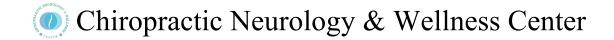
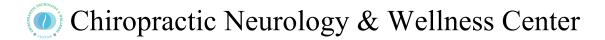


Extended Comprehensive Patient History

Today's Date:			
Today's Date:			
Date of Birth:MONTH/DAY/YEAR	Age:		
			Gender:
Preferred Name:		SSN:	
Address:			
City:		State:	Zip:
Phone:	Cell:	Email: _	
			Name:
•		,	
Please list your children and t	heir ages:		
			,
Work Status: L Employed L	」Retired □ Disabl	ed 🗆 Student (School Nai	me):
Occupation:			
Employer:		Employer Phone	: ()
Name/Phone Number of Eme	argency Contact:		
	-		
Who referred you to our office)?		
Please list your 5 major health	h concorne in order	of importance:	
riease list your 5 major nealti	r concerns in order	or importance.	
1			
2			
3			
4			
5			



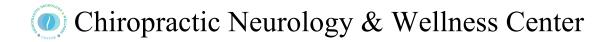
SLEEP HABITS
I go to bed at PM. I usually have difficulty falling asleep ☐ Yes ☐ No
I frequently wake up in the middle of the night, between 1:00AM to 3:00AM $\ \square$ Yes $\ \square$ No I typically wake up to start my day at $\ ___$ AM.
After waking, I usually feel \square Well Rested \square Tired \square Exhausted Do you snore? \square Yes \square No
I have had a sleep study performed and the doctor diagnosed me with Sleep Apnea Yes No The Sleep Study was performed: When? by whom:
I use a sleep aid (C-PAP or medication): ☐ Yes ☐ No
EATING HABITS I typically eat breakfast at AM and it usually consists of
My morning routine does/does not include cigarettes. My morning routine includes coffee. Yes No I have a morning snack at AM and it consists of
I eat lunch at PM and it consists of
I have an afternoon snack atPM and it consists of
I eat dinner at PM and it consists of
I have an evening snack atPM and it consists of
I eat out times/week. I eat fish times/week. I eat raw nuts/seeds times/week.
The three worst foods I eat during the average week
The three healthiest foods I eat during the average week:
Have you ever had a nutritional consultation? ☐ Yes ☐ No Have you made any changes in your eating habits because of your health? ☐ Yes ☐ No Describe:
Do you currently follow a special diet or nutritional program? ☐ Yes ☐ No
Check all that apply:
□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ Dairy-Free □ Soy-Free □ Gluten-Free □ Vegetarian □ Vegan □ Organic
☐ Special Program for Weight Loss/Maintenance Type:



EATING HABITS, contd. Daily Fluid Intake: I typically consume: _____ glasses/bottles of water daily ____ cups of tea (black/green/herbal) ___ cups of coffee / choose one: □ decaf □ regular □ Starbucks's_____ _____ soft drinks (diet/decaf/regular);_____ energy drinks; ____ alcoholic beverages/week. Daily Routine: I begin work at _____ □ am □ pm and typically finish by ____ □ am □ pm My occupational stress level is _____ (List 1 to 10, with 0 = no stress and 10 = severe stress). My personal stress level is (List 1 to 10, with 0 = no stress and 10 = severe stress). My exercise level is: ☐ Non-Existent ☐ Minimal (1-2 days/wk) ☐ Moderate (3-4 days/wk) ☐ Intense (5 days/wk) Type of Exercise □ Walking □ Running □ Biking □ Weight Training □ Aerobic □ Pilates □ Yoga □ Golf Other Exercise: Currently Smoking? ☐ Yes ☐ No How many years?_____ Packs per day:_____ Attempts to quit: _____ Previous Smoking? How many years? _____ Packs per day: ____ Second-hand smoke? □ Yes □ No **SUPPLEMENTS** Please list the supplements/vitamins you currently take. Dose Frequency Start Date Reason **MEDICATIONS** Please list the Prescribed and Over-the-Counter medications you currently take. Medication Dose Frequency Start Date Reason

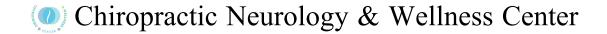
Describe:

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No



MEDICATIONS, contd.

