

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) _____

Main Phone: (_____) _____ Other Phone (_____) _____

email address: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M F

Name of Spouse: _____ Employer _____

Who told you 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:

Doctor of Chiropractic: Name: _____ Date: _____

MD / DO: Name: _____ Date: _____

Physical Therapist: Name: _____ Date: _____

Acupuncture: Name: _____ Date: _____

Other: _____

Name: _____ Date: _____

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

- | | |
|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chicken pox | Other: _____ |
| <input type="checkbox"/> Diabetes | _____ |
| <input type="checkbox"/> Eczema | _____ |
| <input type="checkbox"/> Emphysema | _____ |
| <input type="checkbox"/> Epilepsy | _____ |
| <input type="checkbox"/> Glaucoma | _____ |
| <input type="checkbox"/> Goiter | _____ |
| <input type="checkbox"/> Graves' Disease | _____ |
| <input type="checkbox"/> Hypothyroid | |
| <input type="checkbox"/> Heart Disease | |
| <input type="checkbox"/> Hepatitis | |
| <input type="checkbox"/> Malaria | |
| <input type="checkbox"/> Measles | |
| <input type="checkbox"/> Multiple Sclerosis | |
| <input type="checkbox"/> Mumps | |
| <input type="checkbox"/> Pneumonia | |

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

Caesarean 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): 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: _____

Did you ever become ill 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

Full term Premature Pregnancy Complications?: _____

Breast Fed. How long: _____ Bottle-fed

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

Did you eat candy, sugar, 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: _____

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

Environmental Assessment

Mercury

- Yes No Do you have amalgam (silver) filings in your teeth? If yes, How many? _____
- Yes No Have you ever had an amalgam 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 Did your mother have amalgam fillings when pregnant with you?
- 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 any dental bridges?
- Yes No Have you had any root canals? If yes, how many _____
- Yes No Have you had any tooth extractions?
- Yes No Do you have any dental implants, retainers or other metal in your mouth? Ex _____
- _____
- Yes No Did you wear contact lenses during the 1980's or early 1990's?
- Yes No Did you take oral contraceptives during the 1980's or early 1990's?
- Yes No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?
- Yes No Have you noticed any adverse reactions to these shots?
- 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?

Lead

- Yes No Does your occupation involve soldering or metal salvage?
- Yes No Have you done any old home repair or sandblasting? If yes, when _____
- Yes No Are you exposed to paints a lot?
- Yes No Was your home built before 1978?
- Yes No Have you ever worn cosmetics containing kohl or that is a deep black or deep red color?
- Yes No Are you around a lot of fake leather or vinyl (furniture, handbags, clothing, etc.?)
- Yes No Do you get stomach aches in the morning?

General Toxicity

- Yes No Have you ever lived near, on or by a golf course, freeway or high tension electrical wires? If yes, please explain:
- _____
- _____
- Yes No Have you ever worked around chemicals such as in a beauty salon, auto repair shop, factory, 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 repellants 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 at 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?

Lyme Disease

- Yes No Have you ever been diagnosed with Lyme Disease?
- Yes No Have you had dry sockets or infected tooth extractions?
- Yes No Do you have pain in the small joints of your body (hands, feet, spine)
- Yes No Have you ever been bitten by a tick or recluse spider?
- Yes No Have you ever seen a bulls-eye rash on any part of your body?
- Yes No Did the bulls-eye rash appear shortly after a tick or spider bite or time spent outdoors?
- Yes No Was your mother ever diagnosed with Lyme Disease?
- Yes No Do you frequently go camping, hunting or are you involved in outdoor activities – especially in wooded or grassy areas?

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 pump 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 for a while 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

Endocrine System Assessment (Check Any Symptoms that Currently Apply to You)

