



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

New Patient History

Today's Date:

Name _____ Sex _____ Sex at Birth _____
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) _____
Who referred you to the Center for Chiropractic & Wellness?
Who is responsible for the bill?
Name of Spouse or Insured _____ Employer _____
Spouse (Insured's) Birth Date: _____

Emergency Contact information

Name _____ Phone Number _____ Relationship 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 services 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.

Date of last: PAP

Bone Density Scan

Mammogram

Age of 1st period (menarche)

Age of last period (menopause)

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 the 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:

Medicine	Dosage	Reason	How Long	Prescribed by	Date of last checkup

Please indicate the user 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 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 and 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

Metabolic Assessment Form

Name:

Age:

Sex:

Date:

PART I

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

- 1.
- 2.
- 3.
- 4.
- 5.

PART II

Please select the appropriate number for all questions below. 0 as the least/never to 3 as the most/always.

<p>Category I Feeling that bowels do not empty completely Lower abdominal pain relieved by passing stool or gas Alternating constipation and diarrhea Diarrhea Constipation Hard, dry, or small stool Coated tongue or “fuzzy” debris on tongue Pass large amount of foul-smelling gas More than 3 bowel movements daily Use laxatives frequently</p> <p>Category II Increasing frequency of food reactions Unpredictable food reactions Aches, pains, and swelling throughout the body Unpredictable abdominal swelling Frequent bloating and distention after eating Abdominal intolerance to sugars and starches</p> <p>Category III Intolerance to smells Intolerance to jewelry Intolerance to shampoo, lotion, detergents, etc. Multiple smell and chemical sensitivities Constant skin outbreaks</p> <p>Category IV Excessive belching, burping, or bloating Gas immediately following a meal Offensive breath Difficult bowel movement Sense of fullness during and after meals Difficulty digesting fruits and vegetables; Undigested food found in stools</p> <p>Category V Stomach pain, burning or aching 1-4 hours after eating Use antacids Feel hungry an hour or two after eating Heartburn when lying down or bending forward Temporary relief by using antacids, food, milk, or carbonated beverages Digestive problems subside with rest and relaxation Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine</p> <p>Category VI Roughage and fiber cause constipation Indigestion and fullness last 2-4 hours after eating Pain, tenderness, soreness on left side under rib cage Excessive passage of gas</p>	<p>Category VI (continued) Nausea and/or vomiting Stool undigested, foul smelling, mucous like, greasy, or poorly formed Frequent urination Increased thirst and appetite</p> <p>Category VII Greasy or high-fat foods cause distress Lower bowel gas and/or bloating several hours after eating Bitter metallic taste in mouth, especially in the morning Burpy, fishy taste after consuming fish oils Difficulty losing weight Unexplained itchy skin Yellowish cast to eyes Stool color alternates from clay colored to normal brown Reddened skin, especially palms Dry or flaky skin and/or hair History of gallbladder attacks or stones Have you had your gallbladder removed?</p> <p>Category VIII Acne or unhealthy skin Excessive hair loss Overall sense of bloating Bodily swelling for no reason Hormone imbalances Weight gain Poor bowel function Excessively foul-smelling sweat</p> <p>Category IX Crave sweets during the day Irritable if meals are missed Depend on coffee to keep going/get started Get light-headed if meals are missed Eating relieves fatigue Feel shaky, jittery, or have tremors Agitated, easily upset, nervous Poor memory/forgetful Blurred vision</p> <p>Category X Fatigue after meals Crave sweets during the day Eating sweets does not relieve cravings for sugar Must have sweets after meals Waist girth is equal or larger than hip girth Frequent urination Increased thirst and appetite Difficulty losing weight</p>
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Category XI

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

Category XII

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

Category XIII

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

Category XIV

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

Category XV

Heart palpitations
 Inward trembling
 Increased pulse even at rest
 Nervous and emotional
 Insomnia
 Night sweats
 Difficulty gaining weight

Category XVI

Diminished sex drive
 Menstrual disorders or lack of menstruation
 Increased ability to eat sugars without symptoms

Category XVII

Increased sex drive
 Tolerance to sugars reduced
 “Splitting” type headaches

Category XVIII (Males Only)

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

Category XIX (Males Only)

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

Category XX (Menstruating Females Only)