Do you have any allergies t	o medications? □ yes □ no If yes, pl	ease list below.
□ NSAIDS (Advil, Aleve, Ast□ Antibiotics more than 3 to	regular use of any of the following (select spirin) Tylenol Allergy shots Allergy shots Allergy shots Facial/equal Revit Facial/Eye Revit Re	Acid Blocking Drugs (Prilosec, Zantac) one, etc.)
MEDICAL HISTORY		
Current Physician		Phone
When was your last adjustn Please list all other chiropra	revious Chiropractic care? Yes Note that the representation of	
current complaints:	E	
1		
2	6	
3	7	
4	8	
Preventive Tests and Date	of Last Test. Check box if yes and provide	de date of test.
☐ Full Physical	□ Blood Test	☐ Bone Density
□ Colonoscopy		□ Stool Test
□ CT Scan	□ X-Rays	□ Upper GI Series
□ Ultrasound		□ Cardiac Stress
☐ Salivary Hormones		
□ Other:		
Surgeries. Check box if yes	and provide date of surgery	
□ Appendectomy	Hysterectomy +/- Ovaries	□ Gall Bladder
• • •	□ Tonsillectomy	
	□ Heart Surgery	
□ Pacemaker		
□ Other:		



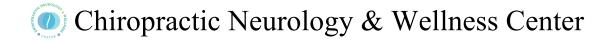
MEDICAL HISTORY, contd.

Please list and date your significant infections, traumas, and accidents.
1
2
3
4
5
Recent Trips?
Foreign Travel? Yes No Where?
Wilderness Camping? □ Yes □ No Where?
Have you been DIAGNOSED with any of the following diseases?
Gastrointestinal ☐ Irritable Bowel Syndrome ☐ Inflammatory Bowel Disease ☐ Crohn's ☐ Ulcerative Colitis ☐ Gastritis or Peptic Ulcer ☐ GERD (reflux) ☐ Celiac Disease ☐ Other
Cardiovascular
 □ Heart Attack □ Stroke □ Elevated Cholesterol □ Elevated Triglycerides □ Arrhythmia □ High Blood Pressure □ Rheumatic Fever □ Mitral Valve Prolapse □ Anemia □ Other
Cancer
□ Asthma □ Breast Cancer □ Colon □ Ovarian Cancer □ Prostate □ Skin Cancer □ Other
Metabolic/Endocrine
□ Type I Diabetes □ Type II Diabetes □ Hypoglycemia □ Metabolic Syndrome □ Insulin resistance or Pre-Diabetic □ Hypothyroidism (low thyroid) □ Hyperthyroidism (overactive thyroid □ Hoshimoto's Autoimmune Thyroid □ Polycystic Ovarian Syndrome □ Infertility □ Weight Loss □ Weight Gain □ Frequent Weight Fluctuations □ Bulimia □ Anorexia
☐ Binge Eating Disorder ☐ Night Eating Disorder ☐ Eating Disorder (Non-Specific)



MEDICAL HISTORY, contd.

Genital and Urinary Systems			
☐ Kidney Stones ☐ Gout ☐ Interstitial Cyst	itis □ Frequent Urinary Tı	ract Infections Frequent Ye	ast Infection
$\hfill\Box$ Erectile Dysfunction or Sexual Dysfunctio	n		
□ Other			
Inflammatory/Autoimmune			
□ Chronic Fatigue Syndrome□ Autoimmu□ Severe Infectious□ Poor Immune /Fu		, , ,	3
 □ Environmental Allergies □ Other 	emical Sensitivities		
Respiratory Diseases			
□ Asthma □ Chronic Sinusitis □ Bronchitis □ Other	•		p Apnea
Skin Diseases			
□ Eczema □ Psoriasis □ Acne □ Other □		□ Skin Cancer	
Neurologic/Mood			
□ Depression □ Anxiety □ Bipolar [Disease □ Schizoph	renia 🗆 Headaches	
☐ Migraines ☐ ADD/ADHD ☐ Autism	☐ Mild Cognitive Im	pairment $\ \square$ Memory Probl	ems
□ Parkinson's Disease □ Multiple Sclerosi	s □ ALS □ S	Seizures	
□ Other			
Musculoskeletal/Pain			
□ Osteoarthritis □ Fibromyalgia	□ Chronic Pain		
□ Other			
Women Only Obstetric History (Check box if yes and pro	ovide number; females on	ly)	
Are you pregnant? \square Yes \square No How m	-		
□ Pregnancies □ Caesarean	<u>-</u>	-	
□ Abortion □ Post-Partum De			
☐ Gestational Diabetes ☐	Breast Feeding for how lo	na?	



