All answers on this form are kept confidential according to HIPPA regulations.

New Patient History Today's Date _____

Name_____ Sex_____ Sex at Birth _____
(last name, first name, middle initial) (M or F) (M or F)

Date of Birth _____ Email _____

Address _____

City_____ State_____ Zip_____ Age_____ Height/Weight _____

Home Phone ( )_____ Cell Phone ( )_____ Work Phone ( )_____

Occupation_____ Employer _____

Marital Status _____ Number of Children _____(living) _____(deceased)
(Single; Married; Separated; Divorced)

Who referred you to the Center for Chiropractic & Wellness? _____

Who is Responsible for Bill? _____

Name of Spouse or Insured_____ Employer _____

Spouse [Insured's] Birth Date: _____

Emergency Contact Information

Name_____ Phone Number_____ Relation to You _____

Primary Care Physician: Name _____ Phone ( ) _____

His/Her Address _____

Other doctors seen for this condition _____

_____

Diagnosis and type of treatment _____

_____

_____

What are your main reasons for seeking treatment today? _____

_____

_____

Have you lost any days of work? Yes_____ No_____ Dates: _____

What type of service do you desire?

_____1) Temporary relief of symptoms/pain control
_____2) Eradication of the tendencies causing your condition.
_____3) Balanced optimum health care. Elimination of root/cause of problem, if possible.
_____4) Maintenance care.

How would you classify your condition?:

_____1) Minor.
_____2) Involved.
_____3) Fairly severe and progressively getting worse.

FOR WOMEN
Date of last: PAP _____ Bone Density Scan _____ Mammogram _____
Age of 1st period (menarche) _____ Age of last period (menopause) _____

FOR MEN
Date of last prostate checkup _____ PSA results _____ Manual prostate exam results _____
Lab results _____

FOR EVERYONE
Have you had or do you have the following Sexually Transmitted Diseases:

_ Gonorrhea _ Syphilis _ HIV/AIDS _ HPV _ Chlamydia _ Herpes Date _____

Please check the appropriate boxes if you currently have, or have had in the past, any of the following addictions. *If you are currently in a state of recovery, please also indicate recovery period.*

_ Prescription Drugs Please indicate drug(s) and length of time of addiction: _____
_ Street Drugs Please indicate drug(s) and length of time of addiction: _____
_ Alcohol Please indicate length of time of addiction: _____
_ Tobacco Please indicate length of time of addiction: _____

List any medications and supplements you are currently taking (feel free to request more paper from the front desk):

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

Please indicate the use and frequency of the following:

	Yes	No	How much and how often?
Coffee/black tea			
Non-medical drugs			
Tobacco			
Alcohol			
Water Intake			
Soda Pop			

List any accidents, surgeries, hospitalizations, or trauma (include date): _____

Lab Results (include copies): _____

List any allergies, food sensitivities, or food cravings that you have. _____

Is there anything in your personal or medical history that you have not yet listed (example: recent personal or occupational trauma)? If yes, please explain. _____

History of Chief Concern 1) Provide an outline, chronologically, of your past experience in treating your primary concern. Note any diagnoses made, tests done to confirm the diagnosis, treatments and your response to those treatments. 2) Include specific therapies done and your response to them; medications tried and your reactions, positive or negative.

This is an outline that we will review during your first visit. It need not be exhaustive or highly detailed. Some past responses to medications predict future responses to herbs, nutrients, and supplements. Please do not hesitate to request additional paper from the receptionist.

DOCTOR'S NOTES

Medication History*

Please check any of the following medications you have taken in the past or are currently taking.

Noradrenergic and Specific Sertonergic Antidepressants (NaSSAs)

- ☐ Remeron
- ☐ Zispin
- ☐ Avanza
- ☐ Norset
- ☐ Remergil
- ☐ Axit

Tricylic Antidepressants (TCAs)

- ☐ Elavil
- ☐ Endep
- ☐ Tryptanol
- ☐ Trepiline
- ☐ Asendin
- ☐ Asendis
- ☐ Defanyl
- ☐ Demolox
- ☐ Moxadil
- ☐ Anafranil
- ☐ Norpramin
- ☐ Pertofrane
- ☐ Prothiaden
- ☐ Adapin
- ☐ Sinequan
- ☐ Tofranil
- ☐ Janamine
- ☐ Gamanil
- ☐ Aventyl
- ☐ Pamelor
- ☐ Opipramol
- ☐ Vivactil
- ☐ Rhotrimine
- ☐ Surmontil

