New Patient History

(Please print clearly and answer all questions)

Name (please print) _____ Date _____

If a minor child, name of parents: _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

Shipping Address (if different) _____

Best Phone: (_____) _____ Other Phone (_____)_____

email address: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M F

Name of Spouse: _____ Employer _____

How did you find out about our office? _____

Please list *the main problem you would like us to help you with on line number one:*
On the other lines please list any other health problems you have (up to three) *in order of importance to you.*

1. _____ 3. _____

2. _____ 4. _____

With regards to the number one problem you are seeing the doctor for, please answer all of the following questions:

When did you first notice it: _____

Is this problem: [ ] Staying the same [ ] Getting worse [ ] Improving

What do you believe caused this problem: [ ] Automobile Accident (date: _____)

[ ] Work Related Injury (date: _____)

[ ] Other injury [ ] Illness Other: _____

Did this problem: [ ] Come on suddenly without an apparent cause [ ] Develop gradually over time [ ] Begin after a specific accident [ ] Begin after an illness: What illness?_____

What treatments have you tried (*medical treatments, home remedies, etc.)*

What makes this problem worse?

How often do you experience this condition?

Is it constant or does it come and go? [ ] Constant [ ] Comes and goes

Have you had any laboratory testing done in the last six months? [ ] Yes [ ] No

When was the last time you felt really good? _____

Do Not Write In This Space

If you are **currently under the care** of a physician or other health care professional please give their name and date of last visit if you can:

Doctor of Chiropractic: Name:_____ Date: _____

MD / DO / CNP: Name: _____ Date: _____

Physical Therapist: Name: _____ Date: _____

Acupuncture: Name: _____Date: _____

Other:

_____

Name: _____ Date: _____

How many doctors have you seen in the past for your current health problem(s): _____

How many other doctors are you currently seeing for your current health problem(s) _____

Please write a "C" if you currently have the following or a "P" if you had it in the past.

___ AIDS
___ Alcoholism
___ Allergies
___ Arteriosclerosis
___ Arthritis
___ Cancer
___ Chicken pox
___ Diabetes
___ Eczema
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Graves' Disease
___ Hypothyroid
___ Heart Disease
___ Hepatitis
___ Malaria
___ Measles
___ Multiple Sclerosis
___ Mumps
___Pneumonia

___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Tuberculosis
___ Typhoid
___ Ulcers
Other:
_____
_____
_____
_____
_____

Surgical History
Check any you have had:
___ Appendix removed
___ Heart Surgery
___ Cancer surgery
___ Cosmetic surgery
___ Eye surgery
___ Pace maker
___ Tonsils removed
___ Vasectomy
___ Oral Surgery
___ Gastric Surgery
___ Bone Surgery
___ Back Surgery
___ Brain Surgery
___ Radiation treatment
___ Chemotherapy

Other:
_____
_____
_____

Medications you are currently taking:

Medication	Reason For Use

Have you ever taken NSAIDS (*ie Advil, Aleve, Motrin, Asprin, Ibuprofen, etc.)* for 3 days or longer at a time? [ ] Yes [ ] No

Have you taken Tylenol regularly? [ ] Yes [ ] No If "yes", for how long: _____

For what reasons have you used these pain medications? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you used acid blocking medications (*Tagamet, Zantac, Prilosec, Protonics, etc.)* regularly or for more than three months? Yes No

Have you taken antibiotics more than one time a year? [ ] Yes [ ] No

Have you taken antibiotics longer than 10 days at a time? [ ] Yes [ ] No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids (*prednisone or cortisone*) in any form, including pills, creams, etc.? [ ] Yes [ ] No

Women Only:

Are you pregnant? [ ] Yes [ ] No [ ] Maybe, but not certain. Are you nursing? _____

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian or breast cysts, etc.?)_____

_____

Menstrual cycle: Do you have regular monthly periods? Yes No Perimenopause Menopause

Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moody Cravings Heavy bleeding Back pain Headaches Clots

[ ] Cesarean delivery [ ] Postpartum depression [ ] Miscarriage [ ] Abortion [ ] Baby over 8 lbs. [ ] Baby under 6 lbs.