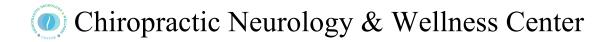
MEDICAL HISTORY, contd.

Menstrual History Age at First Period	Menses Frequency:	l enath:
-	Clotting? □ Yes □ No	
	skipped? □ Yes □ No How Long?	Last menstrual period:
		 Patch □ NuvaRing □ How Long?
	·	phragm □ IUD □ Partner Vasectomy □ Tubal Ligation
Women's Disorders –	· Hormonal Imbalances	
☐ Fibrocystic Breasts	□ Endometriosis □ Fibroids □ Infertilit	y □ Painful Periods □ Heavy Periods □ PMS
Last Mammogram:	Breast Biopsy/Date:	BRCA Gene Test? □ (+) □ (-)
Last PAP Test:	□ Normal □ Abnormal	
Last Bone Density Te	st: Results: □ High □	Low Within Normal Range
Are you in menopaus	e? □ Yes □ No Age when menopaus	e began:
Do you suffer any of t	hese menopausal symptoms? □ Hot Fl	ashes □ Mood Swings □ Concentration
	Dryness □ Decreased Libido □ Loss of	Control of Urine Use of hormone replacement
Men Only Male Disorders Date of your last PSA	Test: PSA level: [□ 0-2 □ 2-4 □ 4-10 □ >10 □ Never had Test
Have you had any of	the following in the last year? \square Prostate	e Enlargement □ Prostate infection
☐ Prostate Cancer	☐ Prostate "shots" (I.e. Eligard) ☐ Cl	hange in Libido Impotence
$\hfill\Box$ Difficulty Obtaining	an Erection $\hfill\Box$ Decreased Frequency of	Morning Erections □ Enlarged breasts
☐ Fluid Discharge fro	m Nipples □ Nocturia (Urination at night	:) □ Urgency/Hesitancy/Change in Urinary Stream
☐ Loss of Control of U	Jrine	
	oxification Assessment dverse food reactions or sensitivities?	∃Yes □ No
-	toms:	
Do you have any adve	erse reaction to caffeine? \square Yes \square No	
•	ne do you feel: \square Irritable or Wired \square Act to (Check all that apply):	cne & Pains
□ MSG □ Aspartam	e (NutraSweet) 🗆 Bananas 🗆 Garlic 🗅	□ Onion □ Cheese □ Citrus □ Chocolate
	☐ Sulfites (Wine, dried fruit, salad bars)	☐ Preservatives (i.e., sodium benzoate)
	cantly affect you? (Check all that apply):	
•	☐ Perfumes/Colognes ☐ Auto Exhaust I	



