# Wellness Consultation Policies

**Cancellation Policy**: There is a $50 charge for cancellations of less than 24 hours or failure to show up for a scheduled appointment.

**Email Policy**: Email may be used for answering brief clarifying questions at your practitioner's discretion. If you are emailing about a new or more detailed concern, you will be asked to schedule a phone or office consultation to ensure effective communication and comprehensive care.

Costs of any laboratory tests are paid directly to the lab and do not include the fee for follow-up consultation to discuss the results.

## Consultation Fees:

| Practitioner | 90 minutes | 60 minutes | 30 minutes | 15 minutes |
|---|---|---|---|---|
| PharmD, DC, or ND | $195 | $145 | $85 | $30 |
| Classical Homeopath, CCN, L.Ac., MS, RD, or RN | N/A | $110 | $75 | N/A |
| ACN, Ayurvedic, Certified Herbalist, NA, or LMT | N/A | $85 | $55 | N/A |
| Chiropractic Adjustment | $40 per visit | | | |

# HIPAA 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.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, 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, to pay your health care bills, to support the operation of the physician’s practice and any other use required by law.

<u>Treatment</u>: 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 of management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that physician has the necessary information to diagnose or treat you.

<u>Payment</u>: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health care plan to obtain approval for the hospital admission.

<u>Healthcare Operations</u>: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students 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 indicated your physician. We may also call you by name in the waiting room when

your physician 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 may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health Issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; 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.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information**. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled 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.

**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 state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to 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 contact of your complaint. **We will not retaliate against you for filing a complaint**.

This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Austin's Favorite Pharmacy

# Privacy Notice Acknowledgement Form

The Federal Health Insurance and Portability and Accountability Act (HIPAA) regulates how health care providers may use and disclose health information, and also requires that patients be notified of the provider's privacy practices.

I, __________________________ (*Printed Name of Patient or Patient's Representative*), acknowledge receipt of the "Privacy Notice Acknowledgement Form" and "Wellness Consultation Policies".

__________________________________________ ______________________

Signature (*Patient or Patient's Representative*) Date

# Wellness Consultation Consent Form

I hereby understand, agree, and attest to the following:

1. I fully understand that the Wellness Consultant I am seeing in this office is not a physician, and I am not consulting for medical, diagnostic, or treatment procedures. The appointments do not involve the diagnosing, prognosticating, treating or prescribing of medicines or the treatment of disease, or any act which will constitute the practice of medicine in this state, for which a license is required.

2. Since the Wellness Consultant is not a medical doctor or primary care physician, it is recommended that I continue services with my primary care physician.

3. The services offered by the Wellness Consultant are at all times restricted to helping me gain a better understanding of 'health' (not disease), so that I will have greater self-awareness and be able to use a self-care plan for daily living.

4. The wellness plan offered (which may include discussion and or sale of nutritional supplements, nutrition and lifestyle modifications, homeopathic remedies, vitamins, minerals, food grade herbs, and other dietary supplements) pertains to the whole body concept of nutrition rather than addressing a specific ailment or condition.

5. The Wellness Consultant does not provide emergency or after-hours care. In the event of an emergency, I will dial 911 or proceed to the nearest emergency room.

6. Laboratory testing may be conducted for screening purposes only and does not constitute a diagnosis of any medical condition. It is my responsibility to follow up with a medical doctor if any of the lab results are abnormal.

7. Women who are pregnant or planning pregnancy must inform their Wellness Consultant, as this will likely alter the recommendations that are made.

8. Since they are not prescribing physicians, the Wellness Consultants will not be able to advise me to discontinue or change doses of my medications. I am advised to consult with my prescribing physician concerning any modifications of my pharmaceutical medications.

9. Potential benefits of following a wellness plan include health optimization, symptomatic relief, and disease prevention. Potential risks include rare allergic reactions, paradoxical reactions to supplements (example: valerian is a relaxing herb for most people, but it is stimulating in some people), and drug-supplement interactions. Although there is a growing body of information regarding such interactions, I understand that not all drug-supplement interactions are known at this time.

10. There are wide individual differences in response to a wellness plan, and no guarantees are made that I will gain any benefit nor suffer any adverse consequences.

