New Patient History

(Please print clearly and answer all questions.)

Name (please print) _____ Date _____

If a minor child, name of parents: _____

Address _____ Apt # _____

City _____ State _____ ZIP _____

Shipping Address (if different) _____

Main Phone: (_____) _____ Other Phone (_____)_____

email address: _____

Occupation _____ Employer _____

Date of Birth _____ Age _____ Sex: M F

Name of Spouse: _____ Employer _____

Who told you about our office? _____

Please list *the main problem you would like us to help you with on line number one:*
On the other lines please list any other health problems you have (up to three) *in order of importance to you.*

1. _____ 3. _____

2. _____ 4. _____

With regards to the number one problem you are seeing the doctor for, please answer all of the following questions:

When did you first notice it: _____

Is this problem: [ ] Staying the same [ ] Getting worse [ ] Improving

What do you believe caused this problem: [ ] Automobile Accident (date: _____)

[ ] Work Related Injury (date: _____)

[ ] Other injury [ ] Illness Other: _____

Did this problem: [ ] Come on suddenly without an apparent cause [ ] Develop gradually over time [ ] Begin after a specific accident [ ] Begin after an illness: What illness?_____

What treatments have you tried (*medical treatments, home remedies, etc.)*

What makes this problem worse?

How often do you experience this condition?_____

Is it constant or does it come and go? [ ] Constant [ ] Comes and goes

Have you had any laboratory testing done in the last six months? [ ] Yes [ ] No

When was the last time you felt really good? _____

I

Do Not Write In This Space

f you are currently under the care of a physician or other health care professional please give their name and date of last visit if you can:

Doctor of Chiropractic: Name:_____ Date: _____

MD / DO: Name: _____ Date: _____

Physical Therapist: Name: _____ Date: _____

Acupuncture: Name: _____Date: _____

Other:

_____

Name: _____ Date: _____

Please write a "C" if you currently have the following or a "P" if you had it in the past.

___ AIDS
___ Alcoholism
___ Allergies
___ Arteriosclerosis
___ Arthritis
___ Cancer
___ Chicken pox
___ Diabetes
___ Eczema
___ Emphysema
___ Epilepsy
___ Glaucoma
___ Goiter
___ Graves' Disease
___ Hypothyroid
___ Heart Disease
___ Hepatitis
___ Malaria
___ Measles
___ Multiple Sclerosis
___ Mumps
___Pneumonia

___ Rheumatic Fever
___ Scarlet Fever
___ Stroke
___ Tuberculosis
___ Typhoid
___ Ulcers
Other:
_____
_____
_____
_____
_____

Surgical History
Check any you have had:
___ Appendix removed
___ Heart Surgery
___ Cancer surgery
___ Cosmetic surgery
___ Eye surgery
___ Pace maker
___ Tonsils removed
___ Vasectomy
___ Oral Surgery
___ Gastric Surgery
___ Bone Surgery
___ Back Surgery
___ Brain Surgery
___ Radiation treatment
___ Chemotherapy

Other:
_____
_____
_____

Medications you are currently taking:

Medication	Reason For Use

Have you ever taken NSAIDS (*ie Advil, Aleve, Motrin, Asprin, Ibuprofen, etc.)* for 3 days or longer at a time? [ ] Yes [ ] No

Have you taken Tylenol regularly? [ ] Yes [ ] No If "yes", for how long: _____

For what reasons have you used these pain medications? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you used acid blocking medications (*Tagamet, Zantac, Prilosec, Protonics, etc.)* regularly or for more than three months? Yes No

Have you taken antibiotics more than one time a year? [ ] Yes [ ] No

Have you taken antibiotics longer than 10 days at a time? [ ] Yes [ ] No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids (*prednisone or cortisone*) in any form, including pills, creams, etc.? [ ] Yes [ ] No

Women Only:
Are you pregnant? [ ] Yes [ ] No [ ] Maybe, but not certain. Are you nursing? _____

Any gynecologic surgeries (hysterectomy, endometriosis, ovarian or breast cysts, etc.?)_____

_____

Menstrual cycle: Do you have regular monthly periods? Yes No Perimenopause Menopause

Circle any of the following symptoms you experience associated with your period:

Cramping Bloating Moody Cravings Heavy bleeding Back pain Headaches Clots

[ ] Caesarean delivery [ ] Postpartum depression [ ] Miscarriage [ ] Abortion [ ] Baby over 8 lbs. [ ] Baby under 6 lbs.