Selective Serotonin Reuptake Inhibitors (SSRIs)

- ☐ Paxil
- ☐ Zoloft
- ☐ Prozac
- ☐ Celexa
- ☐ Lexapro
- ☐ Luvox
- ☐ Cipramil
- ☐ Emocal
- ☐ Seropram
- ☐ Cipralex
- ☐ Fontex
- ☐ Dapoxetine
- ☐ Seromex
- ☐ Seronil
- ☐ Sarafem
- ☐ Fluctin
- ☐ Faverin
- ☐ Seroxat
- ☐ Aropax
- ☐ Deroxat
- ☐ Rexetin
- ☐ Paroxat
- ☐ Lustral
- ☐ Serlain

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

- ☐ Effexor
- ☐ Pristiq
- ☐ Meridia
- ☐ Serzone
- ☐ Dalcipran
- ☐ Desipramine
- ☐ Duloxetine

Selective Serotonin Reuptake Enhancers (SSREs)

- ☐ Stablon
- ☐ Coaxil
- ☐ Tatinol

Monoamine Oxidase Inhibitors (MAOIs)

- ☐ Marplan
- ☐ Aurorix
- ☐ Manerix
- ☐ Moclodura
- ☐ Nardil
- ☐ Adeline
- ☐ Eldepryl
- ☐ Azilect
- ☐ Marsilid
- ☐ Iprozid
- ☐ Ipronid
- ☐ Rivivol
- ☐ Zyvox
- ☐ Zyvoxid

Dopamine Receptor Agonists

- ☐ Mirapex
- ☐ Sifrol
- ☐ Requip

Norepinephrine and Dopamine Reuptake Inhibitors (NDRI)

- ☐ Wellbutrin XL

D2 Dopamine Receptor Blockers (antipsychotics)

- ☐ Thorazine
- ☐ Prolixin
- ☐ Trilafon
- ☐ Compazine
- ☐ Mellaril
- ☐ Stelazine
- ☐ Vesprin
- ☐ Nozinan
- ☐ Depixol
- ☐ Navane
- ☐ Fluanxol
- ☐ Clopixol
- ☐ Acuphase
- ☐ Haldol
- ☐ Orap
- ☐ Clozaril
- ☐ Zyprexa
- ☐ Zydis
- ☐ Seroquel XR
- ☐ Geodon
- ☐ Solian
- ☐ Invega
- ☐ Abilify

GABA Antagonist Competitive Binder

- ☐ Flumazenil

Agonist Modulators of GABA Receptors (benzodiazepines)

- ☐ Xanax
- ☐ Lexotanil
- ☐ Lexotan
- ☐ Librium
- ☐ Klonopin
- ☐ Valium
- ☐ ProSom
- ☐ Rohypnol
- ☐ Dalmane
- ☐ Ativan
- ☐ Loramet
- ☐ Sedoxil
- ☐ Dormicum
- ☐ Serax
- ☐ Restoril
- ☐ Halcion

Agonist Modulators of GABA Receptors (nonbenzodiazepines)

- ☐ Ambien CR
- ☐ Sonata
- ☐ Lunesta
- ☐ Imovane

Acetylcholine Receptor Antagonists Antimuscarinic Agents

- ☐ Atropine
- ☐ Ipratropium
- ☐ Scopolamine
- ☐ Tiotropium

Acetylcholine Receptor Antagonists Ganglionic Blockers

- ☐ Mecamylamine
- ☐ Hexamethonium
- ☐ Nicotine (high doses)
- ☐ Trimethaphan

Acetylcholine Receptor Antagonists Neuromuscular Blockers

- ☐ Atracurium
- ☐ Cisatracurium
- ☐ Doxacurium
- ☐ Metocurine
- ☐ Mivacurium
- ☐ Pancuronium
- ☐ Rocuronium
- ☐ Succinylcholine
- ☐ Tubocurarine
- ☐ Vecuronium
- ☐ Hemicholinium

Acetylcholinesterase Reactivators

- ☐ Pralidoxime

Cholinesterase Inhibitors (reversible)

- ☐ Donepezil
- ☐ Galantamine
- ☐ Rivastigmine
- ☐ Tacrine
- ☐ THC
- ☐ Carbamate Insecticides
- ☐ Edrophonium
- ☐ Neostigmine
- ☐ Physostigmine
- ☐ Pyridostigmine

Cholinesterase Inhibitors (irreversible)

- ☐ Echothiophate
- ☐ Isoflurophate
- ☐ Organophosphate Insecticides
- ☐ Organophosphate-containing nerve agents

*Please refer to prescribing physician for nutritional interactions with any medications you are taking.