[ ] Used birth control medications in the past. *How long?* _____

Are you currently on any type of birth control? [ ] Yes [ ] No *If yes, what type?* _____

Date of last bone density test: _____ Results: [ ] Normal [ ] Osteopenia (early bone loss) [ ] Osteoporosis

Date of last mammogram: _____ Date of last gynecological exam: _____

Sleep: Do you have any sleep problems (please circle any that apply): Insomnia Trouble falling asleep

Wake up off and on several times a night Wake up and can't go back to sleep Bad dreams

Any other sleep problems? _____

Exercise: What kind of exercise do you do? _____

How often: _____ How long at a time: _____

Food Allergies:_____

Medication Allergies: _____

Have you traveled outside the United States? [ ] Yes [ ] No. If yes, where and what year: _____

_____

Did you ever become ill in another country or shortly after returning from going outside the country? [ ] Yes [ ] No

Have you been wilderness camping: [ ] Yes [ ] No: If yes, where: _____

List any household pets, farm animals or other animals you or your family members are in close contact with:

_____

_____

Your Personal Birth History (answer these as best you can)

[ ] Full term [ ] Premature Pregnancy Complications?: _____

[ ] Breast Fed. How long (if you know): _____ [ ] Bottle-fed

Do you know about when you were introduced to solid foods? _____

Were you a C-section delivery? Yes No Unknown

Did you eat candy, sugary foods, soft drinks, etc. as a child? [ ] Yes [ ] No If yes, would you estimate eating: a lot on occasion rarely

Dental History

List any dental surgeries: _____

[ ] Silver fillings [ ] Gold fillings [ ] Root Canals [ ] Implants [ ] Tooth extractions [ ] Bleeding Gums [ ] Gingivitis

Do you get regular dental check-ups? [ ] Yes [ ] No What tooth paste do you use: _____

Have you ever had Fluoride treatments? [ ] Yes [ ] No

[ ] Yes [ ] No Have you ever had a dental amalgam / filling removed? If Yes, how many? _____

[ ] Yes [ ] No If you had amalgams removed, was it done by a biological dentist using a safe protocol?

[ ] Yes [ ] No Have you ever worked in a dental office? If so, how long? _____

[ ] Yes [ ] No Have you had any dental crowns? If yes, how many _____

[ ] Yes [ ] No Have you had a root canal done? If yes, how many _____

[ ] Yes [ ] No Do you have a dental bridge?

[ ] Yes [ ] No Have you had any tooth extractions?

[ ] Yes [ ] No Do you have any tattoos with red ink?

[ ] Yes [ ] No Do you eat tuna, shark, swordfish or Atlantic Salmon more than twice a week?

[ ] Yes [ ] No Do you have any body piercings? If you do, where are they? _____

_____

Vaccine History

[ ] Yes [ ] No Have you received a flu shot? If "yes", when was your last flu vaccination? _____

[ ] Yes [ ] No Have you received any vaccinations other than for COVID-19 **within the last 10 years**?

[ ] Yes [ ] No Have you been vaccinated for COVID-19? If you have, which vaccine was used? ____ Pfizer ____ Moderna ____Johnson & Johnson _____ Other

[ ] Yes [ ] No If with with the Pfizer or Moderna vaccines, have you had any boosters? How many? _____

[ ] Yes [ ] No Have you noticed any adverse reactions to these shots? Explain:_____

_____

_____

General Toxicity

[ ] Yes [ ] No Have you ever lived near, on or by a golf course, freeway or high tension electrical wires?

[ ] Yes [ ] No Have you ever lived down wind from a feed lot or factory?

[ ] Yes [ ] No Have you ever worked around chemicals such as in a beauty salon, auto repair shop, factory, dry cleaners, etc.?

[ ] Yes [ ] No Do you have your house sprayed with pesticides for pest control?

[ ] Yes [ ] No Do you spray for weeds around your home?

[ ] Yes [ ] No Do you use conventional insect repellents on yourself or family?

[ ] Yes [ ] No Do you use conventional sunscreen?

[ ] Yes [ ] No Do you use conventional perfumes, after shave, deodorants or cosmetics on a daily basis?

[ ] Yes [ ] No Do you get your hair colored?

[ ] Yes [ ] No Do you use aerosol hairspray?

[ ] Yes [ ] No Do you get your nails done? If so, how often: _____

[ ] Yes [ ] No Do you use air freshener in your home, work or car?

