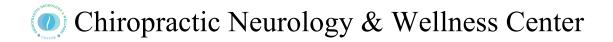


New Patient Comprehensive History

Today's Date:		
MONTH/DAY/YEAR		
Date of Birth: MONTH/DAY/YEAR	Age:	
		Gender:
Preferred Name:	SSN	
Address:		
City:	State:	Zip:
Phone:Ce	ell: Email: _	
AREA CODE + NUMBER	AREA CODE + NUMBER	
Marital Status: ☐ Single ☐ Divorce	ced □ Widowed □ Married: Spouse's	Name:
Please list your children and their a	ues.	
•		
Work Status: ☐ Employed ☐ Retir	red 🗆 Disabled 🗆 Student (School Na	me):
Occupation:		
Employer:	Employer Phone	: ()
Name/Phone Number of Emergenc	y Contact:	
Who referred you to our office?		
who referred you to our office!		
Please list your 5 major health cond	corns in order of importance:	
riease list your 5 major nealth cond	cerns in order of importance.	
1		
2		
3		
4		
5.		
U.		

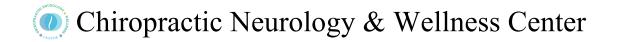


SLEEP HABITS I go to bed at _____ PM. I usually have difficulty falling asleep ☐ Yes □ No I frequently wake up in the middle of the night, between 1:00AM to 3:00AM ☐ Yes □ No I typically wake up to start my day at _____ AM. After waking, I usually feel... □ Well Rested □ Tired □ Exhausted Do you snore? ☐ Yes ☐ No I have had a sleep study performed and the doctor diagnosed me with Sleep Apnea $\ \square$ Yes $\ \square$ 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 at PM and it consists of I eat dinner at _____ PM and it consists of _____ I have an evening snack at _____ PM 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? \Box Yes \Box 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: _____



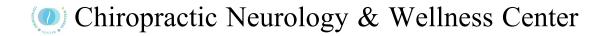
EATING HABITS, contd.

Daily Fluid Intake				
				y cups of tea (black/green/herbal)
•			•	llar Starbucks's
soft drinks (diet/	decaf/regular);_	ene	ergy drin	ks; alcoholic beverages/week.
Daily Routine				
I begin work at	□ am □ pm	and typ	ically fin	ish by $\ \square$ am $\ \square$ pm
				0 = no stress and $10 = severe stress$).
My personal stress leve	el is(List	1 to 10, v	vith 0 = r	no stress and 10 = severe stress).
My exercise level is:	□ Non-Exister	nt		☐ Minimal (1-2 days/wk)
	☐ Moderate (3	3-4 days/v	wk)	□ Intense (5 days/wk)
Type of Exercise				
• •	a □ Bikina 1	□ Weiaht	Training	g □ Aerobic □ Pilates □ Yoga □ Golf
Other Exercise:	•	o.g		, = 7.0.02.0 = 1 maios = 1.0ga = 0.0m
Currently Smoking? □	Yes □ No Ho	w many	years?	Packs per day: Attempts to quit:
Previous Smoking? Ho	w many vears?	Pa	acks ner	day: Second-hand smoke? ☐ Yes ☐ No
r revious officiality: 110	w many years:		icks per	day coond hand smoke: 🗆 103 🗀 100
SUPPLEMENTS				
Please list the supplem	ents/vitamins yo	ou current	tly take.	
	_	_	0	
Supplement 1.		Frequency		
2				
0			<u> </u>	•
MEDICATIONS				
	ed and Over-the	e-Counter	medicat	tions you currently take.
				,
Medication	Dose	Frequency	Start Date	Reason
1				•
2				
3				
5				
6			_	
Have your medications	or supplements	ever cau	ised you	unusual side effects or problems? $\ \square$ Yes $\ \square$ No
Describe:				



MEDICATIONS, contd.

	o medications? □ yes □ no If yes, pl	
Have you had prolonged or ☐ NSAIDS (Advil, Aleve, A) ☐ Antibiotics more than 3 t	regular use of any of the following (selections) Tylenol Allergy shots Fines/year Corticosteroids (prednisons of any kind? Facial/Eye Revitives? Yes No	ct all that apply). Acid Blocking Drugs (Prilosec, Zantac) one, etc.)
MEDICAL HISTORY		
Current Physician		Phone
When was your last adjustr	revious Chiropractic care? Yes Note that the representation of	
current complaints:		
1	5	
2	6	
3		
4	8	
Preventive Tests and Date	of Last Test. Check box if yes and provide	de date of test
□ Full Physical		Bone Density
□ Colonoscopy		☐ Stool Test
□ CT Scan		
□ Ultrasound		□ Cardiac Stress
☐ Salivary Hormones		
,	and provide date of surgery	- 0 11 51 11
	□ Hysterectomy +/- Ovaries □ Table Hastered	
	☐ Tonsillectomy	
	□ Heart Surgery	⊔ Angiopiasty/Stent
□ Pacemaker		
☐ Other:		



MEDICAL HISTORY, contd.