Metabolic Assessment Form™

Name: ______________________________ **Age:** ______ **Sex:** _____ **Date:** ____________________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________________ **4.** ______________________________

2. ______________________________ **5.** ______________________________

3. ______________________________

PART II **Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.**

Category I

Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting proteins and meats; undigested food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category VI

Difficulty digesting roughage and fiber	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent loss of appetite	0	1	2	3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0	1	2	3
Abdominal distention after certain probiotic or natural supplements	0	1	2	3
Decreased gastrointestinal motility, constipation	0	1	2	3
Increased gastrointestinal motility, diarrhea	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Suspicion of nutritional malabsorption	0	1	2	3
Frequent use of antacid medication	0	1	2	3
Have you been diagnosed with Celiac Disease, Irritable Bowel Syndrome, Diverticulosis/ Diverticulitis, or Leaky Gut Syndrome?	Yes	No		

Category VIII

Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		

Category IX

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category X

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful between meals	0	1	2	3
Blurred vision	0	1	2	3

Category XI

Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition

Category XII

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XIII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIV

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XVI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3

Category XVI *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVIII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XIX *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 24 days)	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XX *(Menopausal Females Only)*

How many years have you been menopausal? _____ years

Since menopause, do you ever have uterine bleeding?	Yes			No
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

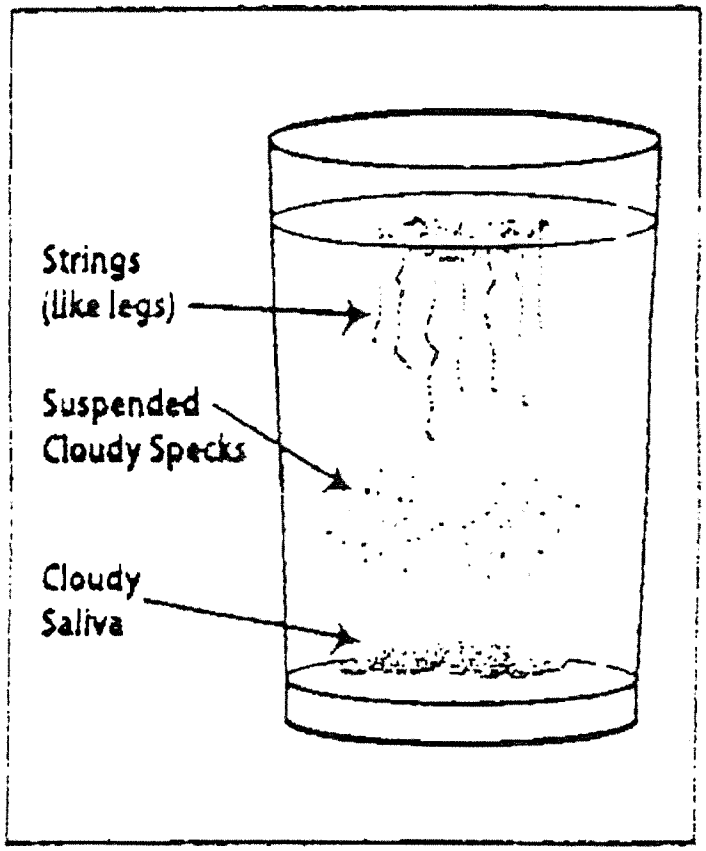
Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Do-it-yourself Candida Test



- Spit first sputum in the morning before putting anything in the mouth into a glass of water
- Check the water every 15 minutes for up to one hour
- If you see strings (like legs) traveling down into the water from the saliva floating on the top, or "cloudy" saliva that sinks to the bottom of the glass, or cloudy specks suspended in the water then the saliva is carrying a fungal overgrowth
- If no strings and the saliva is floating after I hour it appears you are Candida free
- Support with Zymex, Zymex II, Lact Enz, Lactic Acid Yeast, Immuplex, and alkalize the gut

Patient name: _____

FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

_____

_____

2. List medications you are currently taking:

_____

_____

3. Any known drug allergies? _____

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

_____

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

_____

_____

_____

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____
7. Last thermography? _____ Unusual results? _____
8. List significant non-GYN health issues (diabetes, surgeries, etc.):

_____

_____

LIFESTYLE INDICATORS **< = less than > = greater than**

Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day	or stopped recently	_____(when?)
Coffee	None	<2 cups/day	>2 cups/day	or stopped recently	_____(when?)
Soda	None	<2 cans/day	>2 cans/day	or stopped recently	_____(when?)
Sweets/refined carbs		<twice/day	>twice/day	or stopped recently	_____(when?)