[ ] Yes [ ] No Do you drink tap water?

[ ] Yes [ ] No Does your spouse or other family member work around chemicals?

Mold

How old is the house you live in? _____ How long have you lived there? _____

Have you developed any health problems or symptoms since moving in? Yes No If yes, what are they?

_____

[ ] Yes [ ] No Do you see mold growing in your home, at your work place or school?
[ ] Yes [ ] No Have you ever had water damage at home, work or your school?
[ ] Yes [ ] No Does your home, workplace or school have a damp or mildew smell?
[ ] Yes [ ] No If you have a basement, do your symptoms get worse when you go in to it?
[ ] Yes [ ] No Does your basement ever get wet?
[ ] Yes [ ] No Do you have a crawl space under your home?
[ ] Yes [ ] No If you spend some time away from your home or work place, do your symptoms improve?
[ ] Yes [ ] No Does anyone in your home have asthma or asthma- like symptoms?
[ ] Yes [ ] No Does anyone in your family have chronic sinus infections or irritation?

Microbiome Health

[ ] Yes [ ] No Do you pass sulfur smelling or foul smelling gas?
[ ] Yes [ ] No Do you get bloating, burping or get a noisy gut after eating carbs like grains, sugar or starchy vegetables?
[ ] Yes [ ] No Do nutritional supplements or vitamin pills bother you?
[ ] Yes [ ] No Have you been a vegetarian or vegan for any length of time?
[ ] Yes [ ] No Does eating meat cause you digestive problems?
[ ] Yes [ ] No Have you used anti-acids, proton pup inhibitors or other acid blocking medications?
[ ] Yes [ ] No Have you taken birth control or hormone replacement therapy for any length of time?
[ ] Yes [ ] No If you drink alcohol, do you get brain fog or a toxic feeling, even after 1 drink?
[ ] Yes [ ] No Have you been on antibiotics for an extended period of time or repeatedly as a child or adult?
[ ] Yes [ ] No Were you delivered by caesarian section?
[ ] Yes [ ] No Where you breast fed? If yes, how long (if you know) _____
[ ] Yes [ ] No Does your gut feel better after you take antibiotics?
[ ] Yes [ ] No I have had multiple episodes of abdominal pain or discomfort in the past year.
[ ] Yes [ ] No My bowel movements are irregular (constipation and / or diarrhea)
[ ] Yes [ ] No My digestive symptoms interfere with my daily life.
[ ] Yes [ ] No I frequently have a sore throat, especially in the morning

Check Any Symptoms that Currently Apply to You

Hypothyroid

___ Weight gain
___ Constipation
___ Feeling cold (especially hands and feet) even on warm days
___ Low basal temperature
___ Fatigue, exhaustion and low energy (even after 12 hours sleep)
___ Slow reflexes
___ Slow, weak pulse
___ Slowness of thought processes (brain fog)
___ Indecisiveness
___ Poor memory and concentration
___ Sluggishness
___ Muscle weakness
___ Pain and stiffness in muscles or joints
___ Deepening, hoarse voice
___ Depression, mood swings and severe PMS
___ Thick, dry, coarse skin
___ Creviced, cracking skin on heels, elbows and knee caps
___ Enlarged thyroid gland in throat area
___ Lump in throat (hard to swallow)
___ High cholesterol
___ Menstrual cycle irregularities (prolonged, shortened, heavy)
___ Infertility
___ Numbness and tingling (especially in hands and face)
___ Fluid retention (swelling of face and feet)
___ Brittle hair and nails
___ Hair loss
___ Shortness of breath on exertion
___ Allergies
___ Back pain
___ Blood pressure problems
___ Breast tenderness
___ Irregular heartbeat
___ Chest pain
___ Digestive disturbances
___ Dizziness
___ Dry eyes and mouth
___ Headaches and migraines
___ Irritability
___ Pale skin
___ Palpitations
___ Reduced sex drive

