Men's Health History Questionnaire

Please help me to provide you with a complete evaluation by taking time to fill out this questionnaire carefully. All your answers will be held absolutely confidential. If you have questions, please ask me. If there is anything you wish to bring to my attention that is not asked on this form, please note it in the Comments section. Thank you! Sarah Steed, L. Ac.

Name: **Address:**

Birth date: **Age:** **Height:** **Weight:**

Home Phone: **Work Phone:**

Occupation: **Marital Status:**

Emergency Contact: **Relationship to you :**

Emergency Contact Phone:

Have you tried acupuncture or Chinese herbal medicine before?

Main Problem you would like to address:

How long has it been since you first noticed any symptoms?

To what extent does this problem affect your daily activities (work, sleep, eating, exercise, etc.)?

Have you been given a diagnosis for the problem by your family physician?

What types of treatment, therapy or medication have you tried for this problem?

Past Medical History:

☐Asthma	☐Hepatitis	☐Thyroid Disease
☐Cancer	☐High Blood Pressure	☐Low Blood Pressure
☐Heart Disease	☐Seizures	☐Venereal Disease
☐Diabetes	☐High Cholesterol	☐HIV/AIDS
☐Fainting Spells	☐Irregular Heartbeat	

☐Do you need antibiotics for heart disease prevention when you visit the dentist?

Accidents or significant trauma (describe):

Blood clots or Phlebitis:

Surgeries (type & year):

Allergies:

List medications you have taken in the past two months (include vitamins, herbs, drugs, etc.):

Other relevant medical history:

Family Medical History (parents, siblings, grandparents):

☐Asthma	☐Hepatitis	☐Thyroid Disease
☐Cancer	☐High Blood Pressure	☐Low Blood Pressure
☐Heart Disease	☐Seizures	☐Other
☐Diabetes	☐High Cholesterol	☐Alcoholism
☐Fainting		

Occupational stress factors (physical, psychological, chemical

Lifestyle

Describe your overall or general emotional status:

Social relationships (support network):

Do you follow a regular exercise program? No **If so, please describe:**

Describe your average daily diet: number of meals:

What do you snack on and how much?

Typical Meal:

Breakfast:

Lunch:

Dinner:

Please check any of the following habits that apply. How often and how much:

☐Alcohol: **☐Cigarette smoking:**

Coffee, tea, cola (caffeine beverages):
Cravings:
Are you generally warm or cold?
What season do you prefer?
Generally, how thirsty are you?
What temperature is your fluid preference?
Sleep patterns: How much sleep do you need?
Do you awake feeling refreshed?
Do you suffer from insomnia frequently? No **If so describe:**

Do you experience any of the following?
Tremors: **Recent weight change:** **Sweat easily:**

Poor balance bleeding or bruise easily:

Do you sigh frequently?

Do you have any areas of numbness or tingling?

Skin and Hair

Rashes	**Ulcerations**	**Hives**
Eczema	**Dry hair**	**Hair loss**
Psoriasis	**Perspiration (night sweats, etc.)**	

Head, Eyes, Ears, Nose, Throat

Dizziness **Headaches (location)**
Lack of coordination

Spots in front of eyes	**Dry eyes**	**Poor vision**	**Red Eyes**
Night blindness	**Cataracts**	**Glasses**	**Blurry vision**
Earaches	**Ringing in ears**	**Poor hearing**	
Chronic sinus drainage		**Sinus pain**	
Recurrent sore throat		**Dry Nose**	
Nose Bleeds		**Grinding teeth**	
Sores on lips, tongue or gums		**Facial pain**	
Teeth problems		**Jaw clicks**	

Cardiovascular

Irregular heartbeat	**Palpations**	**Fainting**
Cold hands or feet	**Swelling of hands or feet**	
Difficulty in breathing	**Varicose veins**	

Respiratory

Cough **Difficulty breathing when lying down?**
Shortness of breath with daily activity **Sinus drainage**
Excessive phlegm (describe):
Any other lung problems

Gastrointestinal

Describe your appetite (poor, excessive):
Do you get nauseated often?

Diarrhea	**Constipation**	**Gas**
Vomiting	**Belching**	**Abdominal distention**
Indigestion/reflux		
Bad breath	**Rectal pain**	**Hemorrhoids**

Taste in mouth (sour, bitter, sweet etc.)
Abdominal pain or cramps
Stool, bowel movement (frequency)
Any other problems with stomach or intestines

Genitourinary

Pain on urination	**Frequent urination**	**Blood in urine**
Urgency to urinate	**Unable to empty bladder**	**Kidney stones**
Decrease in flow	**Impotence**	**Sores on genitals**

Do you wake up at night to urinate (how many times)

Any other genital or urinary problems

Muscular-skeletal

Neck pain	**Knee pain**	**Foot/ankle**	**Hand/wrist**
Low back pain/soreness		**Upper back pain**	
Shoulder pain	**Hip pain**	**Muscular pain/weakness**	

Other Comments:

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

(Concent 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