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? (circle) Y N Amount _____
3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively

Patient name: _____

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness/Irritable (circle)						
Overly Reactive/Short fuse/Anger (circle)						
Low Mood/Depression (circle)						
Low Blood Sugar/High Blood Sugar						
Lowered self-esteem/self-image (circle)						
Care for others before yourself						
Sadness/Crying (circle)						
Trouble Concentrating						
Memory difficulties						
Fatigue/Anemia (circle)						
Increased Appetite/Constant hunger (circle)						
Sweet cravings/Carbs/Chocolate (circle)						
Caffeine/Stimulant cravings (circle)						
Salt cravings						
Headaches/Migraines (circle)						
Muscle Pain/Joint Aches/Backache (circle)						
Weight gain/Trouble Losing Weight (circle)						
Weight loss						
Water Retention						
Bloating/Belching/Gas (circle)						
Stomach Burning/Nausea/Indigestion (circle)						
Constipation						
Light colored stool						
Loose stool/Diarrhea/IBS (circle)						
Acne/Rashes/Brown Spots (circle)						
Excessive facial hair/body hair (circle)						
Body/Head hair loss (circle)						
Infertility						
Lowered libido/Heightened libido (circle)						
Hot flashes/Night Sweats (circle)						
Palpitations						
Breast tenderness/Breast cysts (circle)						
Nipple discharge						
Vaginal infections/Yeast Infections (circle)						
Urinary Frequency/ Incontinence/Infections (circle)						
Dry eyes/Dry skin/Overall dryness (circle)						
Changes to Labia/Clitoral tissue (atrophy, thinning, discoloration, itching, burning) (circle)						
Vaginal changes (dryness, tearing, decreasing size) (circle)						

Any other symptoms? _____

Patient name: _____

REPRODUCTIVE HEALTH HISTORY *(please fill in or circle the appropriate answer)*

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using a method of birth control? Yes No
   If yes, what method? _____
3. Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No
   When and for how long? _____
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____
   What type of IUD did you use? copper hormone other _____
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods *(such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)*

   _____

   _____

   _____
6. Have you used, or are you currently using fertility or treatment? Yes No
   If yes, please explain. _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? (Specify dates of use)

   _____

8. Have you been pregnant before? Yes No Age(s) of children: _____
   Number of pregnancies? _____ Details/ Complications: _____
   Number of live births: _____ _____
   Miscarriages: _____ _____
   Premature births: _____ _____
   Cesarean births: _____ _____
   Stillbirths: _____ _____
   Abortions: _____ _____
   Ectopic pregnancies _____ _____
9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____
    Treatment and/or Medication: _____
11. Have you had a vaginal infection? Yes No If yes, what? _____
    Treatment and/or Medication: _____
12. Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No
    Fibrocystic Breasts? Yes No Endometriosis? Yes No
    Polycystic Ovarian Syndrome (PCOS)? Yes No Lichen Sclerosis? Yes No
    Vulvodynia? Yes No

Patient name: _____

FOR CYCLING-AGE WOMEN *(please fill in or circle the appropriate answer)*

1. First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No
   If yes, please give details. _____
3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
   <20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical menstrual flow: Light Medium Heavy Details: _____
7. How many *pads* and/or *tampons* (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How often? _____
9. Do you spot? Yes No At what point in your cycle? _____
10. Do you experience cramping? None Mild Moderate Severe
    At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
    At what point in your cycle? _____ Change in breast size? Yes No
14. Do experience nipple discharge? Yes No If yes, when? _____ Color? _____

FOR MENOPAUSAL WOMEN *(please fill in or circle the appropriate answer)*

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? complete *(ovaries AND uterus)* partial *(uterus only)*
3. Date of hysterectomy: _____ Reason for hysterectomy: _____
4. List any other GYN related surgeries: _____
5. Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*

Patient name: _____

MENOPAUSAL WOMEN, CONT'D

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No
   If yes, what were you prescribed? _____
   What dosage? _____ For how long? _____
7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No
   If yes, what? _____
   What dosage? _____ For how long? _____
8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No
   If yes, what? _____
   For how long? _____
9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No
   If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes No
   Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

