David Boman, DC, CFMP, OT/L, MBA
601 Franklin Ave, Suite 4E
Waco, Texas 76701
254-307-3113
www.rootswaco.com
info@rootswaco.com

HEALTH QUESTIONAIRE FOR MEN

Personal Information

Full name _____ Name you wish to be called _____

Street Address _____

City _____ State _____ Zip _____

Phone: H) _____ W) _____ E-Mail: _____

Date of birth ____/____/____ Gender: M Insurance Company: _____

Occupation: _____ Employer: _____

Who were you referred by? _____

Person to contact in case of emergency _____ Phone _____

Primary Concern

What brings you to my office? _____

_____

_____

Date of original condition: _____ Date of most recent occurrence: _____

Was there an event that created the condition? _____

Have you had this or similar conditions in the past? _____

What makes it better? _____ Worse? _____

Is the condition getting worse? _____Constant? _____

Worse at a certain time of day?_____

Is this condition interfering with: Work? _____Sleep? _____ Activity? _____Other? _____

Please list your goals for treatment, (immediate and future), and if you are also concerned with optimizing your overall health and well-being.

_____

_____

_____

Health History

List other current health issues & problems: _____

_____

_____

List other practitioners seen, treatments, self-care activities, and results:_____

_____

_____

_____

List illness you have had not previously mentioned, if any: _____

_____

List all surgeries you have had, with dates and results: _____

_____

_____

Have you ever been in an accident or seriously injured? (if so, please describe)_____

_____

_____

Do you have any dental or TMJ problems? Y N (if so, please describe) _____

_____

Have you had your wisdom teeth or other teeth removed? Y N *Have you ever had a root canal? Y N

(if yes note which teeth) _____

List all medications, vitamins, herbs and other supplements you are now taking, the dose, and reason for taking (please bring actual bottles w/pills in with you to your appointment):

_____

_____

_____

List all medications and other substances (i.e.: foods) to which you are allergic: _____

_____

Family History

Please list age(s) and health problems (if any); if deceased, please list age at death and cause of death:

Father _____ Mother_____ Children_____

Grandparents _____ Brothers _____ Sisters_____

General

*Describe your use of: Cigarettes/Tobacco _____Alcohol _____ Other drugs_____

*Describe your present exercise habits including frequency per week, duration, and heart rate: _____

_____

_____

* How many hours per night do you sleep? ____ * Do you fall right asleep? Y N * Do you wake up feeling refreshed? Y N * Do you sleep through the night without awaking? Y N * Do you remember your dreams? Y N

* Do you snore? Y N *Do you have nightsweats? Y N * Do you have nightmares? Y N

* Do you grind your teeth at night (bruxism)? Y N * Do you have restless legs (RLS)? Y N

*When did you last receive the following (leave blank if it does not apply to you), (please remember to bring copies).

