

BACK TO HEALTH

CHIROPRACTIC

25 W. Lincoln Ave. Charleston, IL 61920 (217) 345.9600 FAX (217) 345.3045

WELCOME TO OUR OFFICE

In compliance with Federal and State Consumer Protection and Informed Consent Laws, we present the following basic outline of usual and customary procedures and fees.

OFFICE FINANCIAL POLICY: Our policy is to extend you the courtesy of allowing you to assign your insurance benefits directly to us. This policy reduces your out-of-pocket expenses and allows you to place your family under care.

If you do not have insurance: All payments are expected at the time of service or by an authorized payment plan. Your personal balance may not exceed \$100 at any time or care may be terminated. Our payment plans make care an affordable part of your budget.

If you have insurance: All deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed \$100 or care may be terminated. Our payment plans make care an affordable part of your family budget.

You are considered a cash patient until you bring in your completed insurance forms, and we qualify and accept your insurance coverage. We do not accept assignment for secondary insurance carriers, but will be happy to provide you with a claim form for your secondary carrier.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card to collect full payment.

When your schedule of visits is once a month or longer, you will not be eligible for Insurance assignment. Charges for services rendered will be due as they are rendered. We will continue to provide you with an insurance claim form.

If you discontinue care for any reason other than discharge by the doctor, all balances will become immediately due and payable in full by you, regardless of any claim submitted.

For your convenience, you may retain your credit card number on file with us.

Card # _____
Expiration Date _____ Name as it appears on card: _____

Treatment Permission: I give permission to Dr. Schuster to administer treatment and perform such general procedures, as he deems necessary in the diagnosis and treatment of my condition. Any risk regarding care will be explained to me upon my request.

Payment Responsibilities: I understand that I am personally responsible for all charges whether or not paid by any third party. I agree that all charges are payable, collectible, and prosecutable in Coles County and that if I do not make payment on my account after it is 90 days past due, the account may be turned over for collections and I may be charged the cost of collections. I agree to pay all reasonable costs incurred to collect the debt. This includes, unless prohibited by law, all reasonable attorney's fees, filing fees, court costs, collection agency fees or contingencies, service fees, and other related collection costs or contingencies. This provision also shall apply if I file a petition or any other claim for relief under any bankruptcy rule of law of the United States, or if another files such petition or other claim for relief against me. All portions of any bill sent me by Back to Health Physician's Group, LTD shall be assumed valid unless disputed in writing within 30 days of receiving the bill.

Assignment of Right to Payment/Lien Against Benefits: I hereby authorize Back to Health Physician's Group, LTD to file my claim. I assign them my right to receive any and all payments or recoveries from any insurance company, attorney, or third party for professional services rendered by Back to Health Physicians Group, LTD. I convey a lien against any funds and authorize and direct any third party to withhold sums from any benefits, judgments, verdict, settlements, or recoveries, and to adequately protect and to make payment for these services directly to Back to Health Physician's Group, LTD pursuant to this assignment and lien.

Assignment of Cause of Action: In the event that any insurance company or other third party that may be obligated to make payment to me or to Back to Health Physicians Group, LTD, for the charges made for services, refuses to make such payment upon demand, I hereby assign, transfer, and convey to Back to Health Physicians Group, LTD, the cause of action that might exist in my favor against any such company or person. I authorize Back to Health Physicians Group, LTD, to prosecute said action either in my name or their name to collect fees due for care rendered at Back to Health Physicians Group, LTD, and legal expenses and to resolve said claims as they see fit.

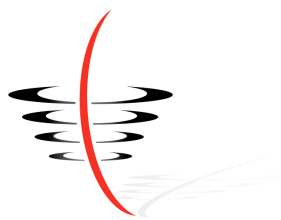
Authorization to Process Draft: I agree that Back to Health Physicians Group, LTD, shall be appointed as my agent to endorse drafts or sign my name on checks for payment of my bill for services rendered.

Limited Release of Medical Information: I authorize Back to Health Physicians Group, LTD, to make inquiries and to release any pertinent information to any insurance company, adjuster, or attorney to facilitate collection under these assignments.