Perimenopausal
 Alternating menstrual cycle lengths
 Extended menstrual cycle (greater than 32 days)
 Shortened menstrual cycle (less than 24 days)
 Pain and cramping during periods
 Scanty blood flow
 Heavy blood flow
 Breast pain and swelling during menses
 Pelvic pain during menses
 Irritable and depressed during menses
 Acne
 Facial hair growth
 Hair loss/thinning

Category XXI (Menopausal Females Only)

How many years have you been menopausal?
 Since menopause, do you ever have uterine bleeding?
 Hot flashes
 Mental fogginess
 Disinterest in sex
 Mood swings
 Depression
 Painful intercourse
 Shrinking breasts
 Facial hair growth
 Acne
 Increased vaginal pain, dryness, or itching

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?
 List the three worst foods you eat during the average week:
 List the three healthiest foods you eat during the average week:

Rate your stress level on a scale of 1-10 during the average week:
 How many times do you eat fish per 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:

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

1. Do you use any of the following?

Alcohol	if stopped recently, when?
Coffee	if stopped recently, when?
Soda	if stopped recently, when?
Sweets/refined carbs	if stopped recently, when?

2. Do you smoke cigarettes/cigars or use nicotine gum or other stimulants? Amount

3. How would you rate your stress level? (1=Low, 10=Extreme)

4. How would you rate your stress handling? (1=Poor, 10=Excellent)

5. How often do you exercise?

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						
Overly reactive Short fuse Anger						
Low mood Depression						
Low blood sugar High blood sugar						
Lowered self-esteem self-image						
Care for others before yourself						
Sadness Crying						
Trouble concentrating						
Memory difficulties						
Fatigue Anemia						
Increased appetite Constant hunger						
Sweet cravings Carbs Chocolate						
Caffeine Stimulant cravings						
Salt cravings						
Headaches Migraines						
Muscle pain Joint Aches Backache						
Weight gain Trouble losing weight						
Weight loss						
Water retention						
Bloating Belching Gas						
Stomach burning Nausea Indigestion						
Constipation						
Light colored stool						
Loose stool Diarrhea IBS						
Acne Rashes Brown spots						
Excessive facial hair Body Hair						
Body hair loss Head hair loss						
Infertility						
Lowered libido Heightened libido						
Hot flashes Night sweats						
Palpitations						
Breast tenderness Breast cysts						
Nipple discharge						
Vaginal infections Yeast infections						
Urinary Frequency Incontinence Infections						
Dry eyes Dry skin Overall dryness						
Changes to labia Clitoral tissue atrophy thinning discoloration itching burning						
Vaginal changes: Dryness tearing decreasing size						
Any other symptoms?						

Reproductive Health History (please fill in or select 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?
If yes, what method?
3. Are you, or have you used: oral injected patch ring hormone contraceptives?
Or used Emergency Contraception (aka “the day after” pill)?
When and for how long?
4. Are you, or have you used an IUD? _____ 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 currently using fertility or treatment?
If yes, please explain:
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? _____ If yes, what hormone(s), dosage, and for how long? (Specify dates of use)

8. Have you been pregnant before? _____ Age(s) of children: _____
Number of pregnancies: _____ Details/Complications: _____
Number of live births: _____ Details/Complications: _____
Miscarriages: _____ Details/Complications: _____
Premature births: _____ Details/Complications: _____
Cesarean births: _____ Details/Complications: _____
Stillbirths: _____ Details/Complications: _____
Abortions: _____ Details/Complications: _____
Ectopic pregnancies: _____ Details/Complications: _____
9. If you have had a miscarriage, how many weeks pregnant were you?
10. Have you had an abnormal Pap test? _____ Details/Reason: _____
Treatment and/or medication: _____
11. Have you had a vaginal infection? _____ If yes, what?
Treatment and/or medication: _____
12. Any history of... _____ Ovarian cysts? _____ Uterine fibroids?
Fibrocystic breasts? _____ Endometriosis?
Polycystic Ovarian Syndrome (PCOS)? _____ Lichen Sclerosus?
Vulvodynia?

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, and Sarah Steed, 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, and Sarah Steed, 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, and Sarah Steed, 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 your 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: Functional Medicine/NET

15 Minute Appt. \$30.00

Sarah Steed, 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 \$40

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