*Cholesterol or other blood tests _____

* Prostate Exam _____*Other_____

Pain Questionnaire

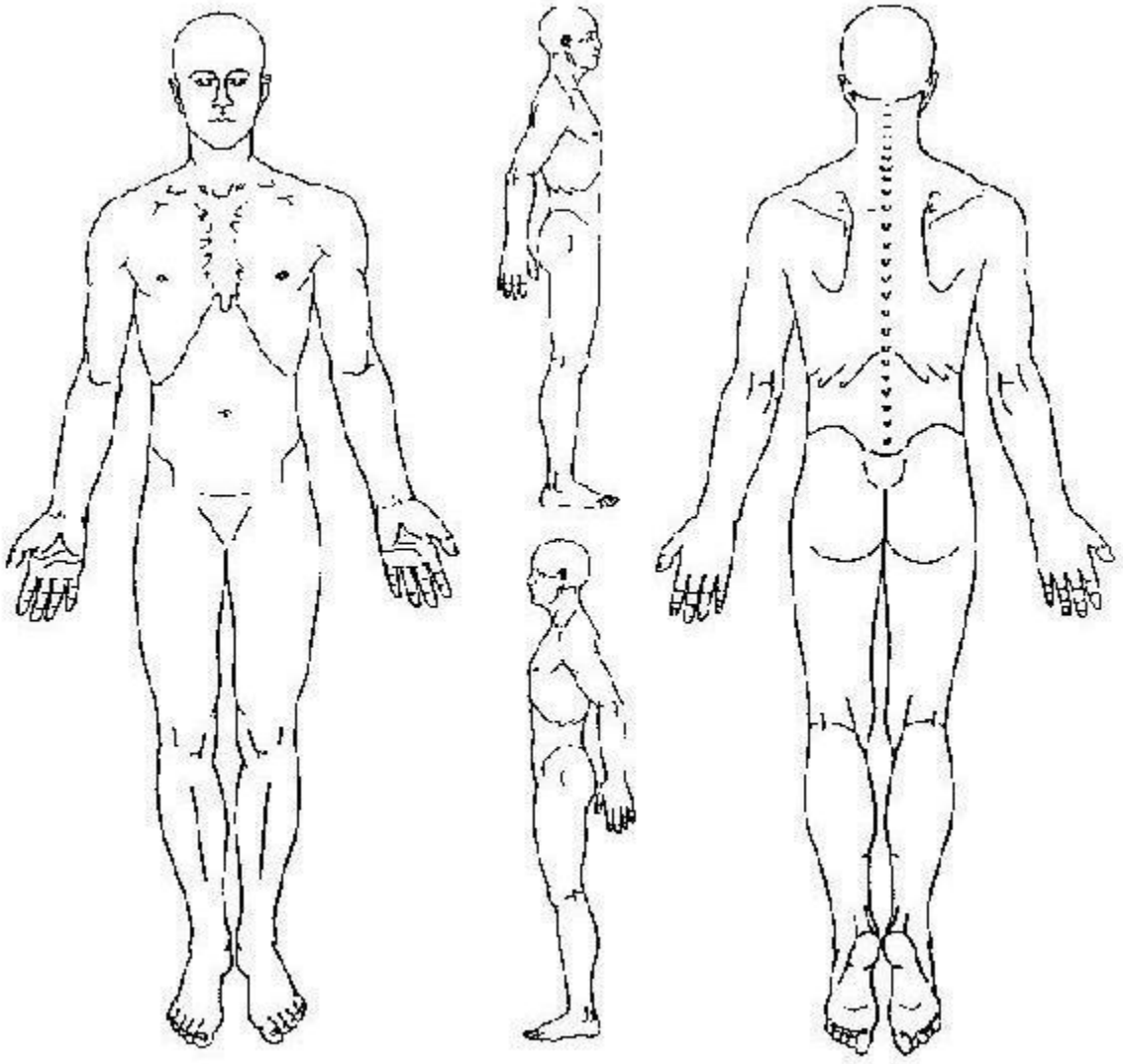
(Skip to the next section if you are not currently experiencing pain.)

Please place a single vertical line through the scale below at the point that best describes your pain. (0 is no pain, 10 is the worst pain imaginable)