[ ] Used birth control medications in the past. *How long?* _____

Are you currently on any type of birth control? [ ] Yes [ ] No *If yes, what type?* _____

Date of last bone density test: _____ Results: [ ] Normal [ ] Osteopenia (early bone loss) [ ] Osteoporosis

Date of last mammogram: _____ Date of last gynecological exam: _____

Sleep: Do you have any sleep problems (please circle any that apply): Trouble falling asleep Wake up off and on several times a night Wake up and can't go back to sleep Bad dreams

Any other sleep problems? _____

Exercise: What kind of exercise do you do? _____

How often: _____ How long at a time: _____

Food Allergies:_____

Medication Allergies: _____

Have you traveled outside the United States? [ ] Yes [ ] No. If yes, where: _____

_____

Did you ever become ill shortly after returning from going outside the country? [ ] Yes [ ] No

Have you been wilderness camping: [ ] Yes [ ] No: If yes, where: _____
List any household pets, farm animals or other animals you or your family members are in close contact with:

_____

<u>Your Personal Birth History</u>

[ ] Full term [ ] Premature Pregnancy Complications?: _____

[ ] Breast Fed. How long (if you know): _____ [ ] Bottle-fed

Do you know about when you were introduced to solid foods? _____

Did you eat candy, sugar, soft drinks, etc. as a child? [ ] Yes [ ] No If yes, would you estimate eating: a lot on occasion rarely

Dental History

List any dental surgeries: _____

[ ] Gold fillings [ ] Root Canals [ ] Implants [ ] Tooth extractions [ ] Bleeding Gums [ ] Gingivitis

Do you get regular dental check-ups? [ ] Yes [ ] No What tooth paste do you use: _____

Have you ever had Fluoride treatments? [ ] Yes [ ] No

Environmental Assessment

Mercury

[ ] Yes [ ] No Do you have amalgam (silver) filings in your teeth? If yes, How many? _____

[ ] Yes [ ] No Have you ever had an amalgam removed? If Yes, how many? _____

[ ] Yes [ ] No If you had amalgams removed, was it done by a biological dentist using a safe protocol?

[ ] Yes [ ] No Did your mother have amalgam fillings when pregnant with you?

[ ] Yes [ ] No Have you ever worked in a dental office? If so, how long? _____

[ ] Yes [ ] No Have you had any dental crowns? If yes, how many _____

[ ] Yes [ ] No Have you any dental bridges?

[ ] Yes [ ] No Have you had any root canals? If yes, how many _____

[ ] Yes [ ] No Have you had any tooth extractions?

[ ] Yes [ ] No Do you have any dental implants, retainers or other metal in your mouth? Ex_____
_____

[ ] Yes [ ] No Did you wear contact lenses during the 1980's or early 1990's?

[ ] Yes [ ] No Did you take oral contraceptives during the 1980's or early 1990's?

[ ] Yes [ ] No Did you receive yearly flu shots or have you recently received a flu shot, allergy shot or a vaccination?

[ ] Yes [ ] No Have you noticed any adverse reactions to these shots?

[ ] Yes [ ] No Do you have any tattoos with red ink?

[ ] Yes [ ] No Do you eat tuna, shark, swordfish or Atlantic Salmon more than twice a week?

Lead

[ ] Yes [ ] No Does your occupation involve soldering or metal salvage?

[ ] Yes [ ] No Have you done any old home repair or sandblasting? If yes, when _____

[ ] Yes [ ] No Are you exposed to paints a lot?