Signature: _____ DATE: _____

This is NOT a consumer credit transaction. Dr. Schuster is DBA/Back to Health Physicians Group.

Witness: _____ DATE: _____



BACK TO HEALTH
CHIROPRACTIC

RECORD RELEASE AUTHORIZATION

DOCTOR/HOSPITAL: _____

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORDS TO:

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

Patient's Signature

Date

Patient's Name (Please Print)

Parent/Guardian Signature (If patient under 18 yrs old)

Relationship To Patient

Witness To The Above Signatures

Please Print Name

NOTICE OF INFORMATION PRACTICES

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment, or practice operations will be made only after obtaining your consent. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days a request to do so. There may be a reasonable cost-based fee for photocopying, postage and Preparation.

You may request changes to your records. Our practice has the right to accept or deny your request.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you by mail, email or telephone for appointment reminders, announcements, and to inform you about our practice and its staff.

Our practice is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be prominently displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our Office Manager.

Patient Signature _____

Name _____ Phone _____

The effective date of this Notice of Information Practices is _____

INFORMED CONSENT TO PARTICIPATE IN ACTIVE REHABILITATION

The goals of the rehabilitation program include:

1. Determining the cause and extent of your problem.
2. Providing therapeutic exercise programs, and/or soft tissue mobilization, to strengthen you, increase your cardiovascular endurance, range of motion and flexibility, and decrease your pain.
3. Return you to full-duty, non-restricted work status and lifestyle.

ALL EQUIPMENT AND TESTS WILL BE THOROUGHLY EXPLAINED TO YOU PRIOR TO USE.

Your participation in the rehabilitation program is voluntary. You can stop at any point in the program. Should you stop your program, we are obligated to notify your doctor, insurance company, attorney, and Employer, if it is applicable.

Back To Health Physician's Group LTD is providing a course of treatment called S.A.S.T.M. (sound assisted soft tissue mobilization). Participation in this course of treatment may or may not benefit you. Benefits of participation may include improvement of your biomechanics.

There are also risks inherent in any athletic activity. These risks include muscle, joint, or ligament injury; falls which could lead to fracture bruising, cuts, or eye injuries; overuse injuries such as stress fractures, increased blood pressure, fainting, disorder of heartbeat, and in rare instances, heart attack or stroke which could result in death.

If at any point during the evaluation or rehabilitation process you have any questions, we will answer them to the best of our ability or refer you to someone more qualified.

Please be advised that there are no guarantees that your personal goals and/or those listed above will be met to your satisfaction. The success of any rehabilitation process lies in the combined efforts of you and your provider.

In consideration of permitting me to participate in this evaluation & rehabilitation program, and in full recognition and appreciation of the dangers inherent in this course of treatment to which I may be exposed during my participation, I agree to assume all of the risk and responsibility surrounding my participation in said program. I do for myself, my heirs, and my personal representatives hereby hold harmless, indemnity, release, and forever discharge Back To Health Physician's Group LTD, and all of it's directors, officers, agents, and employees from and against any and all claims, demands and actions, or causes of action, on participation and which results from causes beyond the control of and without the fault of negligence of Back To Health Physician's Group LTD, it's directors, officers, agents, or employees during my participation in this course of treatment.

Signature of Participant

Date

Signature of Witness

Date

INFORMED CONSENT FOR EXAMINATION AND TREATMENT

I (we) hereby consent to the performance of examination and treatment on me or on _____, by the licensed doctors of chiropractic, medical doctors, and/or licensed physical therapists that may be employed by or engaged in practice in this clinic.

I have the opportunity to discuss with the doctor(s) or other clinic personnel the nature and purpose of the different physical therapy procedures and chiropractic treatment (manipulation/adjustment). I understand the neither chiropractic nor medical treatment is an exact science and that my care may involve judgments based upon facts and information known to the doctor. The doctor uses this judgment to attempt to anticipate or explain risks and complications and an undesirable result does not necessarily indicate an error in judgment. No guarantee for results can be made or expected but rather I wish to rely on the doctor to choose and recommend the best course of treatment, based upon facts known, that is in my best interests.