0.....|.....|.....|.....|.....|.....|.....|.....|.....|.....10

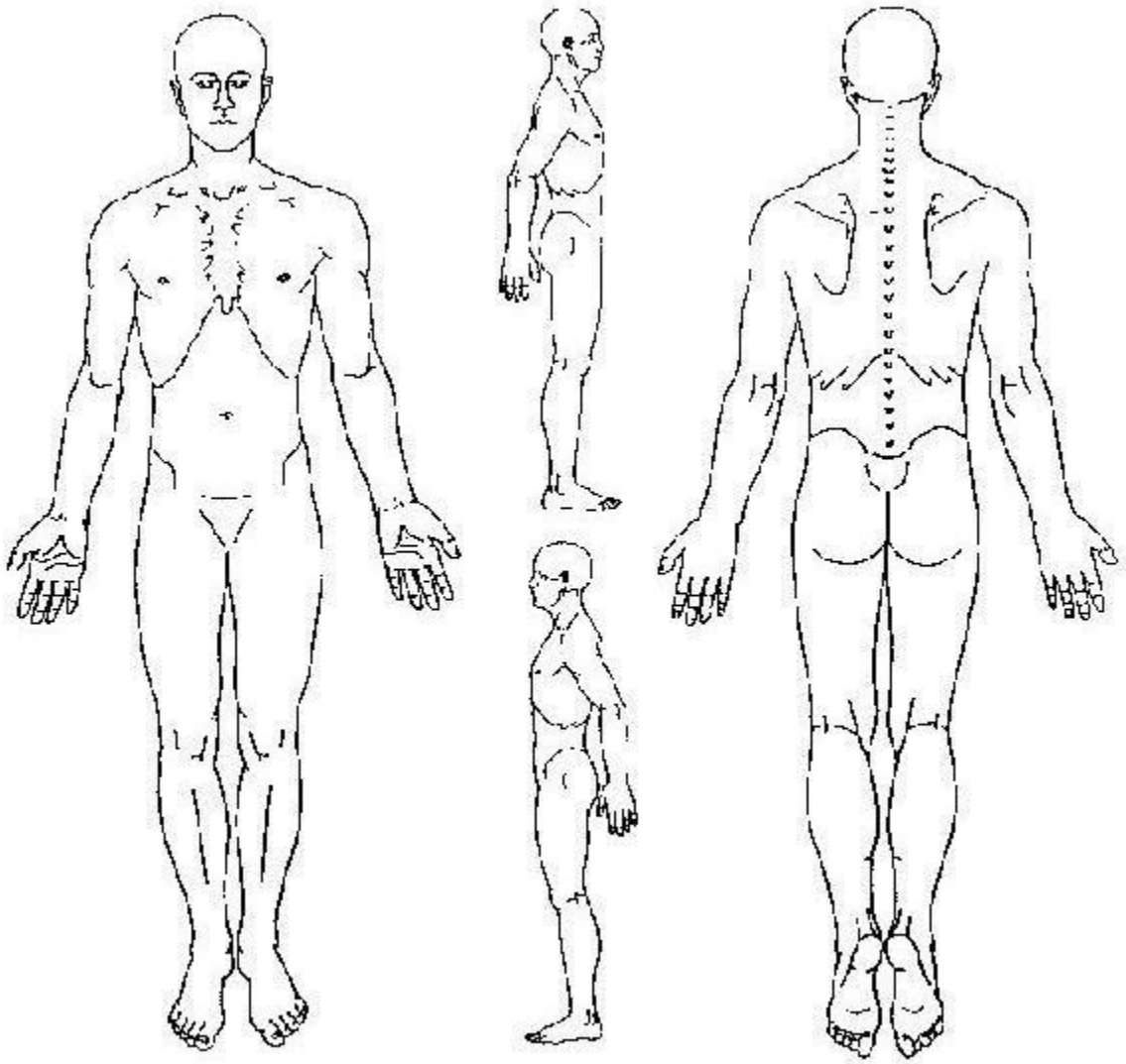
Place the letters listed below on the diagrams to indicate the type and location of your current sensations.

A = Ache	**B = Burning**	**N = Numbness**	**O = Other**
P = Pins & Needles	**S = Stabbing**	**T = Throbbing**	



History of Injury

Please mark with an "X" **all the places on your body which have ever been injured** (sprains, strains, broken bones, scars from surgeries or accidents, severe bruises, falls, etc.). Please also include any tattoos and piercings, other than ear.



SYMPTOM SURVEY

Circle the symptom if you are currently experiencing it or it is a common occurrence. Underline the symptom if it is now not a problem, but was sometime in the past, (over 3 months ago).