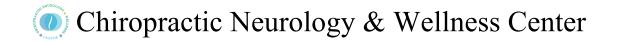
ENVIRONMENTAL FACTORS

•	nvironment, are you expo magnetic Radiation D		Vell Water		
Have you ever turned ye	ellow (jaundiced)? □ Ye	es □ No			
Have you ever been told Explain:	d you have Gilbert's Syn	drome o	a Liver Disorder	? □ Ye	es □ No
☐ Herbicides ☐ Insecti	istory of significant expo icides/Pesticides □ Org k length of exposure:	anic Sol	vents □ Heavy N	/letals	ch as:
Have you lived or worke	elothes frequently? ☐ Yeled in a damp or moldy er or farm animals? ☐ Yes	nvironme		old exp	osures? □ Yes □ No
Review of Symptoms: (I	Please check all boxes t	hat apply	')		
General					
□ Cold Hands & Feet			□ Low Body Te	•	□ Low Blood Pressure
•	☐ Difficulty Falling Asle	eep	☐ Early Waking		□ Fatigue
□ Fever	☐ Flushing		☐ Heat Intolera	nce	☐ Night Walking
□ Nightmares	☐ No Dream Recall				
Head, Eyes & Ears	Distanta d Osmas of O				□ Far Fullman
☐ Conjunctivitis	☐ Distorted Sense of S		☐ Distorted Tas		☐ Ear Fullness
☐ Ear Pain	☐ Ear Ringing/Buzzing		•		☐ Eye Crusting
☐ Eye Pain	☐ Hearing Loss	oiooo	☐ Hearing Prob		☐ Headache
☐ Migraine☐ Macular Degen.	☐ Sensitivity to Loud N☐ Vitreous Detachmen		□ Vision Proble□ Retinal Detact	,	er triair glasses)
Musculoskeletal	Unitedus Detachmen		- Helinai Delac	iiiiiGiit	
☐ Back Muscle Spasm	□ Calf Cramps	□ Chos	st Tightness	□ Foot	Cramps
☐ Joint Deformity	☐ Joint Pain		•		Stiffness
☐ Muscle Pain	☐ Muscle Spasm				cle Weakness
☐ Tension Headaches	•		Muscle Spasm		
☐ Muscle Twitch Aroun			cle Twitch Arms (
Mood/Nerves	-, -, -, -, -, -, -, -, -, -, -, -, -, -			090	
☐ Agoraphobia	☐ Anxiety	□ Blac	k-outs	□ Depr	ession
□ Dizziness	□ Vertigo	□ Faint		□ Fear	
□ Irritability	☐ Light-Headedness	□ Num	9		r Phobias
□ Panic Attacks	□ Paranoia	□ Seiz			dal Thoughts
☐ Tingling	□ Tremor/Trembling		al or Auditory Ha		_



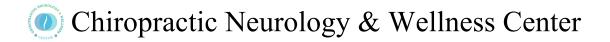
SYMPTOM HISTORY

Difficulty with					
□ Concentrating	☐ Balance ☐ Thi	inking	□ Judgment	□ Speech	□ Memory
Digestion					
☐ Anal Spasms	□ Bad Teeth	□ Blee	ding Gums	□ Oral Blisters	;
☐ Blood in Stools	□ Burping	□ Canl	ker Sores	□ Cold Sores	
☐ Cracking at the corne	ers of lips	□ Crar	nps	☐ Heartburn	
□ Dentures	□ Diarrhea	□ Fiss	ures	□ Nausea	
☐ Dry Mouth	☐ Excess Flatulence/	gas			
☐ Hemorrhoids	□ Indigestion	□ Sore	Tongue	□ Difficulty Sw	allowing
□ Vomiting	☐ Alternating Diarrhea	a/Constipa	ation	\square Periodontal	Disease
□ Constipation	☐ Lower Abdominal P	Pain	□ Upper Abdo	minal Pain	
☐ Strong Stool Odor	☐ Undigested Food in	Stool	☐ Mucus in Sto	ools	
Bloating of					
☐ Lower Abdomen	☐ Whole Abdomen	□ Bloa	ting after meals		
Intolerance to					
□ Lactose	☐ All Dairy Products	☐ Glute	en □ Corr	า	
□ Eggs	□ Soy	□ Fatty	/Foods □ Yea	st	
Skin Problems					
☐ Acne on Back	□ Acne on Chest	□ Acne	e on Face	☐ Acne on Sho	oulders
□ Athlete's Foot	☐ Bumps on Back of	Upper Arr	ns	□ Dark Circles	under eyes
□ Cellulite	□ Ears get cold	□ Easi	ly Bruise	□ Lack of Swe	ating
$\hfill\Box$ Too Much Sweating	□ Eczema	☐ Hive	s	☐ Jock Itch	
☐ Lackluster Skin	☐ Moles w/Color/Size	Changes		☐ Oily Skin	
□ Pale Skin	□ Patchy Dullness	□ Rasl	า	\square Red Face	
□ Sensitivity to Bites	□ Shingles	□ Sens	sitivity to Poison	lvy/Oak	
☐ Skin Darkening	☐ Strong Body Odor	□ Hair	Loss	□ Vitiligo	
Itchy Skin					
$\ \square$ Skin in General	□ Anus	□ Arm	5	☐ Ear Canals	
□ Eyes	□ Feet	□ Han	ds	□ Legs	
□ Nipples	□ Nose	□ Peni	s	□ Roof of Mou	th
□ Scalp	□ Throat				
Dryness of					
□ Eyes	□ Feet	□ Han	ds (Cracks or Pe	eel)	
□ Hair	☐ Mouth/Throat	□ Scal	p (Dandruff)	☐ Skin in Gene	eral