Please list and date your significant infections, traumas, and accidents.
1
2
3
4
5
Environmental & Detoxification Assessment
Do you have known adverse food reactions or sensitivities? $\ \square$ Yes $\ \square$ No
If yes, describe symptoms:
Do you have any adverse reaction to caffeine? ☐ Yes ☐ No
When you drink caffeine do you feel: □ Irritable or Wired □ Acne & Pains
Do you adversely react to (Check all that apply):
□ MSG □ Aspartame (NutraSweet) □ Bananas □ Garlic □ Onion □ Cheese □ Citrus □ Chocolate
□ Alcohol/Red Wine □ Sulfites (Wine, dried fruit, salad bars) □ Preservatives (i.e., sodium benzoate) □ Other:
Which of these significantly affect you? (Check all that apply):
□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other:



ENVIRONMENTAL FACTORS In your work or home environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold □ Well Water Have you ever turned yellow (jaundiced)? ☐ Yes ☐ No Have you ever been told you have Gilbert's Syndrome or a Liver Disorder? ☐ Yes ☐ No Explain: Do you have a known history of significant exposure to any harmful chemicals such as: ☐ Herbicides ☐ Insecticides/Pesticides ☐ Organic Solvents ☐ Heavy Metals Chemical name, date, & length of exposure:_ Do you dry clean your clothes frequently? \square Yes \square No Have you lived or worked in a damp or moldy environment or had other mold exposures? □ Yes □ No Do you have any pets or farm animals? \square Yes \square No Review of Symptoms: (Please check all boxes that apply) General □ Cold Hands & Feet □ Cold Intolerance □ Low Body Temp □ Low Blood Pressure ☐ Daytime Sleepiness ☐ Difficulty Falling Asleep □ Early Waking □ Fatigue □ Fever □ Flushing ☐ Heat Intolerance □ Night Walking □ Nightmares □ No Dream Recall Head, Eyes & Ears □ Conjunctivitis ☐ Distorted Sense of Smell □ Distorted Taste □ Ear Fullness □ Ear Pain □ Ear Ringing/Buzzing ☐ Lid Margin Redness ☐ Eye Crusting □ Eye Pain ☐ Hearing Loss ☐ Hearing Problems □ Headache □ Migraine ☐ Sensitivity to Loud Noises ☐ Vision Problems (other than glasses) □ Macular Degen. □ Vitreous Detachment □ Retinal Detachment Musculoskeletal ☐ Back Muscle Spasm ☐ Calf Cramps ☐ Chest Tightness □ Foot Cramps ☐ Joint Deformity ☐ Joint Pain □ Joint Redness □ Joint Stiffness ☐ Muscle Pain ☐ Muscle Spasm ☐ Muscle Stiffness □ Muscle Weakness ☐ Tension Headaches ☐ TMJ Problems □ Neck Muscle Spasm □ Tendonitis ☐ Muscle Twitch Around Eyes ☐ Muscle Twitch Arms or Legs Mood/Nerves □ Agoraphobia □ Black-outs □ Anxiety □ Depression □ Dizziness □ Vertigo □ Fainting □ Fearfulness □ Irritability ☐ Light-Headedness □ Numbness □ Other Phobias