11. While I may experience immediate benefits from the wellness plan, I understand that the most effective results will occur when I make a long-term commitment to rebuild my health, which will likely involve some lifestyle modifications.

__________________________________________ __________________________________________

Signature of Client or Client's Representative: Printed Name of Client or Client's Representative:

Phone Number:(__________)_________-_______________ Date: ____________________________

Referred By: _______________________________________

PEOPLES Rx
Austin's Favorite Pharmacy
*Wellness Center*

**List any Allergies or Reactions to Medications:**

______________________________

______________________________

______________________________

**List any Food Allergies or Reactions:**

______________________________

______________________________

______________________________

## GENERAL HEALTH QUESTIONNAIRE

***Please Print***

Date: __________ I prefer to be contacted by: ____ home phone ____ cell phone _____ email

Mr. / Mrs. / Ms.: ______________________________
First Last middle

Address: ______________________________
street city state zip

Home Phone: __________________ Cell Phone: __________________

Email: ______________________________

Sex: _____ Age: _______ Birthdate: _____/_____/_____

Height: ______ Weight: ______ Desired Weight: ______ Frame Size: Sm Med Lg

Marital Status: M S D W Number of Children: ______ Age of Youngest: ____________

Occupation: __________________ Employer: __________________

Is your lifestyle/occupation: Strenuous ____ Moderate ____ Light ____ Sedentary ____

Do you drink alcohol: _____ How much/how often: ____________ How many years: _____

Do you smoke: _____ How much/how often: ______________ How many years: ______

If quit, when: ________ Years smoked: _______ How much/how often: ______________

Blood Type: _____ A _____ B _____ AB _____ O How did you hear about us? ____________

Primary reason you came to us for analysis: ______________________________

Please list any major surgeries (what and when): ______________________________

______________________________

______________________________

What have you been medically diagnosed as having: ______________________________

______________________________

______________________________

16-1

L.I.F.E.
LaValle Institute For Education

Health Appraisal Questionnaire

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Blood and/or urine test in last year: YES NO If no, most recent date: _______________

Please bring a copy of the results to your first visit. Testing may be required if you have not had recent testing.

**Current Medical Doctor: ____________________ Office Phone: ____________________**

| Condition | Yourself | Age at Diagnosis | Family Members Diagnosed | Age at Diagnosis/Indicate if deceased |
|---|---|---|---|---|
| High blood pressure | | | | |
| Heart Disease/attack<br>High Cholesterol | | | | |
| Per. Vascular Disease | | | | |
| Stroke | | | | |
| Thyroid | | | | |
| Adrenal Fatigue | | | | |
| Diabetes (specify type) | | | | |
| Asthma/Lung Disorders | | | | |
| Tuberculosis | | | | |
| Arthritis (please specify) | | | | |
| Lupus | | | | |
| Drug or alcohol addiction | | | | |
| Mental illness (please specify) | | | | |
| Dementia or Alzheimer's | | | | |
| Parkinson's Disease | | | | |
| Multiple Sclerosis | | | | |
| Other neurological diseases | | | | |
| Lung Cancer | | | | |
| Breast Cancer | | | | |
| Ovarian Cancer<br>Colorectal Cancer | | | | |
| Celiac or Food Allergies | | | | |
| Communicable Diseases/STDs (please specify) | | | | |
| Other: | | | | |
| Other: | | | | |
| Other: | | | | |
| Other: | | | | |

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**INSTRUCTIONS: Place a check mark by each of the following items that apply.**

***medications you take:***

___Acetaminophen
___Antacids
___Antibiotic/Antifungal
___Antidepressant
___Antidiabetic/Insulin
___Aspirin
___Chemotherapy
___Cortisone/ NSAIDs/ Anti-inflammatories/
___Heart Medications
___High Blood Pressure
___Hormones
___Laxatives
___Lithium
___Oral Contraceptives
___Prostate
___Radiation
___Recreational Drugs Specify___________
___Relaxants/Sleeping Pills
___Thyroid
___Ulcer Medications
Other (list)_____________
______________________