Hyperthyroid

___ Palpitations, fast pulse or irregular heartbeat
___ Trembling and twitches
___ Do not like hot weather or warm rooms
___ Hot flushes and increased sweating
___ Increased appetite
___ Weight loss (especially if eating well)
___ Diarrhea
___ Anxiety, nervousness and/or panic attacks
___ Restlessness
___ Irritability
___ Thin, moist skin
___ Soft, thinning hair
___ Shortness of breath
___ Muscle weakness
___ Insomnia
___ Loss of appetite
___ Swelling around your throat
___ Eye complaints (especially gritty feeling or bulging eyes)
___ Fatigue, exhaustion and lack of energy
___ Menstrual cycle disturbances
___ Infertility
___ Depression and mood swings
___ Bowel disorders
___ Brittle nails
___ Chest pain
___ Cramps
___ Decreased sex drive
___ Easy bruising
___ Hair loss
___ Headaches and migraines
___ Sore throat
___ Swelling of legs

Brain Evaluation (NPH)

[ ] Have trouble walking because my feet feel like they are heavy or "stuck" to the floor.
[ ] Have difficulty walking up stairs
[ ] Trip over road curbs or small elevations in the ground
[ ] Have a "shuffling walk"
[ ] Mental confusion
[ ] Difficulty remembering things or forgetful
[ ] Have trouble paying attention or staying mentally focused
[ ] Experience changes in mood for no obvious reason
[ ] Have lost interest in daily activities
[ ] Have been diagnosed with early dementia or Alzheimer's
[ ] Urinary urgency or incontinence
[ ] Have difficulty understanding or remembering instructions
[ ] Have experienced changes in personality or regular behavior
[ ] Having trouble with using or saying words correctly or normally
[ ] Problems with vision
[ ] Having difficulty making decisions
[ ] Difficulty in making plans or keeping a schedule
[ ] Feel fearful for no good reason
[ ] Have recurring headaches

Adrenal Dysfunction [ ] Anxiety [ ] Nervousness [ ] Not dealing well with stress [ ] Feel dizzy or off balance [ ] Light headed [ ] Impatient or irritable with others [ ] Shaky or tremble [ ] Racing or pounding heart [ ] Sleep problems (can't get to sleep, wake up with a start, wake up and can't go back to sleep, etc.) [ ] Feel nauseated when stressed [ ] Get shaky or grumpy if you miss a meal [ ] Crave salt or salty foods [ ] Achy or painful joints [ ] Feelings of doom [ ] Panic attacks [ ] Emotionally hypersensitive or overreact to people or situations [ ] Have anger outbursts - lose temper easily [ ] Inability to focus on tasks or activities [ ] General body achiness [ ] Headaches [ ] Feel paranoid [ ] Very defensive with others or over react towards others or situations [ ] Hypersensitive skin (do not like being touched) [ ] Clumsy (drop things, bump in to things)	[ ] Hypersensitive to vitamin pills and nutritional supplements [ ] Jumpy or startle easy [ ] Need coffee in the morning to wake up [ ] Coffee makes you sleepy [ ] Exercise makes you nauseated [ ] Get lightheaded, dizzy or like you might faint when moving from kneeling or lying down to standing up [ ] Have allergies (food, pollen, animal dander, chemicals, etc.) [ ] Bright light is irritating, and especially at night with oncoming car lights [ ] Feel tired, but also "wired" or "keyed up" [ ] Digestive problems, irritable bowel symptoms [ ] Dark circles under the eyes [ ] Feel you can't get enough air – "air hunger" [ ] Get motion sickness easily [ ] Nails are weak or ridged [ ] Chronic low blood pressure [ ] Sweat easily [ ] Poor digestion [ ] Feel very fatigued [ ] Get irritated easily [ ] Low back pain [ ] Muscle weakness [ ] Feel jittery [ ] Achy or sensitive scalp [ ] Take a longer time to recover from being sick with a cold or flu [ ] Feelings of confusion

Please circle any of the following that apply to your **immediate** family (father, mother, brothers, sisters, grandparents):

Cancer	Heart Disease	High Blood Pressure	Arthritis	Diabetes	Chronic Back Pain	Stroke
Thyroid problems	Hypoglycemia	Liver Disease	Colitis	Headaches	Osteoporosis	Emphysema
Asthma	Kidney disease	Digestive problems	Allergies	ADD	Mental Illness	Alcoholic
Obesity	Celiac disease	Breast Cancer	Eczema / Psoriasis		Dementia	Parkinson's

Describe health of spouse or partner:_____Number of children, if any: _____

Name of Child	Age	Sex	Any health problems or concerns?
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

Social History:

Alcohol use:

Beer: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Wine: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Hard Liquor: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Tobacco use: Cigarettes Cigars Pipe Chew Snuff _____Daily _____ Weekly How much _____:

If you do not currently use tobacco, <u>but did in the past</u>, for how long?_____How long have you stopped smoking? _____

Coffee use: Regular Decaf How many cups? _____ per day or _____ per week

How would you rate the amount of **stress** you are currently under? ___ None ___ Mild ___ Moderate ___ Severe

What is the cause(s) of your stress:

_____

Activities of Daily Living: Circle the number that best shows how much your current condition interferes with your ability to do the following:.