[ ] Yes [ ] No Was your home built before 1978?

[ ] Yes [ ] No Have you ever worn cosmetics containing kohl or that is a deep black or deep red color?

[ ] Yes [ ] No Are you around a lot of fake leather or vinyl (furniture, handbags, clothing, etc.?

[ ] Yes [ ] No Do you get stomach aches in the morning?

General Toxicity

[ ] Yes [ ] No Have you ever lived near, on or by a golf course, freeway or high tension electrical wires? If yes, please explain:

_____

_____

[ ] Yes [ ] No Have you ever worked around chemicals such as in a beauty salon, auto repair shop, factory, etc.?

[ ] Yes [ ] No Do you have your house sprayed with pesticides for pest control?

[ ] Yes [ ] No Do you spray for weeds around your home?

[ ] Yes [ ] No Do you use conventional insect repellants on yourself or family?

[ ] Yes [ ] No Do you use conventional sunscreen?

[ ] Yes [ ] No Do you use conventional perfumes, after shave, deodorants or cosmetics on a daily basis?

[ ] Yes [ ] No Do you get your hair colored?

[ ] Yes [ ] No Do you use aerosol hairspray?

[ ] Yes [ ] No Do you get your nails done? If so, how often: _____

[ ] Yes [ ] No Do you use air freshener in your home, work or car?

[ ] Yes [ ] No Do you drink tap water?

[ ] Yes [ ] No Does your spouse or other family member work around chemicals?

Mold

How old is the house you live in? _____ How long have you lived there? _____

Have you developed any health problems or symptoms since moving in? Yes No If yes, what are they?

_____

[ ] Yes [ ] No Do you see mold growing at home, at your work place or school?
[ ] Yes [ ] No Have you ever had water damage at home, work or your school?
[ ] Yes [ ] No Does your home, workplace or school have a damp or mildew smell?
[ ] Yes [ ] No If you have a basement, do your symptoms get worse when you go in to it?
[ ] Yes [ ] No Does your basement ever get wet?
[ ] Yes [ ] No Do you have a crawl space under your home?
[ ] Yes [ ] No If you spend some time away from your home or work place, do your symptoms improve?
[ ] Yes [ ] No Does anyone in your home have asthma or asthma- like symptoms?
[ ] Yes [ ] No Does anyone in your family have chronic sinus infections or irritation?

Lyme Disease

[ ] Yes [ ] No Have you ever been diagnosed with Lyme Disease?
[ ] Yes [ ] No Have you had dry sockets or infected tooth extractions?
[ ] Yes [ ] No Do you have pain in the small joints of your body (hands, feet, spine)
[ ] Yes [ ] No Have you ever been bitten by a tick or recluse spider?
[ ] Yes [ ] No Have you ever seen a bulls-eye rash on any part of your body?
[ ] Yes [ ] No Did the bulls-eye rash appear shortly after a tick or spider bite or time spent outdoors?
[ ] Yes [ ] No Was your mother ever diagnosed with Lyme Disease?
[ ] Yes [ ] No Do you frequently go camping, hunting or are you involved in outdoor activities – especially in wooded or grassy areas?

Microbiome Health

[ ] Yes [ ] No Do you pass sulfur smelling or foul smelling gas?
[ ] Yes [ ] No Do you get bloating, burping or get a noisy gut after eating carbs like grains, sugar or starchy vegetables?
[ ] Yes [ ] No Do nutritional supplements or vitamin pills bother you?
[ ] Yes [ ] No Have you been a vegetarian or vegan for any length of time?
[ ] Yes [ ] No Does eating meat cause you digestive problems?
[ ] Yes [ ] No Have you used anti-acids, proton pup inhibitors or other acid blocking medications?
[ ] Yes [ ] No Have you taken birth control or hormone replacement therapy for any length of time?
[ ] Yes [ ] No If you drink alcohol, do you get brain fog or a toxic feeling, even after 1 drink?
[ ] Yes [ ] No Have you been on antibiotics for an extended period of time or repeatedly as a child or adult?
[ ] Yes [ ] No Were you delivered by caesarian section?
[ ] Yes [ ] No Where you breast fed? If yes, how long (if you know) _____
[ ] Yes [ ] No Does your gut feel better for a while after you take antibiotics?
[ ] Yes [ ] No I have had multiple episodes of abdomial pain or discomfort in the past year.
[ ] Yes [ ] No My bowel movements are irregular (constipation and / or diarrhea
[ ] Yes [ ] No My digestive symptoms interfere with my daily life.
[ ] Yes [ ] No I frequently have a sore throat, especially in the morning