□ Seizures

□ Visual or Auditory Hallucinations

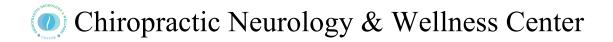
☐ Panic Attacks

□ Tingling

□ Paranoia

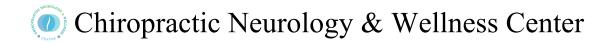
☐ Tremor/Trembling

□ Suicidal Thoughts



SYMPTOM HISTORY

Difficulty with						
☐ Concentrating	□ Balance	□ Thinkin	g □ Judo	gment [□ Speech	□ Memory
Digestion						
□ Anal Spasms	\square Bad Teeth		Bleeding Gu	ims [☐ Oral Blisters	
□ Blood in Stools	□ Burping		Canker Sore	es [☐ Cold Sores	
☐ Cracking at the corne	ers of lips		Cramps		□ Heartburn	
□ Dentures	□ Diarrhea		Fissures		□ Nausea	
☐ Dry Mouth	□ Excess Flatul	ence/gas				
☐ Hemorrhoids	□ Indigestion	Indigestion ☐ Sore Tongue		e [☐ Difficulty Swa	ıllowing
□ Vomiting	☐ Alternating D	arrhea/Co	nstipation		□ Periodontal □	Disease
□ Constipation	☐ Lower Abdom	ninal Pain	□ Upp	er Abdomi	inal Pain	
☐ Strong Stool Odor	□ Undigested F	ood in Sto	ol 🗆 Mud	us in Stoo	ls	
Bloating of						
☐ Lower Abdomen	☐ Whole Abdon	nen 🗆	Bloating after	er meals		
Intolerance to						
□ Lactose	☐ All Dairy Prod	lucts 🗆	Gluten	□ Corn		
□ Eggs	□ Soy		Fatty Foods	□ Yeast		
Skin Problems						
☐ Acne on Back	☐ Acne on Che	st □	Acne on Fac	ce [☐ Acne on Sho	ulders
☐ Athlete's Foot	☐ Bumps on Ba	ck of Uppe	er Arms		☐ Dark Circles	under eyes
□ Cellulite	☐ Ears get cold		Easily Bruise	e [☐ Lack of Swea	ating
☐ Too Much Sweating	□ Eczema		Hives	Ε	Jock Itch	
□ Lackluster Skin	☐ Moles w/Cold	Moles w/Color/Size Changes		Ε	□ Oily Skin	
□ Pale Skin	☐ Patchy Dullne	ess 🗆	Rash		□ Red Face	
□ Sensitivity to Bites	□ Shingles		Sensitivity to	Poison Iv	ry/Oak	
☐ Skin Darkening	□ Strong Body	Odor □	Hair Loss	Γ	☐ Vitiligo	
Itchy Skin						
☐ Skin in General	□ Anus		Arms		☐ Ear Canals	
□ Eyes	□ Feet		Hands		□ Legs	
□ Nipples	□ Nose		Penis		☐ Roof of Mout	h
□ Scalp	□ Throat					
Dryness of						
□ Eyes	□ Feet		Hands (Crad	cks or Peel	l)	
□ Hair	☐ Mouth/Throat		Scalp (Dand	lruff) [□ Skin in Gene	ral



SYMPTOM HISTORY, contd. Lymph Nodes ☐ Enlarged/Tender Neck ☐ Enlarged/Tender Axilla ☐ Enlarged/Tender Groin Nails □ Bitten □ Brittle ☐ Curved Up □ Frayed □ Fungus- Fingers □ White Spots/Lines □ Ragged Cuticles □ Pitting ☐ Thickening of Fingernails or Toenails □ Ridges □ Soft Respiratory □ Bad Breath ☐ Bad Odor in Nose ☐ Cough-Dry □ Cough – Productive □ Hoarseness □ Sore Throat □ Hay Fever □ Nasal Stuffiness □ Nose Bleeds □ Sinus Fullness ☐ Post Nasal Drip □ Sinus Infection □ Snoring □ Wheezing □ Winter Stuffiness Cardiovascular ☐ Angina/Chest Pain ☐ Shortness of Breath ☐ Heart Murmur ☐ Irregular Pulse □ Palpitations □ Phlebitis □ Swollen Ankles/Feet □ Varicose Veins Urinary

□ Infection

□ Urgency

□ Kidney Disease

□ Bed Wetting

☐ Hesitancy

☐ Leaking/Incontinence ☐ Pain/Burning



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								

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.

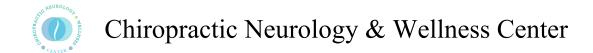
I have had an opportunity to discuss with the doctor named below and/or with office personnel the nature, purpose and risks of Chiropractic adjustments, and other recommended procedures and have had my questions answered to my satisfaction. I understand that the results are not guaranteed.

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>Werequirea48-hournotice 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.

INSURANCE/IN NETWORK: 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.

MEDICARE: 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.

**If you 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:	