10. How would you have described your menstruation?
    Easy Uncomfortable Difficult Debilitating
11. What was your typical menstrual flow? Light Medium Heavy
12. When you were cycling would you consider your cycle regular? Yes No
    If no, explain. _____

Please describe any 'treatment' ever received for cycle issues. _____

_____

_____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia
   How long has this been happening? _____
2. How many hours do you sleep a night on average? _____
3. Do night sweats wake you up? Yes No How often? _____
4. Do you wake up tired? Yes No How long has this been happening? _____
5. Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes No
6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Consent for Purposes of Treatment, Payment And Healthcare Operations

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

I consent to the use or disclosure of my protected health information by Center for Chiropractic & Wellness for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Center for Chiropractic & Wellness. I understand that Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T may refuse to diagnose or treat me, if I do not consent to the disclosure of my protected health information for the purposes stated above. (My signature on this document is evidence of this consent).

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. Center for Chiropractic & Wellness is not required to agree to the restrictions that I may request. However, if Center for Chiropractic & Wellness agrees to a restriction that I request, the restriction is binding on Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T.

I understand I have a right to review Center for Chiropractic & Wellness' Notice of Privacy Practices prior to signing this document. Center for Chiropractic & Wellness' Notice of Privacy Practices has been provided to me. 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 Center for Chiropractic & Wellness. The Notice of Privacy Practices for Center for Chiropractic & Wellness is also provided on request at the main administrative desk of this practice. Notice of Privacy Practices also describes my rights and Center for Chiropractic & Wellness duties with respect to my protected health information.

Center for Chiropractic & Wellness 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 Center for Chiropractic & Wellness office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I have the right to revoke this consent, in writing at any time, except to the extent that Center for Chiropractic & Wellness, Dr. Jennifer Greenfield, Dr. Kira Cervenka, Dr. Monique Santoro, L. Ac., and Kathy Wilson, L.M.B.T. have taken action in reliance on this consent.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Center for Chiropractic & Wellness
Patient Missed Appointment Policy

Definitions:
Policy—a method or course of action designed to influence and determine decisions/a guiding principle or procedure.
Appointment—a meeting with someone at a certain time or place
Missed—fail to keep, do, or be present at

It is our wish that each and every one of our patients receives the very best care and service possible. Your Treatment Program consists of a specific series of treatments given over a pre-planned time span. If you cannot follow this plan, then you will not receive the desired results.

If we did not insist that you meet all of your appointments, we would be doing you a disservice and it would be indicative that we did not care. We do not want to do you a disservice and we do care about you and the success of your program here. Therefore, we have a few simple rules that we insist you follow:

1. Meet all of your scheduled appointments. Arrange the activities in you life so that this can occur.
2. If you become ill, we still want you to come in, because your treatment will help you recover.
3. If you are unable to make it due to an emergency, please call and let us know so that we can reschedule your appointment
4. With the exception of unexpected emergencies, please call and let us know at least 24 hours in advance to change the appointment.
5. All canceled or missed appointments must be rescheduled and made up within 1 week.
6. Service charges for missing an appointment are as follows:

Dr. Jennifer Greenfield: AK/NET/NAET
15 Minute Appt. $30.00
Dr. Monique Santoro L.Ac.
Acupuncture Initial Consult $25
1 Hour Treatments $40
Dr. Jennifer Greenfield, Dr. Kira Cervenka
15 min. Chiropractic Appointment $40
30 min. Chiropractic Appointment $60
Kathy Wilson L.M.B.T
1 hour massage $35
Ion Cleanse:
Cleanse Treatment $25

**** Patients with packages will have one treatment deducted from their package for each 15 minute time slot.**

* Note: Confirmation calls are made the day before each patient's appointment. These calls are a courtesy service, meant to remind patients of their appointment times. However, failure to receive a call does NOT validate a missed appointment.

I have read and understand the above policy

Patient's Name: _____ Signature: _____

Doctor's Signature: _____

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

(Consent to use PHI) Notice of Privacy Practices - Acknowledgement & Consent

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Center for Chiropractic & Wellness or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may review the Notice prior to signing this consent. You may request a copy of the Notice at the Front Desk.

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature	Date
Print Patient's Full Name	Time
Witness Signature	Date

Center for Chiropractic & Wellness
8300 Health Park, Ste 133
Raleigh, NC 27615

919-845-3280

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

If you have any questions about this Notice please contact our Privacy Officer or any staff member in our office.