***you eat, drink, or use:***

___Carbonated Beverages
___Tea, caffinated
___ Water, distilled
___ Water, tap

___Meat with Nitrates/Nitrites
___Margarine
___Saccharin
___Aspartame

___Chew Tobacco
___Smoke Pipe

___Antiperspirants with aluminum
___Hair dyes containing lead

***you:***

___Diet often

___Do not exercise regularly

___Salt food without tasting

___Are under excessive stress

___Are exposed to chemicals at work

___Are exposed to cigarette smoke

___Live within 10 miles of an industrial plant

___Live in an area high in EMFs (within 1/4 mile of an electrical transformer or distribution center)

In the following categories, please indicate symptoms, and intensity:

| Issue | Symptoms | Mild | Moderate | Severe |
|---|---|---|---|---|
| Energy | | | | |
| Sleep | | | | |
| Skin Issues | | | | |
| Gastrointestinal/Digestion | | | | |
| Pain | | | | |
| Focus/Memory | | | | |
| Neurological | | | | |
| Hormonal (i.e. hot flashes, vaginal dryness, low libido, dry skin/hair) | | | | |
| Emotional (anxiety, apathy) | | | | |
| Other: | | | | |


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# Nutrition Assessment

**Sex:** ____ male ____ female
**Pregnant:** ____ no ____ yes **Nursing:** ____ no ____ yes

## Dietary & Nutritional Information

**How often do you eat the following foods? (indicate daily (D), weekly (W), occasionally (O) (Rarely (R)**

______ Fast food
______ processed meats (lunch meats)
______ Refined flour (breads/baked goods)
______ High-fat dairy products
______ Alcoholic beverages
______ Caffeine
______ Refined sugars/sweets
______ Fried foods
______ Red meat

**How many servings of the following foods do you consume daily?**

______fruits (½ cup canned, 1 cup raw or 1 med size fruit)
______vegetables (½ cup cooked or canned, 1 cup raw)
______whole grain products (whole wheat, whole grain oats, brown rice, etc)
______dairy products (milk, cheese, yogurt)
______water

**Please indicate always (A), sometimes (S), never (N) to the following items:**

______I eat when I'm hungry
______I eat when I'm stressed
______I eat when I'm bored
______I have a difficult time deciding what to eat
______I'm not certain if some foods I'm eating are healthy
______I usually overeat
______I don't eat enough
______I don't feel that I get enough food
______I feel physically hungry
______I wake at night to eat
______I consume 50% or more of my calories during the evening

**Foods allergies or intolerances: (Please indicate food and reaction to that food)**

______________________________________________________________

______________________________________________________________

______________________________________________________________

______________________________________________________________




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**Food dislikes: (please list foods that you do not like to eat)**

______________________________________________

______________________________________________

______________________________________________

**What is your typical day's food and beverage intake (please indicate time of meal, foods eaten and serving size):**

Breakfast:_____________________________________

______________________________________________

______________________________________________

______________________________________________

Lunch:________________________________________

______________________________________________

______________________________________________

______________________________________________

Dinner:_______________________________________

______________________________________________

______________________________________________

______________________________________________

Snacks:_______________________________________

______________________________________________

______________________________________________

______________________________________________

Weekly exercise regimen, if any (describe):______________

______________________________________________

______________________________________________

______________________________________________



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***Please List ALL Current Prescription Medications***
***supplements & over the Counter Medications (Including aspirin, ibuprofen, etc.)***
***Please list prescription medications first, OTC second and finally supplements.***

| Medication | Dose | Frequency | Reason Why | Date Discontinued |
|---|---|---|---|---|
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L.I.F.E.
LaValle Institute For Education


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You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled 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.

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 o 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 state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician 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. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. 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 alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. 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.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to 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 contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Austin's Favorite Pharmacy

Austin's Favorite Pharmacy

## Acknowledgement of Receipt of Privacy Practices

By signing this document, I acknowledge that I have read the copy of the Peoples Wellness Center and affiliated entities notice of privacy practices posted at the front desk.

______________________________________________

**Print Name**

______________________________________________

**Signature**

**Date:** ______________________

I hereby give my consent for Peoples Wellness Center and Affiliated Entities to release my protected health information to the following family members.