Hypothyroid

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

Hyperthyroid

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

Adrenal Dysfunction

- | | |
|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Hypersensitive to vitamin pills and nutritional supplements [|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/>] Jumpy or startle easy |
| <input type="checkbox"/> Not dealing well with stress | <input type="checkbox"/>] Need coffee in the morning to wake up |
| <input type="checkbox"/> Feel dizzy or off balance | <input type="checkbox"/>] Coffee makes you sleepy |
| <input type="checkbox"/> Light headed | <input type="checkbox"/>] Exercise makes you nauseated |
| <input type="checkbox"/> Impatient or irritable with others | <input type="checkbox"/>] Get lightheaded, dizzy or like you might faint when moving from kneeling or lying down to standing up |
| <input type="checkbox"/> Shaky or tremble | <input type="checkbox"/>] Have allergies (food, pollen, animal dander, chemicals, etc.) |
| <input type="checkbox"/> Racing or pounding heart | <input type="checkbox"/>] Bright light is irritating, and especially at night with oncoming car lights |
| <input type="checkbox"/> Sleep problems (can't get to sleep, wake up with a start, wake up and can't go back to sleep, etc.) | <input type="checkbox"/>] Digestive problems, irritable bowel symptoms |
| <input type="checkbox"/> Feel nauseated when stressed | <input type="checkbox"/>] Dark circles under the eyes |
| <input type="checkbox"/> Get shaky or grumpy if you miss a meal | <input type="checkbox"/>] Feel you can't get enough air – "air hunger" |
| <input type="checkbox"/> Crave salt or salty foods | <input type="checkbox"/>] Get motion sickness easily |
| <input type="checkbox"/> Achy or painful joints | <input type="checkbox"/>] Nails are weak or ridged |

<input type="checkbox"/> Feelings of doom	<input type="checkbox"/> Chronic low blood pressure
<input type="checkbox"/> Panic attacks	<input type="checkbox"/> Sweat easily
<input type="checkbox"/> Emotionally hypersensitive or overreact to people or situations	<input type="checkbox"/> Poor digestion
<input type="checkbox"/> Have anger outbursts - lose temper easily	<input type="checkbox"/> Feel very fatigued
<input type="checkbox"/> Inability to focus on tasks or activities	<input type="checkbox"/> Get irritated easily
<input type="checkbox"/> General body achingness <input type="checkbox"/> Headaches	<input type="checkbox"/> Low back pain
<input type="checkbox"/> Feel paranoid	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Very defensive with others or over react towards others or situations	<input type="checkbox"/> Feel jittery
<input type="checkbox"/> Hypersensitive skin (do not like being touched)	<input type="checkbox"/> Achy or sensitive scalp
<input type="checkbox"/> Clumsy (drop things, bump in to things)	<input type="checkbox"/> Take a longer time to recover from being sick with a cold or flu
	<input type="checkbox"/> 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, but did in the past, 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: _____ Names: _____

Relationships: Marital status: Single Married Divorced Widow / Widower

Gay / Lesbian Long term Partnership

Nutrition History

How many meals do you eat out per week? _____

<input type="checkbox"/> Fast eater	<input type="checkbox"/> Others in my household have special dietary needs
<input type="checkbox"/> Do not eat at regular times or skip meals.	<input type="checkbox"/> Snack frequently
<input type="checkbox"/> Eat too much	<input type="checkbox"/> Do not like to eat
<input type="checkbox"/> Late night eating	<input type="checkbox"/> Struggle with eating issues
<input type="checkbox"/> Dislike healthy food such as vegetables, etc.	<input type="checkbox"/> Emotional eater (<i>eat when sad, lonely, depressed, bored</i>)
<input type="checkbox"/> Life style interferes with eating regular meals	<input type="checkbox"/> Don't care to cook
<input type="checkbox"/> Eat more than 50% of meals away from home	<input type="checkbox"/> Don't like to shop for food
<input type="checkbox"/> Travel frequently	<input type="checkbox"/> Confused about nutritional advise
<input type="checkbox"/> 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 3 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

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

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

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 lumpy tender have cysts nipple discharge breast prosthesis have breast implants

Immune: Get sick once or more every year Colds or flu hang on for more than 3 days

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 starting 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 ankles feet toes

Other: _____

Allergic to Dental Anesthetics (Novocain, etc.)

Consent to Evaluation and 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 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.

AUTHORIZATION TO EXAMINE AND TREAT

I, the undersigned party, request and authorize the performance upon myself of a physical examination / evaluation. I also consent to the performance of other tests such as blood and urine tests, hair analysis and Muscle Response Testing procedures that are deemed necessary.

In giving this authorization, I understand that these tests or procedures may not actually be done. I also understand that I have the right to refuse any examination, test, or treatment procedure at any time. These services will be performed either by Dr. Vernon S. Redd, or by other qualified health care professionals or support staff that are selected by him and that act under his direction. Should it be determined that my condition may benefit from chiropractic care, nutritional therapy or from the other types of therapies provided at his office, I consent to treatment which may include, but is not limited to, chiropractic adjustments of the spine or other joints of the body, myofascial release, micro current electrotherapy, mechanical percussive therapy, Cold Laser therapy, various rehabilitation exercises and activities, nutritional, homeopathic or herbal therapy, injection therapies, or GRT therapy. I understand that any of the above therapies, except chiropractic adjustments, injection therapies or GRT therapy, may be administered by a staff member under the direction and supervision of the doctor. I also consent to the performance of other diagnostic and therapeutic procedures, in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that Dr. Redd may consider necessary or advisable in the course of my health care.