0 = Not At All 1= Mildly 2 = Moderately 3 = Severely

Sitting 0 1 2 3	Getting out of a chair 0 1 2 3	Standing 0 1 2 3	Walking 0 1 2 3
Lying down 0 1 2 3	Bending over 0 1 2 3	Climbing Stairs 0 1 2 3	Using a computer 0 1 2 3
Driving a car 0 1 2 3	Getting out of a car 0 1 2 3	Looking over shoulder 0 1 2 3	Caring for family 0 1 2 3
Grocery shopping 0 1 2 3	Household chores 0 1 2 3	Reaching overhead 0 1 2 3	Bathing 0 1 2 3
Dressing yourself 0 1 2 3	Sexual activity 0 1 2 3	Sleep 0 1 2 3	Yard Work 0 1 2 3
Exercise 0 1 2 3	Lifting things 0 1 2 3	Kneeling 0 1 2 3	

Have you ever been sexually assaulted? [ ] Yes [ ] No Have you ever been physically assaulted? [ ] Yes [ ] No
Have you ever been emotionally abused? [ ] Yes [ ] No

How well have things been going for you?	Very Well	Fine	Poorly	Does not apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/ boyfriend / girlfriend				
With you children				
With you parents				

Resources for emotional support *Check all that apply*
[ ] Spouse [ ] Family [ ] Friends [ ] Religious / Spiritual [ ] Pets [ ] Other: _____
Who is living with you in your home? Number: _____ Relation: [ ] Spouse or Partner [ ] Child [ ] Other _____
Relationships: Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widow / Widower [ ] Gay / Lesbian [ ] Long term Partnership

Nutrition History

How many meals do you eat out per week? _____

[ ] Fast eater	[ ] Others in my household have special dietary needs
[ ] Do not eat at regular times or skip meals.	[ ] Snack frequently
[ ] Eat too much	[ ] Do not like to eat
[ ] Late night eating	[ ] Struggle with eating issues
[ ] Dislike healthy food such as vegetables, etc.	[ ] Emotional eater *(eat when sad, lonely, depressed, bored, stressed)*
[ ] Life style interferes with eating regular meals	[ ] Don't care to cook
[ ] Eat more than 50% of meals away from home	[ ] Don't like to shop for food
[ ] Travel frequently	[ ] Confused about nutritional advise
[ ] Significant other or family members don't like healthy foods	

In order to improve your health, how willing are you to: rate on a scale of 5 (very willing) to 1 (not willing)

Take several nutritional supplements each day	5	4	3	2	1
Prepare your own meals	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic lab tests to assess your progress	5	4	3	2	1
Get regular bodywork such as chiropractic or massage	5	4	3	2	1
Set regular appointments	5	4	3	2	1
Read books or articles to learn about your health and solutions	5	4	3	2	1
Be fully responsible for your own healing	5	4	3	2	1
How willing are you to give your treatment program enough time to complete?	5	4	3	2	1

Symptom / Systems Survey

Name: _____ Date: _____

Circle any of the following symptoms you currently experience or have had in the last 6 months