____________________________ Relationship to Patient______________
____________________________ Relationship to Patient______________
____________________________ Relationship to Patient______________
____________________________ Relationship to Patient______________
____________________________ Relationship to Patient______________

______________________________________________

**Print Name**

______________________________________________

**Signature**

**Date:** ______________________

***OFFICE USE ONLY***

Date Acknowledgement Received:______________________________

**-OR-**

Reason acknowledgement was not obtained: ______________________

______________________________________________

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# Integrative Health and Medicine Wellness Consultations Waiver

I fully understand the attending consultants are not allopathic doctors (M.D.'s) and do not pretend to be, but are health and wellness consultants. I fully understand the difference between the practice of allopathic medicine and wellness consulting.

I fully understand the services provided by the attending consultants are not allopathic, but holistic or naturopathic in nature. I fully understand the attending consultants perform their services within the parameters of a natural health care and wellness system.

I fully understand the attending consultants do not offer allopathic drugs, surgery or chemical stimulants or radiation therapy. I understand, too, that illness is not being diagnosed nor treated and that my wellness is being measured and increased.

I have solicited the attending consultants' services in good faith, exercising my free will and following the dictates of my own conscience which allows me to select what I understand is most beneficial to my health.

I presently seek counsel, advice, opinions, points of view and/or programs within the scope of the attending consultants' wellness practice. However, should I desire any services not provided by nor within the scope of the attending consultant's wellness practice, which is my prerogative, I fully understand I should seek them elsewhere.

I fully understand the attending consultants are in no way encouraging me to terminate any previous and or current therapies other doctors have started.

I understand these consultants are not diagnosing, nor treating diseases, but are providing information and supplements to restore natural balance and optimum function for health and wellness.

If I am accompanied by and am signing for a minor or incompetent, I give full faith that I am legally and totally responsible.

I understand the ZYTO technology does not diagnose or treat. It is a screening tool designed to gain a better understanding of my degree of "health" (not disease), so I will have a greater self-awareness and be able to use a self-care program for daily living.

I give full faith that I have read and understand this document entirely and that I have received a verbal explanation of the same from the attending consultants and they have satisfactorily answered all of my questions and or doubts.

I am willing and prepared to declare and repeat under oath all of the above statements at the attending consultants' request.

Client's Name: ______________________________________________
(please print)

Client/Responsible Party Signature: ______________________________________

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**Austin's Favorite Pharmacy**

## Office Policies

Dear Patients:
In order to make your experience here as enjoyable and easy as possible we are implementing the following policies, effective immediately:

1) **Appointment Cancellation:** 24-hour notice of appointment cancellation is necessary to serve you in the most efficient way possible and to make sure that appointments are available when you need them. To help with this situation, we are instituting a $25.00 "No Show Fee" for which you will be billed, should you fail to cancel your appointment within 24 hours.

2) **Return phone calls:** Our providers are seeing numerous patients during the day so it can be difficult for them to return phone calls during regularly scheduled patient hours. We ask that you allow up to 24 hours for us to return your phone calls with the exception of weekends and emergencies. If you are experiencing a life-threatening situation, please call the emergency room for immediate assistance.

3) **Late arrivals:** Patients arriving late for their scheduled appointment will be seen as soon as possible. However, should another patient with a scheduled appointment arrive at the same time, they will be seen first.

4) **Test kits:** The cost of testing goes to the laboratories and does not include the follow-up visit, which is necessary to interpret results and adjust your plan moving forward. This visit will be billed at your practitioner's regular rates. Testing may or may not be covered by insurance. Any insurance questions should be directed to your insurance carrier. We do not offer any insurance billing services. Test kits are only sold to current patients to ensure proper care and follow up.

5) **Meet & Greet Visits:** Meet & Greet appointments are a great way to see if you are a good fit with a practitioner before you pay for an initial visit. This visit does not make you a patient and will not include any suggestions or plans for your condition, although testing may be recommended before scheduling your initial consultation.

If you have any questions, please address them to our staff during regular office hours. Thank you for your cooperation and patience.

I, ______________________________, have read and understand the above policies.