Concerning Chiropractic Therapy:

I understand that **chiropractic adjustments** may involve risks of complications, injury or even death from both known and unknown causes. The known risks are as follows:

Stroke: This is the most serious potential complication associated with spinal adjustments, regardless of whether the provider is a chiropractor, medical or osteopathic doctor or other health professional. A stroke occurs when the blood supply to the brain is interrupted and an area of the brain does not receive enough oxygen from the blood stream which results in brain damage. The results of a stroke can be temporary or permanent and can cause temporary dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. Stroke concerns in relation to chiropractic treatment are focused on the vertebral artery in the neck. Two thirds of vertebral artery strokes occur spontaneously. One third are caused by traumatic events. Chiropractic adjustments of the neck can potentially cause a stroke because the vertebral artery in the neck may become injured by the adjustment. However research studies have shown that strokes caused by a chiropractic adjustment are rare. The most recent studies estimate that the incidence of this type of complication occurs in 1 (one) in every 3,000,000 (three million) adjustments to the neck. When stroke has resulted from an adjustment, it has been associated with manual neck adjusting. In our office we do not use this type adjustment. In our office we use the Activator or Arthrostim adjusting instruments. To the best of our knowledge, neck adjustments given by an instrument such as an Arthrostim or Activator instrument, have never been documented to have caused a stroke. However, even though a stroke from a chiropractic adjustment of the neck is very unlikely to occur (and especially so when mechanical instruments are used), you need to be aware that it is possible.

Rib Fracture, Joint Dislocations, Sprain Injury or Muscle Soreness: A *manual* chiropractic adjustment may crack (fracture) a rib, create a joint dislocation or 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. Because we use instruments to perform the adjustments instead of manual adjusting, these types of injuries are impossible to cause. This problem occurs so rarely that there are no statistics available to determine its 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. It 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:

Before you sign this agreement, 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. The Nutrition & Health Center offers nutritional care for our patients. Since nutritional deficiency may or may not be associated with a specific disease, or may or may not be the cause of a disease, or may occur as a result of a disease, it is important for you to understand fully that our sole concern in your case will be your nutritional status and your ability to metabolize and utilize the nutrients that you consume, either in your diet or as nutritional supplements, that may help to improve your body's general physiological function. **Our nutritional programs are not intended to cure or treat any specific disease.**

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.

Neural Therapy, Biopuncture, Prolotherapy and Neural Prolo Injection Therapies

Neural Therapy, Biopuncture, Prolotherapy, Neural Prolotherapy and Trigger Point Injections 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 may use anesthetics (Procaine or Lidocaine) as well as homeopathic medicines as well as nutritional products such as vitamin B12 or dextrose, 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.

Potential Problems with Injection Treatments:

Though side affects are rare, potential problems and side affects with these injection procedures may occur and include infection, localized skin irritation, and possible allergic reactions to the substances injected. The most common side effects with any injection are bruising or minor bleeding.

In rare instances, an injection to the chest or back areas may go too deep and result in a puncture of the lung, causing a collapsed lung which would require hospitalization. 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 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.**

Nutritional 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, including AIDS, Cancer or any infection, 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.

As your health improves, you may find that any prescription medications you are on may need to be adjusted. Do not change your medication without consulting your doctor first.

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 his office staff members. I do not expect the doctor to be able to anticipate and explain all risks and potential complications. Dr. Vernon S. Redd 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 his staff who act under his 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)

Witnessed by: _____ Date: _____

Consent to Treatment of a Minor Child

I hereby authorize Dr. Vernon S. Redd or his assistants to administer treatment and diagnostic exams or evaluations, as they deem necessary, to my (relationship) _____ named (name) _____.

Signature (parent or legal guardian) _____ Date: _____

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

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I understand that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved insurance carrier.

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 is due when received.

Return Policy: You may return any unopened nutritional products or prepaid lab requisitions within 15 days of purchase for a full refund.

Authorization of Payment by Insurance Carrier: I hereby assign, transfer and set over to Dr. Vernon S. Redd 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 Redd, which he requests, in relation to my being under his care.

Signature: _____ Date: _____

Print Name: _____