SYMPTOM HISTORY, contd.

Lymph Nodes			
☐ Enlarged/Tender Nec	ck □ Enlarged/Ter	nder Axilla 🗆 Enla	rged/Tender Groin
Nails			
□ Bitten	☐ Brittle	☐ Curved Up	☐ Frayed
☐ Fungus- Fingers	☐ White Spots/Lines	□ Pitting	□ Ragged Cuticles
□ Ridges	□ Soft	☐ Thickening of Finger	nails or Toenails
Respiratory			
□ Bad Breath	☐ Bad Odor in Nose	☐ Cough-Dry	☐ Cough – Productive
☐ Hoarseness	☐ Sore Throat	☐ Hay Fever	□ Nasal Stuffiness
□ Nose Bleeds	□ Post Nasal Drip	□ Sinus Fullness	☐ Sinus Infection
□ Snoring	☐ Wheezing	☐ Winter Stuffiness	
Cardiovascular			
☐ Angina/Chest Pain	$\hfill\Box$ Shortness of Breath	☐ Heart Murmur	☐ Irregular Pulse
□ Palpitations	□ Phlebitis	☐ Swollen Ankles/Feet	□ Varicose Veins
Urinary			
□ Bed Wetting	☐ Hesitancy	□ Infection	☐ Kidney Disease
☐ Leaking/Incontinence	e □ Pain/Burning	□ Urgency	
Male Reproductive			
☐ Penis discharge	☐ Ejaculation problems	☐ Genital pain ☐ Impo	tence Lumps in Testicles
Female Reproductive			
☐ Breast Cysts/Lumps	☐ Breast Tenderness	□ Ovarian Cysts	□ Poor Sex Drive
□ Vaginal Odor	☐ Vaginal Discharge	□ Vaginal Itch	□ Vaginal Pain with Sex
Premenstrual			
☐ Bloating Breast Tend	erness Carbohydrate	e Craving	tion ☐ Decreased Sleep
☐ Diarrhea ☐ Fatig	jue 🗆 Increased Sl	eep Irritability	
Menstrual	D. C. J	la Destada	adala = 0 a la Balan
·		ular Periods □ No p	eriods
☐ Spotting Between Pe	riods		



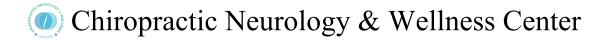
SYMPTOM HISTORY, contd.

Please check the appropriate box under the number on all questions below. **0** as the "least/never" to **3** as the "most/always"

Category I	0	1	2	3
Feeling that bowels do not empty completely				
Lower abdominal pain relieved by passing stool or gas				
Alternating constipation and diarrhea				
Diarrhea				
Constipation				
Hard, dry, or small stool				
Coated tongue or "fuzzy" debris on tongue				
Pass large amount of foul-smelling gas				
More than 3 bowel movements daily				
Use laxatives frequently				
Category II	0	1	2	3
Excessive belching, burping, or bloating				
Gas immediately following a meal				
Offensive breath				
Difficult bowel movements				
Sense of fullness during and after a meals				
Difficulty digesting fruits and vegetable (undigested foods in stool)				
Category III	0	1	2	3
Stomach pain, burning, or aching 1-4 hour after eating				
Use antacids				
Feel hungry an hour or two after eating				
Heartburn when lying down or bending forward				
Temporary relief by using antacids, food, mild, or carbonated beverages				
Digestive problems subside with rest and relaxation				
Heartburn due to spicy foods, chocolate, citrus, pepper, alcohol, and caffeine				
Category IV	0	1	2	3
Roughage and fiber cause constipation				
Indigestion and fullness last 2-4 hours after eating				
Pain, tenderness, soreness on left side under rib cage				
Excessive passage of gas				