Endocrine System Assessment (Check Any Symptoms that Currently Apply to You)

Hypothyroid

___ Weight gain
___ Constipation
___ Feeling cold (especially hands and feet) even on warm days
___ Low basal temperature
___ Fatigue, exhaustion and low energy (even after 12 hours sleep)
___ Slow reflexes
___ Slow, weak pulse
___ Slowness of thought processes (brain fog)
___ Indecisiveness
___ Poor memory and concentration
___ Sluggishness
___ Muscle weakness
___ Pain and stiffness in muscles or joints
___ Deepening, hoarse voice
___ Depression, mood swings and severe PMS
___ Thick, dry, coarse skin
___ Creviced, cracking skin on heels, elbows and knee caps
___ Enlarged thyroid gland in throat area
___ Lump in throat (hard to swallow)
___ High cholesterol
___ Menstrual cycle irregularities (prolonged, shortened, heavy)
___ Infertility
___ Numbness and tingling (especially in hands and face)
___ Fluid retention (swelling of face and feet)
___ Brittle hair and nails
___ Hair loss
___ Shortness of breath on exertion
___ Allergies
___ Back pain
___ Blood pressure problems
___ Breast tenderness
___ Irregular heartbeat
___ Chest pain
___ Digestive disturbances
___ Dizziness
___ Dry eyes and mouth
___ Headaches and migraines
___ Irritability
___ Pale skin
___ Palpitations
___ Reduced sex drive

Hyperthyroid

___ Palpitations, fast pulse or irregular heartbeat
___ Trembling and twitches
___ Do not like hot weather or warm rooms
___ Hot flushes and increased sweating
___ Increased appetite
___ Weight loss (especially if eating well)
___ Diarrhea
___ Anxiety, nervousness and/or panic attacks
___ Restlessness
___ Irritability
___ Thin, moist skin
___ Soft, thinning hair
___ Shortness of breath
___ Muscle weakness
___ Insomnia
___ Loss of appetite
___ Swelling around your throat
___ Eye complaints (especially gritty feeling or bulging eyes)
___ Fatigue, exhaustion and lack of energy
___ Menstrual cycle disturbances
___ Infertility
___ Depression and mood swings
___ Bowel disorders
___ Brittle nails
___ Chest pain
___ Cramps
___ Decreased sex drive
___ Easy bruising
___ Hair loss
___ Headaches and migraines
___ Sore throat
___ Swelling of legs

Adrenal Dysfunction

[ ] Anxiety
[ ] Nervousness
[ ] Not dealing well with stress
[ ] Feel dizzy or off balance
[ ] Light headed
[ ] Impatient or irritable with others
[ ] Shaky or tremble
[ ] Racing or pounding heart
[ ] Sleep problems (can't get to sleep, wake up with a start, wake up and can't go back to sleep, etc.)
[ ] Feel nauseated when stressed
[ ] Get shaky or grumpy if you miss a meal
[ ] Crave salt or salty foods
[ ] Achy or painful joints
[ ] Hypersensitive to vitamin pills and nutritional supplements [ ] Jumpy or startle easy
[ ] Need coffee in the morning to wake up
[ ] Coffee makes you sleepy
[ ] Exercise makes you nauseated
[ ] Get lightheaded, dizzy or like you might faint when moving from kneeling or lying down to standing up
[ ] Have allergies (food, pollen, animal dander, chemicals, etc.)
[ ] Bright light is irritating, and especially at night with oncoming car lights
[ ] Feel tired, but also "wired" or "keyed up"
[ ] Digestive problems, irritable bowel symptoms
[ ] Dark circles under the eyes
[ ] Feel you can't get enough air – "air hunger"
[ ] Get motion sickness easily