Headaches: Side of head back of head front / sinus eyes top of head tingling in hands / feet drop things dizziness numbness in hands / feet shaking of hands poor balance
Memory: Good Fair Poor **Mental Focus / Concentration**: good fair poor Have cold hands and feet even in summer time
Ears: noise in the ears (ringing, hissing, etc.) loss of hearing plugged ears wax buildup drainage itching pain
Eyes: burning dry itching ache tearing or watery muscle twitching of eyelid or around the eyes blurred vision light bothers eyes red / bloodshot floaters styes **Sinus:** Dry Drain Plugged post-nasal drip sneezing green or yellow mucus frequent nose bleeds smell loss taste loss
Throat: Sore Swelling Hoarseness Difficulty swallowing burning Foot order
Lungs: Cough – dry / productive recurring lung infections allergies or hay fever difficulty breathing asthma
Shortness of breath: constant / with mild exertion or activity hoarseness **Mouth**: bad breath canker sores in mouth
gums bleed with brushing or flossing tooth pain jaw pain or clicking dry mouth difficulty swallowing
Immune: Fever Chills sore throat get frequent colds / flu swollen glands general ill feeling Stiffness or soreness of joints in the morning
Get sick once or more every year Colds or flu hang on for more than 3 days
Chest: tension tightness pressure heaviness pain congestion irregular heart beat racing heart beat
Stomach / GI System: Heartburn Indigestion Cramps Nausea Vomiting Bloating Gas or flatulence Burping Ulcers Stomach pain with eating
Stomach pain 2-3 hours after eating Have problems with: Gluten (wheat) Eggs Dairy Sugar Corn Soy
Other foods you have problems with: _____
Frequency of bowel movements: once a day twice or more a day every two days or longer blood in stool stool floats mucus in stool
Feel my bowel movement is incomplete painful bowel movement anal itching diarrhea constipation
Is your stool: Normal shape and consistency hard mushy pebble shaped ribbon shaped dry have hemorrhoids

Women: Vagina: Burning itch dry pain with intercourse discharge (color _____) bad odor
Menses: Post menopausal Regular Irregular Last menstrual period _____ short cycle (less than 28 days) long cycle (over 28 days) spotting
Flow: heavy moderate light clots long brief Cramps: none mild medium severe menstrual back pain
Swelling: face hands feet breasts whole body **Hot flashes**: none mild moderate severe
PMS: None Mild Moderate Severe painful ovulation ovarian cysts uterine fibroids
Breast tissue is: smooth ropy or lumpy tender have cysts nipple discharge breast prosthesis have breast implants
Other: Decrease in energy irritable loss of stamina can not lose excess weight or tend to gain weight easily

Skin: Acne: face chest back shoulders Dry Itching Fungus Psoriasis Eczema Cellulite skin tags rash age spots small red moles
Hair: Excessive hair loss brittle / breaks easily finger nails break easily **Urination:** How often do you get up at night to urinate? _____
Do you have: Urgency burning pain Leak if you sneeze/cough Frequent bladder infections How many times do you urinate during the day? _____
Sleep: Hours a night _____ Difficulty falling asleep Wake up and cannot get back to sleep Sleep all night but do not feel rested
Wake up several times a night but go back to sleep each time Do not remember dreams Have nightmares Have night sweats
General restlessness at night Wake up between 1am and 3am Awaken suddenly (jolt) Aching or restless legs (especially at night)

Men: Low mood irritable pessimism discouragement loss of energy loss of strength and stamina loss of body hair
withdrawal from activities and people less productive at work decreased initiative loss of motivation or drive erectile dysfunction (ED)
decreased spontaneous morning erections increased fat in the breasts increased fat in the hips or waist difficulty staring urination dribbling
history of prostate problems losing interest in things in general (work, family, activities)

Circle any of the following that you experience often:
Sadness Grief Depression Moodiness Irritable Worry Anger Nervousness Frustration Anxiety Panic Crying Fear Guilt
Compulsive over-eater / under eater Like to eat something sweet after meals Feel energetic after meals Experience fatigue or get sleepy after you eat
Energy crash between 3 and 6 pm Crave sweets, pasta or bread Crave salt or salty foods Feel shaky, get headaches or grumpy if meals missed
Appetite: Good Fair Poor Energy: good low up and down Sex Drive: good low none hyper Healing: Good Slow
Pain / Stiffness: Face neck upper back mid back low back shoulders arms elbows wrist hands fingers sacroiliac hips buttocks thighs lower legs knees ankles feet toes
Other:_____ Allergic to Dental Anesthetics (Novocain, etc.)

Consent to Treatment

Every type of health care is associated with some risk of a potential problem or may achieve less than the desired outcome for both the Doctor and the patient. This includes chiropractic care, nutritional/herbal therapy and the general area of what is referred to as holistic or functional medicine. We want you to be informed about the potential problems associated with chiropractic care and the other therapies we use before consenting to treatment. **This is called an informed consent.**

Medicare and Our Office: If you are 65 or older, you need to be aware that **we do not provide any health care services that are covered by Medicare.** If you are 65 or older, and desire chiropractic care, we ask that you obtain such care from some other chiropractor where such services are provided. We are happy to provide all other non-covered services to you, but you will have to pay for them yourself.