I further understand that there are certain degrees of risk associated with chiropractic health care and physical therapy, which include rarely, but not limited to, fractures, disc injuries, strokes, and strains/sprains and therefore willing to accept and consent to the risk associated with the care that I am about to receive.

I have read, or the above information has been explained regarding consent. I have has an opportunity to ask questions about my examination and treatment. By signing below, I agree and intend this consent form to cover the procedures prescribed for my condition and for any future conditions for which I seek treatment.

Female patients ONLY:

By my signature on this form I do hereby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstruation:

Patient's Name (Print)

Patient's Signature

Date

Relationship or authority if not signed by patient

Witness (Print)

Witness Signature

Patient Basic Information

Personal Information:

Last Name: _____ First Name: _____ Middle Initial: _____ Sex: _____ SS#: _____

Address: _____ City, State, Zip: _____ DOB: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Date of Injury/Onset: _____ Other Doctor(s) that has Treated this Condition: _____ When: _____

Primary Care Physician: _____ Phone: _____ Address: _____

Insurance Information:

Policy Holder (if different than patient): _____ Policy No.: _____

How did you hear About Us? _____

Dominant Hand: Right Left Both

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. Current Symptom: (Please check off the boxes below to describe your symptom. Please check all of your current symptoms.)

<input type="checkbox"/> Headaches	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Front of head			
<input type="checkbox"/> Top of head			
<input type="checkbox"/> Back of head			
<input type="checkbox"/> Jaw	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Eye	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Neck	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Upper Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Mid Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Low Back	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Chest	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Abdomen	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Ribs	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Buttocks	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Upper Arm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Forearm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hand	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hip	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Leg	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Foot	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
Other: _____			

3. Pain Frequency

Up to 1/4 of time 1/4 to 1/2 of time

1/2 to 3/4 of time Most of the time

4. Pain Intensity (how affects daily living)

Doesn't Somewhat

Seriously Completely

5. Does the pain radiate into other body parts?

<input type="checkbox"/> Head	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Neck	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Shoulder	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Arm	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hand	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Hip	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Leg	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Foot	<input type="checkbox"/> L	<input type="checkbox"/> R	<input type="checkbox"/> B
<input type="checkbox"/> Other _____			

6. Actions affecting this pain

	Brings it on	Aggravates it	Relieves it
<input type="checkbox"/> In the A.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> In the P.M.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Fwd.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bending Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting Left	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Twisting Right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Straining	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2. Types of Pain

Dull Sharp Aching Cutting

Throb Burn Numb Tingling

Cramp Spasm Stinging Shooting

Pounding Constricting

Other _____

Other Comments:

Activities of Daily Living Assessment (Only fill in areas affected)

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty.

1 = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it all, because of the pain".

Difficulties with Self Care and Personal Hygiene Activities

Bathing____ Drying hair____ Brushing teeth____ Putting on shoes____ Preparing meals____ Taking out trash____ Showering____
Combing hair____ Making bed____ Tying shoes____ Eating____ Doing laundry____ Washing hair____ Washing face____
Putting on shirt____ Putting on pants____ Cleaning dishes____ Going to toilet____

Difficulties with Physical Activities

Standing____ Walking____ Kneeling____ Bending back____ Twisting left____ Leaning back____ Sitting____ Stooping____
Reaching____ Bending left____ Twisting right____ Leaning left____ Reclining____ Squatting____ Bending forward____
Bending right____ Leaning forward____ Leaning right____ Standing for long periods____ Sitting for long periods____
Walking for long periods____ Kneeling for long periods____

Difficulties with Functional Activities

Carrying small objects____ Lifting weights off floor____ Pushing things while seated____ Exercising upper body____
Carrying large objects____ Lifting weights off table____ Pushing things while standing____ Exercising lower body____
Carrying brief case____ Climbing stairs____ Pulling things while seated____ Exercising arms____
Carrying large purse____ Climbing inclines____ Pulling things while standing____ Exercising legs____

