**Falukos Chiropractic & Wellness, LLC**
**2971 E. Chestnut Expressway**
**Springfield, MO 65802**
**417.869.9898**

## NEW PATIENT MEDICAL HISTORY

Name _____ Date_____

Address _____

City _____ State _____ Zip _____

DOB _____ Age _____ Sex: M F Height _____ Weight _____

Home Phone (_____) _____ - _____ Work Phone (_____) _____ - _____

Email _____

SS# _____ Occupation _____

Referred By _____

Overall Health (circle one) Excellent / Good / Fair / Poor / Other _____

Chief Complaint (Reason you are here) _____

_____

Previous Treatments for this complaint _____

_____

Other Complaints or Problems _____

_____

Current Medications _____

_____

Are you currently under the care of a physician or other health care professional? (if yes, list names and reason) _____

_____

Nutritional Supplements you are taking _____

_____

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If you smoke, drink coffee, or use alcohol indicate how much

Smoke _____ Coffee _____ Alcohol _____

Medical History:

List any Illnesses (dates):

List any Surgeries or procedures (dates):

Past Accidents or Injuries (dates):

Marital Status: S M D W Name of Spouse _____

Describe Health of Spouse _____ Number of Children _____

Name of Children: Age: Sex: Any Health Conditions or Concerns?

1

2

3

4

5

Any family (parents) history of health conditions/Illnesses? _____

_____

Any household pets or animals you or your family are in close contact with? _____

_____

Signature _____ Date _____

**Falukos Chiropractic & Wellness, LLC**
**2971 E. Chestnut Expressway**
**Springfield, MO 65802**

# PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING

**PLEASE READ BEFORE SIGNING:**

I specifically authorize the health practitioners at Falukos Chiropractic & Wellness, LLC to perform a Nutrition Response Testing (NRT) health analysis and to develop a natural, complimentary health improvement program for me, which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health and I understand it's not for the treatment, or "cure" of any disease.

I understand that NRT is a safe non-invasive, method of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that NRT is not a method for diagnosing or treating any disease including conditions of cancer, AIDS, infections or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of NRT or any natural health, nutritional or dietary programs recommended, but rather I understand that NRT is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe and natural programs can be developed for the purpose of bringing about a more optimum sate of health.

I have read and understand the above statements and this permission form applies to this and subsequent visits and consultations.

Date _____

Print Patient Name _____

Signature _____ _____
(If child, Parent/guardian signature) (Print Parent/Guardian Name)

# SYSTEMS SURVEY FORM

Maestro Systems Survey

Patient _____ Doctor _____ Date _____

Birth Date ___/___/___ Approx Weight _____ Vegetarian: Yes ☐ No ☐

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

●○○ Fill in the circle marked 1 for MILD symptoms (occurs rarely).
○●○ Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
○○● Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
○○○ **Leave circles BLANK if they don't apply to you!**

## GROUP 1

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

## GROUP 2

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

## GROUP 3

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

## GROUP 4

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

# SYSTEMS SURVEY FORM - PAGE 2

## GROUP 5

1 2 3

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

## GROUP 6

1 2 3

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

## GROUP 7

### (A)

1 2 3

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

### (B)

1 2 3

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

### (C)

1 2 3

137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance

### (D)

1 2 3

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

### (E)

1 2 3

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

### (F)

1 2 3

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

# SYSTEMS SURVEY FORM - PAGE 3

## GROUP 8

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

## FEMALE ONLY

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

## IMPORTANT

Please list the five main complaints you have in the order of their importance:

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

## MALE ONLY

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

## BARNES THYROID TEST

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

**PRE-MENSES FEMALES AND MENOPAUSAL FEMALES**

Any two days during the month

**FEMALES HAVING MENSTRUAL CYCLES**

The 2nd and 3rd day of flow OR any 5 days in a row

**MALES**

Any 2 days during the month

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

| | | | |
|---|---|---|---|
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |
| Date | _____ | Temperature | _____ |

Name _____

Date _____

## Please Mark The Symptoms You Are Currently Experiencing

Some of the questions may repeat during this questionnaire. Answer all of the questions to the best of your ability. **Y** = Yes, **N** = No; **If you don't know, place a check mark before the question.**