GENERAL

- Low energy -fatigue
- Weakness
- Fever - Chills
- Headaches
- Lack of sleep
- Reduced mental acuity

SKIN

- Dry skin
- Itching
- Varicose veins
- Cold or canker sores/fever blisters
- Boils
- Hives
- Rashes
- Sores
- Change in your skin/nails

EYES

- Cataracts/Glaucoma
- Eye pain
- Double vision
- Far or near sightedness
- Flashing lights
- Spots, specks, or floaters

EARS

- Ear discharge/excessive wax
- Earaches or infections
- Hearing loss
- Ringing/tinnitus
- Vertigo/dizziness

NOSE/SINUS

- Sinus congestion
- Frequent colds/infections
- Nosebleeds

NECK

- Goiter
- Lumps
- Pain/stiffness
- Swollen glands

RESPIRATORY

- Asthma
- Bronchitis
- Cough
- Pneumonia
- Tend to hold breath
- Wheezing
- Sputum
- Trouble breathing w/exercise

CARDIAC / VASCULAR

- Arrhythmia
- Chest pain
- Heart trouble
- Murmur
- High blood pressure
- Palpitations
- Shortness of breath
- Swollen feet or lower legs
- Racing or pounding heart
- Blood clots
- Leg cramps
- Poor circulation

MOUTH/THROAT

- Bleeding gums
- Dentures
- Tooth decay
- Frequent sore throats
- Grind teeth at night
- Hoarse voice/frequent loss of voice

NEUROLOGIC

- Blackouts
- Fainting
- Numbness
- Paralysis
- Dizziness
- Tremors
- Seizures

HEMATOLOGIC

- Anemia
- Bruise easily

ENDOCRINE

- Diabetes
- Excessive thirst or hunger
- Excessive sweating
- Lack of sweating
- Heat or cold intolerance
- Thyroid problem
- Hair loss
- Dizzy when standing/rising quickly
- Excessive weight loss
- Excessive weight gain

URINARY

- Frequent urination
- Blood in urine
- Incontinence
- Painful urination
- Urinate more than once at night

GASTROINTESTINAL

- Belching
- Flatulence/gas
- Black or tarry stools
- Blood in stool
- Change in stool
- Colitis
- Constipation
- Diarrhea
- Distention
- Excessive hunger
- Heartburn
- Food intolerance
- Hemorrhoids
- Indigestion
- Nausea
- Poor appetite
- Stomach pain
- Trouble swallowing
- Vomiting

PSYCHOLOGICAL

- Anxiety
- Depression
- Insomnia / hard to fall asleep
- Nervousness
- Poor memory / forget quickly
- Violent thoughts
- Suicidal ideas
- Tend to worry

MUSCLES & JOINTS

- ☐ Arthritis
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Gout
- ☐ Trouble with/poor posture
- ☐ Chronic pain
- ☐ Pain with specific movement(s)
- ☐ Pain relieved with anti-inflammatory drugs (aspirin, ibuprofen, Vioxx, etc…)
- ☐ Pain, tenderness, or numbness in:
  - Neck
  - Shoulders
  - Arms
  - Elbows
  - Wrist/hands
  - Upper back
  - Lower back
  - Hips
  - Knees
  - Feet/ankles

SEXUAL/HORMONAL

- Prostate problems
- Hernia
- Erection trouble
- Discharge
- Premature ejaculation
- Sexually transmitted disease
- Testicular lump/pain
- Itching/rashes

DIET HISTORY

How much do you drink each day **(8oz)**: Water:____ Juice: _____ Soda Diet: ____ Soda Regular: ____

Coffee: Regular: ____ Decaf: ____ Tea: Regular:____ Tea Sweet :____ Energy Drinks/Other: _____

List oils or fats that you use in cooking: _____

Do you frequently skip meals? Y N Are you on any special diet or nutrition program? Y N
Describe: _____

Are you allergic or sensitive to any foods? Y N If yes, name the foods and describe the problem.
_____

