INFORMATION/APPLICATION FOR CARE

The following information is needed in order to better serve you. Please complete all questions. If you need help please ask the receptionist. PLEASE PRINT

Today's Date _____

Name_____ Home Phone _____ Work Phone _____

Address _____ City _____ State _____ Zip _____

Age _____ Birthdate _____ Marital Status: S M W D No. of Children _____

Please circle one payment type: Cash Check Master Card/Visa American Express

Your Employer _____ Occupation _____ Years on Job _____

Employer Address _____ City _____ State _____ Zip _____

E-Mail _____ Your SS # _____

Do you have Medicare? Yes_____ No_____ Medicaid? Yes_____ No_____

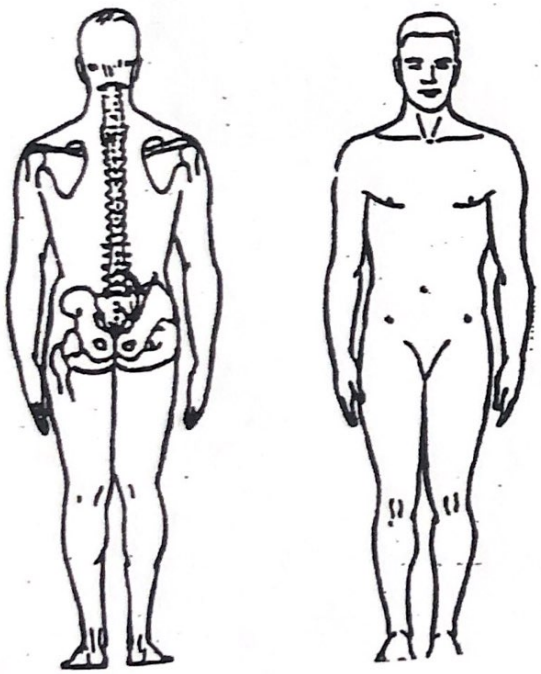
Name of Spouse or Parent _____ Birthdate _____

Spouse employed by _____ Occupation _____ Years on Job _____

Employer Address _____ City_____ State_____ Zip _____

Office phone _____ Spouse SS # _____ Driv Lic #_____

Does your spouse have health insurance at work? Yes_____ No_____



COMPLETE THESE DIAGRAMS

If you are in pain, please mark the exact location of your pain on the diagram. Also describe the type and frequency of your pain, as well as any activity which brings on or aggravates the pain. For example, dull, sharp, consistent, off & on, when standing, when sitting, etc.

MAJOR COMPLAINTS

(Please list any condition you are being treated for or experiencing.)

_____

_____

_____

_____

_____

_____

_____

Referred to our office by: _____

How Payment will be made:

_____ Cash

_____ Check

Type of Insurance

_____ Workmen's Comp.

_____ Credit Card

_____ Health Insurance

_____ Automobile Ins. Policy

Is your condition due to an accident? Yes_____ No_____ Date of Accident _____

Type of accident? Auto_____ Work/On Job_____ At Home_____ Other _____

Have you ever been in an Auto Accident? Past Year _____ Past 5 Years _____ Over 5 Years_____ Never_____

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

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	197 ○○○ Frequent stuffy nose; sinus infections
178 ○○○ Indigestion	188 ○○○ Fatigue	198 ○○○ Allergy to some foods
179 ○○○ Poor appetite	189 ○○○ Skin sensitive to touch	199 ○○○ Loose joints
180 ○○○ Craving for sweets	190 ○○○ Tendency toward hives	
181 ○○○ Muscular soreness	191 ○○○ Nervousness	
182 ○○○ Depression; feelings of dread	192 ○○○ Headache	

FEMALE ONLY

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

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 _____

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