Category IV, contd.	0	1	2	3
Nausea and/or vomiting				
Stool undigested, foul smelling, mucous like, greasy, or poorly formed				
Frequent urination				
Increased thirst and appetite				
Difficulty losing weight				
Category V	0	1	2	3
Greasy or high-fat foods cause distress				
Lower bowel gas and/or bloating several hours after a meal				
Bitter metallic taste in mouth, especially in the morning				
Unexplained itchy skin				
Yellowish cast to eyes				
Stool color alternates from clay colored to normal brown				
Reddened skin, especially palms				
Dry or flaky skin and/or hair				
History of gallbladder attacks or stones				
Have you had your gallbladder removed?				
	_		_	_
Category VI	0	1	2	3
Crave sweets during the day	0 □	1	2 □	3 □
Crave sweets during the day				
Crave sweets during the day Irritable if meals are missed				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision				
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII	0 0 0 0			3
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII Fatigue after meals	0 0 0 0 0			3 3
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII Fatigue after meals Crave sweets during the day	0 0 0 0 0			3 0
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar	0 0 0 0 0 0			3
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar Must have sweets after meals	0 0 0 0 0	0 0 0 0 0 1		3
Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision Category VII Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar Must have sweets after meals Waist girth is equal to or larger than hip girth	0 0 0 0 0			3 0

Category VIII Cannot stay asleep Crave salt Slow starter in the morning Afternoon fatigue Dizziness when standing up quickly Afternoon headaches Headaches with exertion or stress Weak nails	0	1	2	3
Category IX Cannot fall asleep Perspire easily Under high amount of stress Weight gain when under stress Wake up tired even after 6 hours or more of sleep Excessive perspiration or perspiration with little or no activity	0	1	2	3
Category X Tired/sluggish Feel cold-hands, feet, all over Require excessive amount of sleep to function properly Increase in weight even with low-calorie diet Gain weight easily Difficult, infrequent bowel movements Depression/lack of motivation Morning headaches that wear off as the day progresses Outer third of eyebrow thins Thinning of hair on scalp, face, or genitals, excessive hair loss Dryness of skin and/or scalp Mental sluggishness		1		
Category XI Heart palpitations Inward trembling Increased pulse even at rest Nervous and emotional Insomnia Night sweats Difficulty gaining weight	0	1	2	3



Category XII	0	1	2	3
Diminished sex drive				
Menstrual disorders or lack of menstruation				
Increased ability to eat sugars without symptoms				
Category XIII	0	1	2	3
Increased sex drive				
Tolerance to sugars reduced				
"Splitting" – headaches				
Category XIV (Males only)	0	1	2	3
Urination difficulty or dribbling				
Frequent urination				
Pain inside of legs or heels				
Feeling of incomplete bowel emptying				
Leg twitching at night				
Category XV (Males only)	0	1	2	3
Decreased libido				
Decreased number of spontaneous morning erections				
Decreased fullness of erections				
Difficulty maintaining morning erections				
Spells of mental fatigue				
Inability to concentrate				
Episodes of depression				
Muscle soreness				
Decreased physical stamina				
Unexplained weight gain				
Increased in fat distribution around chest and hips				
Sweating attacks				
More emotional than in the past	П	П	П	