Difficulties with Social and Recreational Activities

Bowling____ Jogging____ Swimming____ Ice Skating____ Competitive Sports____ Dating____ Golfing____ Dancing____
Skiing____ Roller Skating____ Hobbies____ Dining out____

Difficulties with Traveling

Driving a motor vehicle____ Riding as a passenger in a motor vehicle____ Riding as a passenger on a train____
Driving for long periods of time____ Riding as a passenger on an airplane____ Riding as a passenger for long periods____

Use the following 1 to 5 scale to describe the difficulties below:

1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = "My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating____ Hearing____ Listening____ Speaking____ Reading____ Writing____ Using a keyboard____

Difficulties with the Senses

Seeing____ Hearing____ Sense of touch____ Sense of taste____ Sense of smell____

Difficulties with Hand Functions

Grasping____ Holding____ Pinching____ Percussive movements____ Sensory discrimination____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep____ Being able to participate in desired sexual activity____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- I have NOT had prior symptoms similar to my current complaints.
- My current complaints DID exist before, but had not been bothering me.
- My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- My history HAS contributed to my current symptoms.
- My history HAS NOT contributed to my current symptoms.
- I'm NOT SURE if my history has contributed to my current Symptoms.

My most recent prior similar symptoms (if applicable) occurred: _____ months ago / years ago **OR on Date:** ____/____/____

Write in below any other Prior Symptom History, not covered above:

1. Description of Accident/Injury/Onset

Enter a full description of the accident, injury or onset in the space below.

2. During and after accident details

Enter the details of your condition during and after the accident/onset.

Automobile Accident Description

Please answer the questions below. If you do not know the answer to any of the questions, do not answer that question.

Please circle your answers to the following questions.

1. Your vehicle type

- Car • Station Wagon
- Van • Pickup Truck
- Large Truck • Bus
- Other _____

2. Your position in vehicle

- Driver • Front Passenger
- Left Rear Passenger
- Right Rear Passenger
- Other _____

3. What was your vehicle doing at the time of the accident?

- Stopped at intersection • Stopped in traffic • Stopped at light
- Making a right turn • Making a left turn • Parking
- Proceeding along • Slowing down • Accelerating
- Other _____

4. Time/Speed/Damage

Time of accident _____
 Your vehicle's speed: _____ mph
 Their vehicle's speed: _____ mph

5. Details of Accident

Visibility at time of accident

- Poor • Fair • Good

Who hit who/what?

- You hit other vehicle
- Other vehicle hit you

6. Road conditions

Road conditions at time of accident

- Icy • Wet • Sandy • Dark • Clean and dry

Point of impact

- Head-On • Left Front • Right Front
- Read-End • Left Rear • Right Rear

Damage to your vehicle

- Mild • Moderate
- Totaled

You hit...(object)

7. Body Position, etc.

Does your vehicle have headrests? Yes No

Did you see the accident coming? Yes No

Were you braced for the impact? Yes No

Did you have a seat belt on? Yes No

Was your shoulder harness on? Yes No

Did driver side airbag deploy? Yes No

What was the position of your headrest at the time of the impact?

- Even with top of head • Even with bottom of head • Middle of neck

What was the direction of your head at the time of the impact?

- Facing straight forward • Turned to the right • Turned to the left

Did passenger side airbag deploy? Yes No Side airbags? Yes No

8. Additional accident information

In the case of a motor vehicle accident, enter any additional information here that is not covered by the above check offs.

9. During the accident:

Did your body strike inside of your vehicle? Yes No

If yes, describe: _____

Did you lose consciousness during the injury? Yes No

If yes, for how long? _____

Your vehicle's estimated damage? _____

Damage to their vehicle: Mild • Moderate • Totaled

Did police show up at the scene? Yes No

Was an accident report filled out? Yes No

Others: _____

10. After the accident:

Check off your symptoms following the accident:

- Headache • Dizziness • Mid back pain • Cold hands
- Neck pain • Nausea • Low back pain • Cold feet
- Neck stiffness • Confusion • Nervousness • Diarrhea
- Fainting • Fatigue • Loss of taste • Depression
- Ringing in ears • Tension • Toe numbness • Anxious
- Loss of smell • Irritability • Constipation • Chest Pain
- Pain behind eyes • Shortness of breath • Sleeping problems

12. Treatment History:

Fill in other doctor(s) seen prior to your first visit to this office.