Concerning Chiropractic Therapy:
Understand that some types of **chiropractic adjustments** may involve risks of complications, injury or even death from both known and unknown causes. Most all of the problems that happen with chiropractic adjustments are associated with those chiropractic treatment methods that involve the sudden thrusting or twisting motions that are done by hand by the doctor. **In our office we do not use this type of chiropractic adjustment. In our office we use the Activator or Arthrostim chiropractic adjusting instruments.** To the best of our knowledge, injures such as stroke, rib fracture, joint injuries, etc. have never been caused by the use of the Activator or Arthrostim instruments. **However, even with more forceful types of chiropractic techniques, injuries are uncommon.**

Stroke: This is the most serious potential complication associated with manual spinal adjustments of the neck, regardless of whether the provider is a chiropractor, medical or osteopathic doctor or other health professional. **To the best of our knowledge, neck adjustments using an Athrostim or Activator instrument have never caused a stroke.**

Rib Fracture, Joint Dislocations, Sprain Injury or Muscle Soreness: It is impossible to cause these types of injuries with the Arthrostim or Activator instruments. A ***manual*** chiropractic adjustment may fracture a rib or create a joint sprain injury. Fractures occur only to those patients who have weakened bones from such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. Sprains can happen to anyone. Even with manual adjusting methods, fractures or other significant injuries occur so rarely that there are no statistics available to determine there probability.

Sometimes a patient will experience soreness after any type of adjustment. This happens usually because muscles begin to engage better than prior to the treatment or because improvements in muscular synergy occur which make previously less functional muscles, more active. Soreness is usually mild to moderate if it occurs at all, and usually only lasts anywhere from an hour or two up to a couple of days.

Nutritional Programs: We want you to understand that our viewpoint concerning nutrition and the need for certain nutrients is not necessarily shared by the American Medical Association, the Food and Drug Administration and quite possibly other similar government agencies or professional organizations. **Our nutritional programs are not intended to cure any specific disease.** The focus of nutritional / herbal therapies are to facilitate the optimal function of your bodies organ and physiological systems. Doing this supports the bodies ability to correct disease and malfunction on its own.

Neural Therapy, Biopuncture, Prolotherapy, Trigger Point Injection Therapy and Mesotherapy
Neural Therapy, Biopuncture, Prolotherapy and Trigger Point Therapy are injection techniques frequently used to help patients with both chronic and acute pain as well as other health problems. Several of the above treatment methods use anesthetics (Procaine or Lidocaine) as well as homeopathic medicines, nutritional products such as vitamin B12 or dextrose, or Sarapin (a biologic drug made from the Picture plant used for neurogenic pain) which are injected into the skin, fat, ligaments, muscle or scars. These treatment methods have been used for many years by physicians all over the world and have been proven to be safe and effective in helping with pain as well as certain other health problems. Mesotherapy is a cosmetic injection therapy that uses homeopathic medicines to help the body to produce more collagen and to facilitate the repair of damaged skin.
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Potential Problems with Injection Treatments:
Though significant side affects are very rare, potential problems and side affects (either expected or unexpected) with these injection procedures may occur and include infection, localized skin irritation, sensation of heaviness or heat in the injected area, dizziness, possible heart arrhythmia (only in very large doses of Procaine or Lidocaine) and possible allergic reactions to the substances injected. The most common side effects with any injection are bruising or minor bleeding or brusing. If you are allergic to any of these medications, reactions could potentially range from simple skin rash to death, though this would be extremely rare. With Procaine or Lidocain, less than 1% of all adverse reactions would be potentially dangerous, and even then, only if the doses administered were much higher than anything we would use.
In very rare instances, an injection to the chest or back areas could go too deep and result in a puncture of the lung, causing a collapsed lung which would require hospitalization to correct. Also, rarely, an injection may result in puncture of the spinal canal, causing a leak of spinal

fluid. This would result in what are called "spinal headaches". The condition is usually self- limiting and will heal in a few days, but it may require a procedure to fix the leak called an epidural blood patch, which has to be performed by an anesthesiologist or other medical professional in the hospital.