RH9

Y N •Crave sweets during the day
Y N •Irritable if meals are missed
Y N •Depend on coffee to keep going or to get started
Y N •Get lightheaded if meals are missed
Y N •Eating relieves fatigue
Y N •Feel shaky, jittery, tremors
Y N •Agitated easily, upset, nervous
Y N •Poor memory, forgetful
Y N •Blurred vision

IR18

Y N •Fatigue after meals
Y N •Crave sweets during the day
Y N •Eating sweets does not relieve cravings for sugar
Y N •Must have sweets after meals
Y N •Waist girth is equal or larger than hip girth
Y N •Frequent urination
Y N •Increased thirst & appetite
Y N •Difficulty losing weight
Y N •Weak immune system – always getting colds
Y N •Insomnia
Y N •Can't lose weight and can't gain muscle
Y N •Depression
Y N •Inflammation of Joints/Muscles
Y N •High blood pressure
Y N •Bloating/gas
Y N •Elevated triglycerides and cholesterol
Y N •High glucose/A1C
Y N •Low HDL

RPA5

Y N •Dry mouth
Y N •Difficulty swallowing supplements or large bites of food
Y N •Slow bowel movements/tendency for constipation
Y N •Chronic digestive complaints
Y N •Bowel or bladder incontinence

ISA7

Y N •Tendency for anxiety
Y N •Easily startled
Y N •White spots on finger nails
Y N •Difficulty relaxing
Y N •Sensitive to bright or flashing lights
Y N •Episodes of racing heart
Y N •Difficulty sleeping

SoA11

Y N •Fatigue
Y N •Dizziness
Y N •Fainting
Y N •Low Blood Pressure
Y N •Eyes, skin yellowing
Y N •Pallor of eyes, nails, gums
Y N •Skin cold
Y N •Shortness of breath
Y N •Muscle weakness
Y N •Heart palpitations / rapid rate
Y N •Fingernails brittle, pallor, spoon-shaped

## Please Mark The Symptoms You Are Currently Experiencing

Some of the questions may repeat during this questionnaire. Answer all of the questions to the best of your ability. **Y** = Yes, **N** = No; **If you don't know, place a check mark before the question.**

CD20

- Y N • Diagnosed with high blood pressure, heart disease, stroke
- Y N • Chest pain, chest tightness, chest pressure and chest discomfort (angina)
- Y N • Shortness of breath
- Y N • Pain, numbness, weakness or coldness in your legs or arms
- Y N • Pain in the neck, jaw, throat, upper abdomen or back
- Y N • Fluttering in your chest
- Y N • Racing heartbeat (tachycardia)
- Y N • Slow heartbeat (bradycardia)
- Y N • Lightheadedness
- Y N • Dizziness
- Y N • Fainting (syncope) or near fainting
- Y N • Pale gray or blue skin color (cyanosis)
- Y N • Swelling in the legs, abdomen or areas around the eyes
- Y N • Easily getting short of breath during exercise or activity
- Y N • Easily tiring during exercise or activity
- Y N • Swelling in the hands, ankles or feet
- Y N • Fatigue
- Y N • Irregular heartbeats that feel rapid, pounding or fluttering
- Y N • Dry or persistent cough
- Y N • Skin rashes or unusual spots

SoD15

- Y N • Fatigue
- Y N • Sleep Disturbance
- Y N • Hormonal Imbalance
- Y N • Headaches
- Y N • Dizziness
- Y N • Blurred Vision
- Y N • Nausea
- Y N • Rapid Heart Beat
- Y N • Aches and pains in joints and muscles
- Y N • Weight Gain
- Y N • Frequent Urination
- Y N • Insatiable Thirst/Hunger
- Y N • Cuts/bruises that heal abnormally slow
- Y N • Weight loss
- Y N • Frequent Urination