______________________________ ______________________________

Signature Date

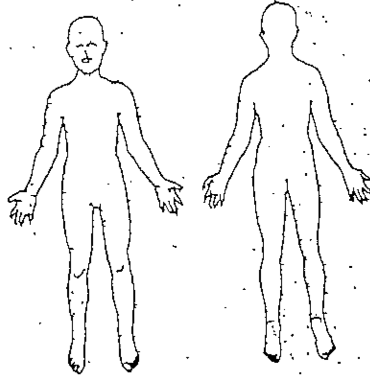
Peoples Wellness Center
13860 US 183 N., Suite C
Austin, Texas 78750
P: 512.219.8600 F:512.219.6770
www.peoplesrx.com

For "Changes ___" ... the doctor what you **can** or **cannot DO** th... ...at from your last visit.
(For example: sleep better, sit ... longer periods of time, jog without pain, etc.)

Indicate your pain level from **1 - 10** ("1" = minor pain. "10" = extreme pain). **Please use a different number for each different p...** the body marked on the body diagrams at each visit.

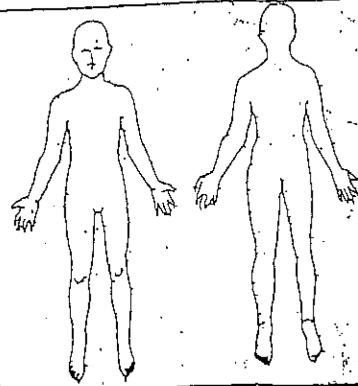
At each visit, circle whether you are **B** (Better) **S** (Same) or **W** (Worse) OVERALL since the beginning of treatment.

Date ___ **B S W**
Any new injury since last visit? ___
Any questions for the doc? ___
Changes: ___



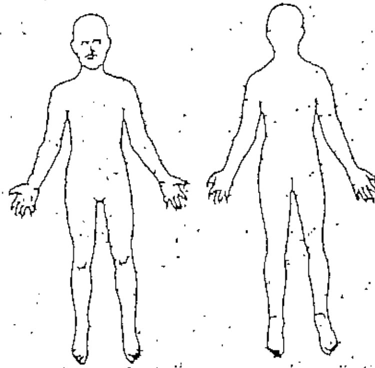
Visit # ___ of ___

Date ___ **B S W**
Any new injury since last visit: ___
Any questions for the doc? ___
Changes: ___



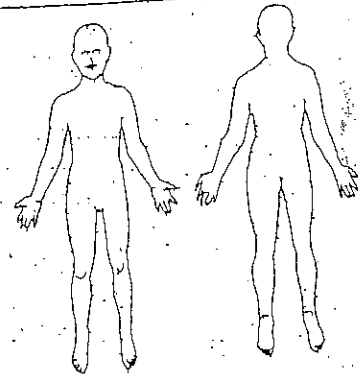
Visit # ___ of ___

Date ___ **B S W**
Any new injury since last visit? ___
Any questions for the doc? ___
Changes: ___



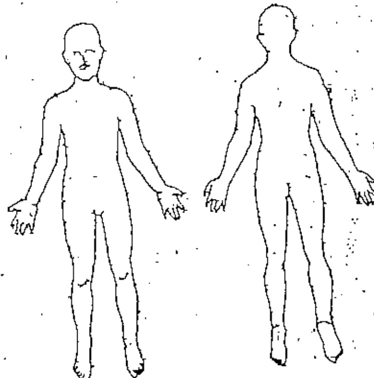
Visit # ___ of ___

Date ___ **B S W**
Any new injury since last visit? ___
Any questions for the doc? ___
Changes: ___



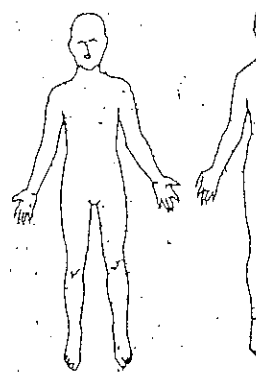
Visit # ___ of ___

Date ___ **B S W**
Any new injury since last visit? ___
Any questions for the doc? ___
Changes: ___



Visit # ___ of ___

Date ___ **B S W**
Any new injury since last visit? ___
Any questions for the doc? ___
Changes: ___



Visit # ___ of ___

Austin's Favorite Pharmacy

**Wellness Center**

List any Allergies or Reactions to Medications:

______________________________
______________________________
______________________________

List any Food Allergies or Reactions:

______________________________
______________________________
______________________________

## GENERAL HEALTH QUESTIONNAIRE

*Please Print*

Date: __________ I prefer to be contacted by: _____ home phone _____ cell phone ______email

Mr. / Mrs. / Ms.: ______________________________
First Last middle

Address: ______________________________
street city state zip

Home Phone: ____________________ Cell Phone: ____________________

Email: ______________________________

Sex: ______ Age: ________ Birthdate: _____/_____/_____

Height: _______ Weight: _______ Desired Weight: _______ Frame Size: Sm Med Lg

Marital Status: M S D W Number of Children: _______ Age of Youngest: ___________

Occupation: ____________________ Employer: ____________________

Is your lifestyle/occupation: Strenuous _____ Moderate _____ Light _____ Sedentary _____

Do you drink alcohol: ______ How much/how often: ____________ How many years: ______

Do you smoke: ______ How much/how often: ______________ How many years: ______

If quit, when: __________ Years smoked: ________ How much/how often: ____________

Blood Type: ______ A _____ B ______ AB ______ O How did you hear about us? ___________

Primary reason you came to us for analysis: ______________________________

Please list any major surgeries (what and when): ______________________________

______________________________

______________________________

What have you been medically diagnosed as having: ______________________________

______________________________

______________________________

Health Appraisal Questionnaire

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# Detailed Case History

**We are glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you. We want your visit with us to be comfortable, helpful, and educational.**

confidential health information

clinic id | date

## 1 PATIENT INFORMATION

last name | first name | m.i.

age | date of birth | sex ☐ male ☐ female

## 2 HEALTH COMPLAINTS

Are you here because you were injured while working, in a motor vehicle collision, or in another accident? ☐ yes ☐ no

What is the reason for your visit?

If you have a **primary** complaint, please complete all questions related to the **primary** complaint.

How long have you been experiencing this **primary** complaint?

How does the **primary** complaint feel? ☐ dull/achy ☐ sharp ☐ numb ☐ tingling ☐ burning ☐ cold

How often do you experience the **primary** complaint? ☐ constantly ☐ daily ☐ weekly ☐ monthly ☐ yearly

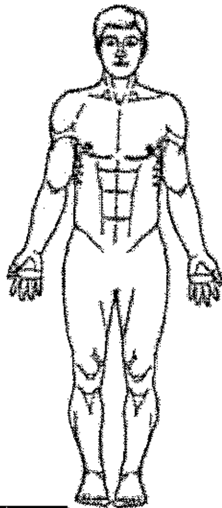
Using the scale below, rate how your **primary** complaint affects your life. (mark only one box below)

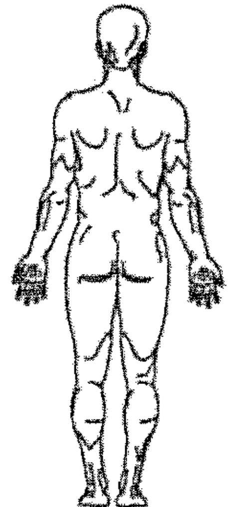
- [1] no pain or discomfort
- [2] slight discomfort
- [3] pain that does not affect my activity
- [4] pain that affects my daily activities
- [5] pain that prevents performing my daily activities
- [6] pain that limits my work schedule
- [7] pain that prevents working at all
- [8] pain that prevents working and all personal activity
- [9] pain that that keeps me bed ridden
- [10] pain that causes thoughts of suicide

If you have missed work because of your **primary** complaint, what was your last day of work?

What do you believe is causing your **primary** complaint?

Please mark the areas of all of your primary complaint on the diagrams to the right. Include any descriptors or comments, that were not mentioned above.