What foods do you dislike? _____ What is/are your favorite food(s)?_____

Circle the foods you crave:
Meats Fats Sweets Salty foods Vegetables Fruits Breads Fatty foods
Spicy foods Sour foods Cereals Dairy Other individual _____

*Do you use: (circle) butter margarine shortening coconut oil Do you eat organic foods? Y N

*Do you know what partially hydrogenated fats are? Y N _____If yes, do you eat them? Y N

*Do you eat from fast food restaurants? Y N -- If yes, how often? _____

What do you usually eat for **breakfast**? _____

What do you usually eat for **lunch**? _____

What do you usually eat for **dinner**? _____

What do you usually eat for **snacks** (in between meals and/or before bed)? _____

What foods do you eat a lot of (at least once a day, every day)? _____

How many bowel movements do you have per day? _____

A Bit More ----

*Type of sport/activity/exercise routine you participate in:_____

*Hours you train/exercise average per week: _____ *Do you train by yourself or with others? (circle)

*Do you use a heart rate monitor? Y N *What type of shoes do you wear? (Name/Style) _____

* Do you wear orthotics/arch supports/or any other devices during the day or when you exercise?

_____

*Have you progressed, regressed, or plateaued in the past year? (circle)

*How many injuries (minor included) or illnesses do you suffer from per year? _____

*If applicable: When & what is your next competition you hope to participate in, or which one do you wish to "peak" for?

_____

The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation. I understand that I am responsible for all payment of fees charged in this office of services rendered.

_____ _____
Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth**: ___/___/_____

Release of Information

Initial next to your selection.

____ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

___ Spouse _____

___ Child(ren) _____

___ Other_____

___ Information is not to be released to anyone.

___ This **Release of Information** will remain in effect until terminated by me in writing.

Messages

Please call ___ my home ___ my work ___ my cell number: _____

If unable to reach me:

___ you may leave a detailed message

___ please leave me a message asking me to return your call

___ Other _____

The best time to reach me is (day)_____ between (time)_____

Please wait to sign in front of the office witness.

Signed: _____ Date: ___/___/____

Witness: _____ Date: ___/___/____

HIPAA PATIENT AUTHORIZATION FORM

We are required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to maintain the privacy of your protected health information (PHI) and to provide you with a Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your PHI, and contains a section describing your rights as a patient under the law. You have the right to review our Notice before signing this Authorization and you are advised to do so. This authorization for release of information covers the period of healthcare from _____, 20___ to _____, 20___.

The patient understands and agrees that:
The Clinic has a Notice of Privacy Practices. The patient has received, and had the opportunity to review, this Notice before signing this Authorization. The Clinic encourages all patients to review the Notice of Privacy Practices.
The Clinic reserves the right to modify the Notice of Privacy Practices to keep up with changes in the law or office practices. We will make all modifications available for review by patients.
All my medical records and protected health information may be disclosed or used for treatment, payment, or health care operations, and for certain marketing purposes. The Clinic will not receive any payment from a third party for marketing purposes in connection with the use or disclosure of your PHI.
The Clinic or its business affiliates may use your PHI to contact you with appointment reminders and educational and promotional items in the future via email, U.S. Mail, telephone, fax and/or prerecorded messages. We **WILL NOT** ever sell or "SPAM" your personal contact information.
The patient has the right to restrict the uses of his or her information, but the Clinic does not have to agree to all such restrictions.

The patient may revoke this Authorization in writing at any time and all future disclosures that require the patient's prior written authorization will then cease. See the Notice of Privacy Practices for additional details.
The Clinic may not condition your treatment or payment on whether you sign this Authorization.
Information used or disclosed pursuant to this Authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

The Authorization was signed by:

Printed Name – Patient or Representative _____

Signature _____ Date_____

Relationship to Patient
(if other than patient) _____

Witness: _____

Printed Name – Clinic Representative

_____ _____
Signature Date