Y N •Unable to fall asleep despite being tired
Y N •Waking up in the middle of the night for no reason
Y N •Heart palpitations at night or when stressed
Y N •Consistently low blood pressure
Y N •Low libido and lack of sex drive
Y N •Low thyroid function, often despite thyroid medications
Y N •Feeling of hypoglycemia though laboratory values are normal
Y N •Depression, often unresolved after anti-depressants
Y N •Hair falling off for no reason
Y N •Irritable under stress
Y N •Anxiety
Y N •Panic attacks
Y N •Feeling "wired", unable to relax
Y N •Feeling of adrenaline rushes in the body
Y N •Foggy thinking
Y N •Inability to handle stress
Y N •Waking up feeling tired in the morning even after a full night's sleep
Y N •Feeling tired in the afternoon between 3:00 and 5:00 pm
Y N •Inability to take in simple carbohydrates (sweets)
Y N •Needing coffee to get going in the morning and throughout the day
Y N •Coffee, tea or energy drinks triggering adrenaline rush and adrenal crashes
Y N •Feeling tired between 9:00 and 10:00 PM, but still finding it hard to go to bed
Y N •Craving for salty food such as potato chips
Y N •Dry skin more than usual
Y N •Exercise helps first, but then makes fatigue worse
Y N •Chemical sensitivities to paint, fingernail polish, plastics
Y N •Electromagnetic force sensitivity, including cell phone and computer monitors
Y N •Delayed food sensitivities, especially to dairy and gluten
Y N •Abdominal fat accumulation for no apparent reason
Y N •Temperature intolerance, especially to heat or sun light
Y N •Premature Menopause
Y N •Constipation for no apparent reason
Y N •Joint pain of unknown origin
Y N •Muscle mass loss
Y N •Muscle pain of unknown reason
Y N •Cold hands and feet
Y N •Premature aging skin
Y N •Inability to concentrate or focus
Y N •Psoriasis of no known reason
Y N •Gastritis despite normal stomach scope
Y N •Dizziness for no known cause
Y N •Chronic Tinnitus (ringing in the ear)
Y N •Numbness and tingling in extremities bilaterally
Y N •Recurrent mouth sores
Y N •Shortness of breath even though breathing is fine
Y N •Grave's disease
Y N •Hashimoto's thyroiditis
Y N •Legs that feel heavy at times
Y N •Dark circles under eyes that do not go away with rest
Y N •Loss of healthy facial skin tone color
Y N •Body feeling tense all over and unable to relax
Y N •Increased heart rate with changes in posture
Y N •Irritable Bowel Syndrome, with more constipation than diarrhea
Y N •Chronic Fatigue Syndrome unimproved with medicine
Y N •Fibromyalgia unresolved after conventional help
Y N •Systemic Candida that gets worse when under stress
Y N •Lyme Disease but unable to fully recover after medication or intolerance to drugs

<u>Females</u>

Y N •Endometriosis
Y N •Polycystic Ovarian Syndrome
Y N •Uterine fibroids
Y N •Fibrocystic breast disease
Y N •Unable to get pregnant, requiring IVF
Y N •Post-partum fatigue and depression
Y N •Recurrent miscarriages during first trimester
Y N •Dysmenorrhea advancing to amenorrhea
Y N •Irregular menstrual cycle that "stops and goes"

# Falukos Chiropractic & Wellness, LLC

## Consent for Purposes of Treatment, Payment & Healthcare Operations

In this document, "I" and "my" refer to the patient, and "Chiropractor" refers to the Falukos Chiropractic & Wellness, LLC.

I consent to the use or disclosure of my protected health information by Chiropractor for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Chiropractor. I understand that analysis, diagnosis or treatment of me by Chiropractor may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Chiropractor is not required to agree to the restrictions that I may request. However, if Chiropractor agrees to a restriction that I request, the restriction is binding on Chiropractor. I have the right to revoke this consent, in writing, at any time, except to the extent that Chiropractor has taken action in reliance on this Consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I have been provided with a copy of the Notice of Privacy Practices of Chiropractor and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Chiropractor. The Notice of Privacy Practices for Chiropractor is also posted in the waiting room at Falukos Chiropractic & Wellness, LLC. This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information.

Chiropractor reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of Chiropractor and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative | Date of Signing

_____ _____

Printed Name of Patient | Description of Personal Representative's Authority

Rev. 4/2017