## 3 PERSONAL HISTORY

Mark the following conditions as they pertain to you.

| condition | | | condition | | | condition | | | condition | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| joint instability | ☐ yes | ☐ no | unstable fractures | ☐ yes | ☐ no | spinal bone tumors | ☐ yes | ☐ no | bleeding disorders | ☐ yes | ☐ no |
| bone demineralization | ☐ yes | ☐ no | vertebral column infection | ☐ yes | ☐ no | vertebrobasilar insufficiency | ☐ yes | ☐ no | cauda equina syndrome | ☐ yes | ☐ no |
| artery aneurysm | ☐ yes | ☐ no | loss of sensation | ☐ yes | ☐ no | joint disease | ☐ yes | ☐ no | malignancy | ☐ yes | ☐ no |
| neurological deficit | ☐ yes | ☐ no | HIV positive | ☐ yes | ☐ no | vascular disease | ☐ yes | ☐ no | stroke sign/symptom | ☐ yes | ☐ no |

## 4 LIFESTYLE & HABITS

| | | | | | |
|---|---|---|---|---|---|
| How often do you exercise? | ☐ never | ☐ 1x/week | ☐ 2x's/week | ☐ 3x's/week | ☐ NA |
| How long do your exercise workouts last? | ☐ >1 hour | ☐ 1 hour | ☐ 30 minutes | ☐ < 30 minutes | ☐ NA |
| How often do you use tobacco? | ☐ never | ☐ daily | ☐ weekly | ☐ monthly | ☐ yearly |
| How many servings of alcohol do you drink each week? | | ☐ 0 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many servings of coffee do you drink each week? | | ☐ 0 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |
| How many servings of soda you drink each week? | | ☐ 0 | ☐ 1-2 | ☐ 3-5 | ☐ >5 |

## 5 INJURIES

List any **auto collisions** that you were involved in , either as the driver or passenger, below. Begin with the most recent.

| type of collision | type of treatment received | date of collision |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

List any **job, sports, or other injuries** that you experienced, below. Begin with the most recent.

| type of injury | type of treatment received | date of injury |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |

## 6 HOSPITAL / MEDICINE

Have you had breast implant surgery? ☐ yes ☐ no

Have you had knee or hip replacement surgery? ☐ yes ☐ no

Do you have a pacemaker? ☐ yes ☐ no

Do you have any other implantable medical devices in your body? ☐ yes ☐ no

Have you ever had a lapse of memory? ☐ yes ☐ no Were you ever knocked unconscious? ☐ yes ☐ no

List any broken bones or dislocations that you had.

List any surgeries that you had.

Have you ever had a spinal tap or spinal injection? ☐ yes ☐ no

## 7 FAMILY HISTORY

Mark the following conditions as they pertain to your immediate family. n=never p=previously c=currently

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| cardiovascular disease | n p c | mother | n p c | father | n p c | brother | n p c | sister |
| diabetes | n p c | mother | n p c | father | n p c | brother | n p c | sister |
| cancer | n p c | mother | n p c | father | n p c | brother | n p c | sister |
| stroke | n p c | mother | n p c | father | n p c | brother | n p c | sister |

I understand and agree to the following:

- A history, consultation, examination, and x-rays are conducted for diagnostic and informational purposes and I am requesting these services
- It is my responsibility to complete the clinic's forms accurately
- It is my responsibility to notify the doctor if any of my information has changed or requires updating
- Original x-rays are the clinic's property and copies of the original film(s) and report(s) will be released to me upon written request

patient or guardian signature

date

# Your Informed Consent

Although Chiropractic is reported to be the safest health care system in the world, some say there are very slight risks associated with it. We feel that is it responsible to let you know the following:

1. Risk of stroke is reported to be 1 in 5 to 8 million or so…
   and the cause has yet to be determined.

2. While extremely rare, there have been reports of ligament sprains and even rib fractures reported.

3. There have been rare reports of disc injuries although no clinical scientific study has ever demonstrated chiropractic care to be the cause.

Chiropractic care has been proven to be both clinically effective and very cost effective. The risk of injuries and complications is so small that chiropractors carry the lowest malpractice insurance premiums of all the health care professionals in the world.

Compared to traditional medical/drug/surgical care, which has a yearly death rate of approximately 200,000 people in America, Chiropractic is an extremely safe health care system.

I have read and understand the above consent, and have had the opportunity to discuss it with my chiropractor.

I consent to the care recommended by my chiropractor. This consent applies to all present and future care for me and my family.

Your Name: ______________________________ Date: __________