Category XVI (Menstruating Females only)	0	1	2	3
Perimenopausal	□ Yes	□ No		
Alternating menstrual cycle lengths	□ Yes	□ No		
Extended menstrual cycle (greater than every 32 days)	□ Yes	s □ No		
Shortened menstrual cycle (less than 24 days)	□ Yes	s □ No		
Pain and cramping during periods				
Scanty blood flow				
Heavy blood flow				
Breast pain and swelling during menses				
Pelvic pain during menses				
Irritable and depressed during menses				
Acne				
Facial hair growth				
Hair loss/thinning				
Category XVII (Menopausal Females only) How many years have you been menopausal?	0	1	2	3
Since menopause, do you ever have uterine bleeding?	□ Yes	□ No		
Hot flashes				
Mental fogginess				
Disinterest in sex				
Mood swings				
Depression				
Painful intercourse				
Shrinking breasts				
Facial hair growth				
Acne				
Increased vaginal pain, dryness, or itching				
Category S	0	1	2	3
Are you losing your pleasure in hobbies and interests?				
How often do you feel overwhelmed with ideas to manage?				
How often do you have feelings of inner rage (anger)?				
How often do you have feelings of paranoia?				
How often do you feel sad or down for no reason?				
How often do you feel like you are not enjoying your life?				
How often do you feel you lack artistic appreciation?				
How often do you feel depressed in overcast weather?				
How much are you losing you enthusiasm for your favorite activities?				
How much are you losing enjoyment for your favorite foods?				



Category S, contd.	0	1	2	3
How much are you losing your enjoyment of friendships and relationships?				
How often do you have difficulty falling into deep restful sleep?				
How often do you have feelings of dependency on others?				
How often do you feel more susceptible to pain?				
How often do you have feelings of unprovoked anger?				
How much are you losing interest in life?				
Category D	0	1	2	3
How often do you have feelings of hopelessness?				
How often do you have self-destructive thoughts?				
How often do you have an inability to handle stress?				
How often do you have anger and aggression while under stress?				
How often do you feel you are not rested even after long hours of sleep?				
How often do you prefer to isolate yourself from others?				
How often do you have unexplained lack of concern for family and friends?				
How easily are you distracted from your tasks?				
How often do you have an inability to finish tasks?				
How often do you feel the need to consume caffeine to stay alert?				
How often do you feel your libido has been decreased?				
How often do you lose your temper for minor reasons?				
How often do you have feelings of worthlessness?				
Category G	0	1	2	3
How often do you feel anxious or panic for no reason?				
How often do you have feelings of dread or impending doom?				
How often do you feel knots in your stomach?				
How often do you have feelings of being overwhelmed for no reason?				
How often do you have feeling of guilt about everyday decisions?				
How often does your mind feel restless?				
How difficult is it to turn you mind off when you want to relax?				
How often do you have disorganized attention?				
How often do you worry about things you were not worried about before?				
How often do you have feelings of inner tension and inner excitability?				

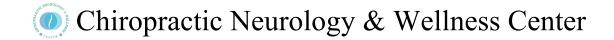
Category ACH	0	1	2	3
Do you feel your visual memory (shapes & images) is decreased?				
Do you feel your verbal memory is decreased?				
Do you have memory lapses?				
Has your creativity been decreased?				
Has your comprehension been diminished?				
Do you have difficulty calculating numbers?				
Do you have difficulty recognizing objects & faces?				
Do you feel like your opinion about yourself has changed?				
Are you experiencing excessive urination?				
Are you experiencing slow mental responses?				



Chiropractic Neurology & Wellness Center

Family Medical History

Check all that apply	Mother	Father	Brother	Sister	Children	Mother's Parents	Father's Parents	Aunts & Uncles
Ages						NA	NA	NA
Cancers								
Heart Disease								
High Blood Pressure								
Obesity								
Diabetes								
Stroke								
Rheumatoid Arthritis								
Psoriatic Arthritis								
Celiac Disease								
Hoshimoto's Disease								
Hypothyroidism								
Multiple Sclerosis								
Lupus (SLE)								
Asthma								
Food Allergies								
Environmental Allergies								
Psoriasis/Eczema								
Parkinson's Disease								
ALS								
Dementia								
Depression								
Bipolar Disease								
ADD/ADHD								
Autism								
Substance Abuse								
Genetic Disorders								
Scoliosis								
Other								
Other								