1. Dr. _____ First visit date: ___/___/___

Specialty: _____ X-rays done? Yes No

Types of treatments received: _____

How many treatments received? ___ Currently treating? Yes No

Did treatments benefit you? Yes No

Last visit date: ___/___/___

2. Dr. _____ First visit date: ___/___/___

Types of treatments received: _____

How many treatments received? ___ Currently treating? Yes No

Did treatments benefit you? Yes No

Last visit date: ___/___/___

13. X-rays done? Yes No Lab work? Yes No

Body parts X-rayed? _____

What lab work? _____

The X-rays revealed: _____

Treatments: • Cervical Collar • Ice Other: _____

Medications: _____

Follow-up instructions: _____

FAMILY HISTORY List any of the diseases listed above which run in your family.

Relative	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Maternal Grandfather	_____	_____	_____	_____	_____
Maternal Grandmother	_____	_____	_____	_____	_____
Paternal Grandfather	_____	_____	_____	_____	_____
Paternal Grandmother	_____	_____	_____	_____	_____

SOCIAL HISTORY Circle the dot and fill in.

Current Weight _____ Have you recently lost or gained weight? _____

Mental Work: • Heavy • Moderate • Light Hours per day _____

Physical Work: • Heavy • Moderate • Light Hours per day _____

Exercise: • Heavy • Moderate • Light Hours per week _____

Smoking: • Current Packs/Day _____ • Previous No. of years _____

Alcohol: Beer/Week _____ Liquor/Week _____

Wine/Week _____ No. of Years _____

Caffeine: (Coffee, Tea, Cola) Cups/Day _____ No. of Years _____

Aspirin: No./Day _____ No. of Years _____ Others _____

MARK THE AREAS OF YOUR SYMPTOMS See the figure to below, Use the following symbols:

Aches ^^^^ Numbness oooo Pins/Needles Stabbing ////

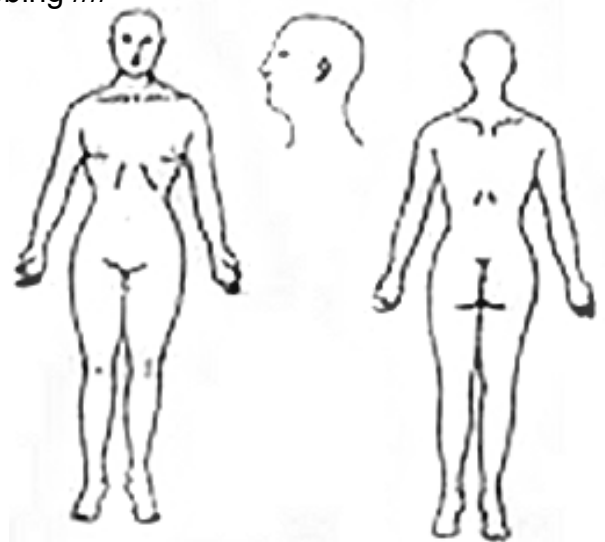
MARK AN "X" ON THE LINES:

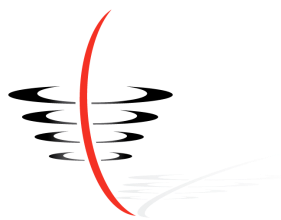
How bad are your symptoms now?

_____ None _____ Most Severe

How bad have they been in the past?

_____ None _____ Most Severe





BACK TO HEALTH CHIROPRACTIC

Name _____ Date _____

What prescription medications and supplements are you taking? Please list here -

Sleep

Do you have trouble falling asleep? ___ Yes ___ No Do you have trouble Staying Asleep? ___ Yes ___ No

What over the counter or prescription medications have you taken for sleep?