Adrenal dysfunction continued…	
[ ] Feelings of doom	[ ] Nails are weak or ridged
[ ] Panic attacks	[ ] Chronic low blood pressure
[ ] Emotionally hypersensitive or overreact to people or situations	[ ] Sweat easily
[ ] Have anger outbursts - lose temper easily	[ ] Poor digestion
[ ] Inability to focus on tasks or activities	[ ] Feel very fatigued
[ ] General body achiness	[ ] Get irritated easily
[ ] Headaches	[ ] Low back pain
[ ] Feel paranoid	[ ] Muscle weakness
[ ] Very defensive with others or over react towards others or situations	[ ] Feel jittery
[ ] Hypersensitive skin (do not like being touched)	[ ] Achy or sensitive scalp
[ ] Clumsy (drop things, bump in to things)	[ ] Take a longer time to recover from being sick with a cold or flu
	[ ] Feelings of confusion

Please circle any of the following that apply to your **immediate** family (father, mother, brothers, sisters, grandparents):

Cancer	Heart Disease	High Blood Pressure	Arthritis	Diabetes	Chronic Back Pain	Stroke
Thyroid problems	Hypoglycemia	Liver Disease	Colitis	Headaches	Osteoporosis	Emphysema
Asthma	Kidney disease	Digestive problems	Allergies	ADD	Mental Illness	Alcoholic
Obesity	Celiac disease	Breast Cancer	Eczema / Psoriasis		Dementia	Parkinson's

Describe health of spouse or partner:_____Number of children, if any: _____

Name of Child	Age	Sex	Any health problems or concerns?
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____
_____	_____	M F	_____

Social History:

Alcohol use:

Beer: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Wine: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Hard Liquor: How often do you drink: [ ] Daily [ ] Weekly [ ] Monthly How many drinks each time? _____

Tobacco use: Cigarettes Cigars Pipe Chew Snuff _____Daily _____ Weekly How much _____:

If you do not currently use tobacco, <u>but did in the past</u>, for how long?_____How long have you stopped smoking? _____

Coffee use: Regular Decaf How many cups? _____ per day or _____ per week

How would you rate the amount of **stress** you are currently under? ___ None ___ Mild ___ Moderate ___ Severe

What is the cause(s) of your stress: _____

_____

Activities of Daily Living: Circle the number that best shows how much your current condition interferes with your ability to do the following:.

0 = Not At All 1= Mildly 2 = Moderately 3 = Severely

Sitting 0 1 2 3	Getting out of a chair 0 1 2 3	Standing 0 1 2 3	Walking 0 1 2 3
Lying down 0 1 2 3	Bending over 0 1 2 3	Climbing Stairs 0 1 2 3	Using a computer 0 1 2 3
Driving a car 0 1 2 3	Getting out of a car 0 1 2 3	Looking over shoulder 0 1 2 3	Caring for family 0 1 2 3
Grocery shopping 0 1 2 3	Household chores 0 1 2 3	Reaching overhead 0 1 2 3	Bathing 0 1 2 3
Dressing yourself 0 1 2 3	Sexual activity 0 1 2 3	Sleep 0 1 2 3	Yard Work 0 1 2 3
Exercise 0 1 2 3	Lifting things 0 1 2 3	Kneeling 0 1 2 3	

Have you ever been sexually assaulted? [ ] Yes [ ] No Have you ever been physically assaulted? [ ] Yes [ ] No

Have you ever been emotionally abused? [ ] Yes [ ] No

How well have things been going for you?	Very Well	Fine	Poorly	Does not apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/ boyfriend / girlfriend				
With you children				
With you parents				