Our Privacy Officer is Alicia Kerins

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out your treatment, collect payment for your care and manage the operations of this clinic. It also describes our policies concerning the use and disclosure of this information for other purposes that are permitted or required by law. It describes your rights to access and control your protected health information. "Protected Health Information" (PHI) is information about you, including demographic information that may identify you, that relates to your past, present, or future physical or mental health or condition and related health care services.

We are required by federal law to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all protected health information that we maintain at that time. You may obtain revisions to our Notice of Privacy Practices by accessing our website www."Click & Type" , calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

A. Uses and Disclosures of Protected Health Information

By applying to be treated in our office, you are implying consent to the use and disclosure of your protected health information by your doctor, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to bill for your health care and to support the operation of the practice.

Uses and Disclosures of Protected Health Information Based Upon Your Implied Consent
Following are examples of the types of uses and disclosures of your protected health care information we will make, based on this implied consent. These examples are not meant to be exhaustive but to describe the types of uses and disclosures that may be made by our office.

- **Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party that has already obtained your permission to have access to your protected health information. For example, we would disclose your protected health information, as necessary, to another physician who may be treating you. Your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your doctor, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

- **Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for chiropractic spinal adjustments may require that your relevant protected health information be disclosed to the health plan to obtain approval for those services.

- Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of this office. These activities may include, but are not limited to, quality assessment activities, employee review activities and training of chiropractic students.

  For example, we may disclose your protected health information to chiropractic interns or precepts that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your doctor. Communications between you and the doctor or his assistants may be recorded to assist us in accurately capturing your responses; We may also call you by name in the reception area when your doctor is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We "Do - Do Not" have open therapy/adjusting areas.

  We will share your protected health information with third party "business associates" that perform various activities (e.g., billing, transcription services for the practice). Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract with that business associate that contains terms that will protect the privacy of your protected health information.

  We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may also use and disclose your protected health information for other internal marketing activities. For example, your name and address may be used to send you a newsletter about our practice and the services we offer, we will ask for your authorization. We may also send you information about products or services that we believe may be beneficial to you. You may contact our Privacy Officer to request that these materials not be sent to you.

Uses and Disclosures of Protected Health Information That May Be Made With Your Written Authorization

Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below.

For example, with your written, signed authorization, we may use your demographic information and the dates that you received treatment from our office, as necessary, in order to contact you for fundraising activities supported by our office. With your written, signed authorization, we may "Click & Type" . *(fill in blank- send birthday cards, newsletters etc.)*

You may revoke any of these authorizations, at any time, in writing, except to the extent that your doctor or the practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Authorization or Opportunity to Object

In the following instance where we may use and disclose your protected health information, you have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your doctor may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the protected health information that is relevant to your health care will be disclosed.

- **Others Involved in Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location or general condition. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Other Permitted and Required Uses and, Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your protected health information in the following situations without your consent or authorization. These situations include:

- **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

- **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your protected health information, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

- **Communicable Diseases:** We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

- **Health Oversight:** We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

- **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

- **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process.

- Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (I) legal process and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the Practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

- Workers' Compensation: We may disclose your protected health information, as authorized, to comply with workers' compensation laws and other similar legally-established programs.

- Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

B. Your Rights

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. A "designated record set" contains medical and billing records and any other records that your doctor and the Practice uses for making decisions about you.

  Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewed. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer, if you have questions about access to your medical record.

- You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply.

  Your provider is not required to agree to a restriction that you may request. If the doctor believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. If your doctor does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your doctor.

  You may request a restriction by presenting your request, in writing to the staff member identified as "Privacy Officer" at the top of this form. The Privacy Officer will provide you with "Restriction of Consent" form. Complete the form, sign it, and ask that the staff provide you with a photocopy of your request initialed by them. This copy will serve as your receipt.

- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to

how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing.

- <u>You may have the right to have your doctor amend your protected health information.</u> This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

- <u>You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.</u> This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy practices. It excludes disclosures we may have made to you, to family members or friends involved in your care, pursuant to a duly executed authorization or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limits.

  You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

C. Complaints

You may complain to us, or the Secretary of Health and Human Services, if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

> Our Privacy Officer is Alicia Kerins you may contact our Privacy Officer, or any staff member, including Dr. Greenfield or Dr. Cervenka at the following phone number 919-845-3280 or our website, at www.chiropractornc.com for further information about the complaint process.

This notice was published and becomes effective on November 20, 2013.