___ Ambien ___ Zanaflex ___ Trazadone ___ Sonata ___ Tylenol P.M. ___ Elavil ___ Neurontin ___ Doxepin ___ Flexeril ___ Xanax
___ Klonopin ___ Ativan ___ Melatonin ___ 5HTP ___ Benadryl ___ Other

Digestion and Elimination

Do you have normal, daily bowel movements (at least one bowel movement a day)? ___ Yes ___ No

If no, please circle one - diarrhea, constipation, or both?

Have you been diagnosed with Irritable Bowel Syndrome (IBS)? ___ Yes ___ No

Bloating ___ Yes ___ No Gas ___ Yes ___ No Indigestion ___ Yes ___ No ___ Reflux?

Intestinal Dysbiosis

Have you ever been on long-term (more than 2 weeks) antibiotic therapy? ___ Yes ___ No

Have you ever had vaginal yeast infections? ___ Yes ___ No

If yes, when was last infection? _____

Do you have chronic vaginal yeast infections (more than 2 a year)? ___ Yes ___ No

Have you taken birth control pills for more than 1 year? ___ Yes ___ No

Do you crave Sugar? ___ Yes ___ No

Does eating sugar make your symptoms worse? ___ Yes ___ No

Do you have rectal itching after eating sugar, fruit, or a lot of starches? ___ Yes ___ No

Have you EVER been on prednisone or cortisone long-term (weeks)? ___ Yes ___ No

Have you EVER been on long term (month or more) non-steroidal anti-inflammatory medications (Vioxx, Celebrex, Naprosyn, Advil, Bextra, Mobic, etc.)? ___ Yes ___ No

Thyroid

Please check any of the following that apply-

___ Fatigue ___ High Cholesterol ___ Chronic Headaches ___ Cold hands/feet ___ Hair loss ___ Irregular periods

___ Severe menstrual cramps ___ Low blood pressure

___ Frequent colds and sore throats ___ Depression ___ Fluid retention ___ Decreased memory ___ Ringing in the ears

___ Decreased concentration ___ Infertility ___ Decreased sex drive ___ Constipation ___ Inappropriate weight gain

Moods

Have you taken any anti-depressants in the past? ___ Yes ___ No

Are you currently taking any antidepressants? ___ Yes ___ No Do you feel ___ Depressed ___ Anxious?

Please list here _____

Immune Function Please check those that apply.

___ Chronic Sinus Congestion ___ Chronic Sinus Infections (2 or more a year) ___ Chronic Sore Throats ___ Chronic
Colds or Flu infections each year ___ Chronic Upper Respiratory Infections (Bronchitis, Pneumonia)

Adrenal Function

If you skip a meal do you feel bad (have headaches, become irritable, get jittery, tired, etc.)? Yes No
Do you have low blood pressure? Yes No Don't Know
Do you crave salty foods? Yes No
Does increased stress or stressful situations make your symptoms worse? Yes No
How's your energy level? Choose 1 to 5, with 5 being the best. _____
How is your concentration and memory on a scale of 1-5, with 5 being best? _____
How do you feel in the morning? Refreshed Hung over Exhausted
 Nauseated Achy All Over
Are you hungry in the morning? Yes No

Please place a check mark by any that apply below

Do you ever have problems with:

Chemical Sensitivities/ Seasonal Allergies: Yes No

CVS:

Chest Pain Palpitations High Cholesterol High Blood Pressure MVP Congestive Heart Failure
 Type I or II diabetes Strokes

Lungs:

Coughing Wheezing Breathing Problems Frequent Respiratory Infections Sinus infections
 Frequent sinus congestion or drainage

GU:

Urinary Frequency Urinary Hesitancy

Male:

Problems with Prostrate (BPH) Low sex drive Erectile dysfunction

Female:

Irregular Periods Heavy periods Bloating/swelling Cramps Mood changes
 Decreased Sex Drive Menopause Perimenopause

Skin:

Rashes Dry Skin Fungus Infections Eczema Psoriasis

Pain:

Do you have Osteoarthritis Yes No
If so where (knees, fingers, back, etc.) _____

Rheumatoid or autoimmune arthritis Yes No
If so where _____

Patient Signature

Date