Please Note: While we do treat patients who have a wide range of health problems, ***the treatment methods we use are not designed or intended to treat or cure any specific disease.*** This is especially applicable to our nutritional / functional medicine programs. Our approach is holistic in that it acts to correct malfunctions and/or imbalances in the nervous system and biochemical/physiological systems of the body. When this is achieved, the body is best positioned to heal itself, regardless what type of health problem may be present. **If you have a serious health problem we recommend you also consult an appropriate medical specialist. As your health improves, you may find that any prescription medications you are taking may need to be adjusted. Do not change your medication without consulting your doctor first.**

Muscle Response Testing is an evaluation technique used in our office and is a form of Applied Kinesiology as developed by Dr. George Goodhart, DC. Please understand that this system is not a method of "diagnosing" or "treating" any disease or medical condition, but is an ancillary method of analysis that helps determine possible physical and nutritional needs of the body that could contribute to various health problems.

Nutritional Supplement Purchase Policy

We know that there are many places online where various herbal and nutritional supplements can be purchased. However, these companies are not committed to nor responsible for your current state of health. In order for us to continue providing the kind of quality care we are committed to, all supplement orders must be placed through our office. Also, please understand that with regards to any supplements purchased from other sources, the person or company you purchase them from will be responsible for educating and providing additional insight about what the product(s) do and how to take them. We can not advise you in these situations.

If you choose to purchase the supplements we recommend elsewhere, either online or from another provider, the fee for all future appointments will increase to $89.00 per visit (plus tax).

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I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my current condition or future preventive or maintenance care. I acknowledge that no promise or guarantee has been made to me regarding the results or outcome of any treatment provided by Dr. Vernon S. Redd or Dr. Catherine Seat or any office staff members. I do not expect the doctor to be able to anticipate and explain all risks and potential complications. Dr. Redd / Dr. Seat has explained the nature and purpose of the procedures he will be using, the risks involved, possible alternatives, as well as no treatment, possible consequences and the possibility of complications to me, to my satisfaction. I therefore elect to undergo examination and treatment from Dr. Redd or Dr. Seat, or their staff who act under their direction. I also verify that the Patient Privacy and Consent Policies form that govern federal HIPP privacy laws has been made available to me.

Signature:_____ Date:_____

(patient or other responsible party or legal guardian)

Please read the following and sign below where indicated. If you have any questions concerning any of the following, please speak with the staff member or the doctor.

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Privacy Statement:

I understand that all health information disclosed in this office is kept strictly confidential and will not be released to anyone with out my written consent. By signing below I agree to allow the Nutrition& Health Center to provide all needed information to the doctors of this office and other health care professionals deemed necessary in the management of my case. This release applies also to any involved insurance carriers.

I grant permission to the Nutrition & Health Center staff to call to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Financial Responsibility: **I understand that I am personally responsible for the payment of 100% of all services and products I receive from the *Nutrition and Health Center*, regardless of how much my, or any other insurance carrier, may or may not pay. Payment for all services or products are due when received.**

***Nutritional Product Return Policy*:** **You may return any unopened nutritional products or prepaid lab requisitions within 15 days of purchase for a full refund. We can not refund any opened products.**

Authorization of Payment by Insurance Carrier: I hereby assign, transfer and set over to Dr. Vernon S. Redd / Dr. Catherine Seat and the *Nutrition and Health Center* and / or its individual providers, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy or any other third party policy, as they may apply to my treatment at the *Nutrition and Health Center*.

I authorize the release of any medical information needed to determine these benefits or to settle a claim. I understand and agree that this authorization shall remain valid and be irrevocable until any balance due on my account is paid in full.

I also give any other medical or health care provider, clinic or hospital, permission to release any information or medical records needed by Dr. Vernon S. Redd or Dr. Catherine Seat, which they request, in relation to my being under their care.

Signature: _____ Date: _____

Print Name: _____

Consent to Treatment of a Minor Child

I hereby authorize Dr. Vernon S. Redd or Dr. Catherine Seat or their assistants to administer treatment and diagnostic exams or evaluations, as they deem necessary,

to my (relationship) _____named (name)_____.

Signature **(parent or legal guardian)**_____ Date:_____