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 (I.e. 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
Have periodic lab tests to assess your progress	5				
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 activites?	□ 5	□ 4	□ 3	□ 2	□ 1
SUPPORT FOR CHANGE					_
Rate on a scale of 5 (very supportive) to 1 (very unsupportive):					
How supportive do you think the people in your household will be?	□ 5	□ 4	□ 3	□ 2	□ 1
Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact How much on-going support and contact (i.e., telephone & email correspond our professional staff would be helpful to you as you implement		ce)			
your personal health program?	□ 5	□ 4	□ 3	□ 2	□ 1
Comments:					
					_

Patient Health Information

We want you to know how your Patient Health Information (PHI) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

- 1. The patient understands and agrees to allow Chiropractic Neurology & Wellness Center (CNWC) to use their patient Health Information (PHI) for the purpose of treatment, payment, health care operations, and coordination of care.
- 2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
- 3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
- 4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
- 5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by CNWB to assure that your records are not readily available to those who do not need them.
- 6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
- 7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Patient's Signature:		Date:
Patient's Name:	PLEASE PRINT	

Informed Consent for Chiropractic Treatment

I hereby request and consent to the performance of Chiropractic adjustments and any other Chiropractic procedures, including examination tests, diagnostic x-rays and physical therapy techniques, on me (or on the patient named below for which I am legally responsible) which are recommended by the doctor of Chiropractic named below and/or other licensed doctors of Chiropractic who now or in the future render treatment to me, while employed by, working for, or associated with, or serving as backup for the doctor of Chiropractic named below.

I understand that, as with any health care procedures, there are certain complications that may arise during a Chiropractic adjustment. Those complications may include, but are not limited to: fractures, disc injuries, dislocations, muscle strain, Homer's Syndrome, diaphragmatic paralysis, cervical myelopathy and costrovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck, leading to, or contributing to serious complications including stroke. I do not expect the doctor to be able to anticipate all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedures which the doctor feels at the time, based upon the facts then known, are in my best interest.

I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

I have read () or have had read to me () the above explanation of the Chiropractic adjustment and related treatment. By signing below I state that I have weighed the risks involved in undergoing treatment and have myself decided that it is in my best interest to undergo the Chiropractic treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Chiropractic Neurology & Wellness Center 618 Frederick St., Santa Cruz, CA 95062 831-460-9200 Name of Doctor Treating this Patient James M. Cartwright, D.C., D.A.C.N.B. www.cartwrightwellnes.com

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE

Printed Name of Patient	Date
Signature of Patient	Date
Signature of Patient's Representative	Date
Witness Signature	Date

FINANCIAL POLICY

All fees are based on individual services rendered, and may vary from visit to visit, depending on the doctor's treatment recommendations.

It is our office policy to maintain your account on a current basis. Charges for treatment are due at the time the service is provided. Any balance that incurs on your account is subject to an interest charge of 10% per month, until paid to a zero balance.

<u>We require a 48-hour notice for ALL cancellations.</u> You will be charged the full amount of your scheduled visit if changes are made within this 48-hour limit. We require that all patients store a credit card on file for any missed appointment fees; however no other charges will be made unless the account becomes past due for a period of 30 days or more.

<u>INSURANCE/IN NETWORK:</u> if you have health insurance, we will verify your coverage; but you are responsible for paying your deductible, co-payments, and non-covered charges, *AT THE TIME THEY ARE RENDERED.* We do not guarantee that all services will be covered by your insurance. We will gladly bill your insurance once, however if they fail to pay within 45 days of billing, you will be responsible for the amount due in full.

NON-INSURED/OUT OF NETWORK: All visits must be paid for *AT THE TIME OF SERVICE*. Any other financial arrangements must be determined prior to services rendered.

<u>MEDICARE</u>: Manipulation is the ONLY service covered by Medicare. You are responsible for payment of the initial visit (call our office for current rate), your annual deductible with Medicare, copayments, and any other services, *AT THE TIME OF SERVICE*.

**Ifyou have been involved in a motor vehicle accident, we can NOT bill Medicare for services related to your accident.

In the event that there is an outstanding balance, which fails to be cured within sixty (60) days, my account with Chiropractic Neurology & Wellness Center may be turned over to collections. I understand that should this occur, I will remain responsible for any and all additional collection fees and/or attorney and court costs.

I agree to the terms of this agreement.

Signature:______ Date:______

Printed name:______