

EARS

_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss

Total _____

NOSE

_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation

Total _____

MOUTH/THROAT

_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, lips
_____ Canker sores

Total _____

SKIN

_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating

Total _____

HEART

_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain

Total _____

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

LUNGS

_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing

Total _____

DIGESTIVE TRACT

_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain

Total _____

JOINTS/MUSCLE

_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness

Total _____

WEIGHT

_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight

Total _____

ENERGY/ACTIVITY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness

Total _____

MIND

_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities

Total _____

EMOTIONS

_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression

Total _____

OTHER

_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge

Total _____

Grand Total _____