Resources for emotional support *Check all that apply*
[ ] Spouse [ ] Family [ ] Friends [ ] Religious / Spiritual [ ] Pets [ ] Other: _____
Who is living with you in your home? Number: _____ Names: _____
Relationships: Marital status: [ ] Single [ ] Married [ ] Divorced [ ] Widow / Widower
[ ] Gay / Lesbian [ ] Long term Partnership

Nutrition History

How many meals do you eat out per week? _____

[ ] Fast eater	[ ] Others in my household have special dietary needs
[ ] Do not eat at regular times or skip meals.	[ ] Snack frequently
[ ] Eat too much	[ ] Do not like to eat
[ ] Late night eating	[ ] Struggle with eating issues
[ ] Dislike healthy food such as vegetables, etc.	[ ] Emotional eater *(eat when sad, lonely, depressed, bored)*
[ ] Life style interferes with eating regular meals	[ ] Don't care to cook
[ ] Eat more than 50% of meals away from home	[ ] Don't like to shop for food
[ ] Travel frequently	[ ] Confused about nutritional advise
[ ] Significant other or family members don't like healthy foods	

In order to improve your health, how willing are you to: rate on a scale of 5 (very willing) to 1 (not willing)

Take several nutritional supplements each day	5	4	3	2	1
Prepare your own meals	5	4	3	2	1
Engage in regular exercise	5	4	3	2	1
Have periodic lab tests to assess your progress	5	4	3	2	1
Get regular bodywork such as chiropractic or massage	5	4	3	2	1
Set regular appointments	5	4	3	2	1
Read books or articles to learn about your health and solutions	5	4	3	2	1
Be fully responsible for your own healing	5	4	3	2	1
How willing are you to give your treatment program enough time to complete?	5	4	3	2	1

Symptom / Systems Survey

Name: _____ **Date:** _____

Circle any of the following symptoms you currently experience or have had in the last 3 months

Headaches: Side of head back of head front / sinus eyes top of head tingling in hands / feet drop things dizziness numbness in hands / feet shaking of hands poor balance
Memory: Good Fair Poor **Mental Focus / Concentration**: good fair poor
Ears: noise in the ears (ringing, hissing, etc.) loss of hearing plugged ears wax buildup drainage itching pain
Eyes: burning dry itching ache tearing or watery muscle twitching of eyelid or around the eyes blurred vision light bothers eyes red / bloodshot floaters styes
Sinus: Dry Drain Plugged post-nasal drip sneezing green or yellow mucus frequent nose bleeds smell loss taste loss
Throat: Sore Swelling Hoarseness Difficulty swallowing burning
Lungs: Cough – dry / productive recurring lung infections allergies or hay fever difficulty breathing asthma
Shortness of breath: constant / with mild exertion or activity hoarseness **Mouth**: bad breath canker sores in mouth
gums bleed with brushing or flossing tooth pain jaw pain or clicking dry mouth difficulty swallowing
Immune: Fever Chills sore throat get frequent colds / flu swollen glands general ill feeling Get sick once or more every year
Colds or flu hang on for more than 3 days
Chest: tension tightness pressure heaviness pain congestion irregular heart beat racing heart beat
Stomach / GI System: Heartburn Indigestion Cramps Nausea Vomiting Bloating Gas or flatulence Burping Ulcers Stomach pain with eating
Stomach pain 2-3 hours after eating Have problems with: Gluten (wheat) Eggs Dairy Sugar Corn Soy
Other foods you have problems with: _____
Frequency of bowel movements: once a day twice or more a day, if more, how many times per day?_____ every two days or longer
Does your stool have: Blood does it float have mucus oil on top of the water feel as though it's incomplete is it a painful bowel movement
anal itching Diarrhea/ constipation **What color is it?:** Light tan/ White/ Black/ Red/ Green/ yellow / Normal brown
Is your stool: Normal shape and consistency hard mushy pebble shaped ribbon shaped dry Do you: have hemorrhoids?
Does your stool: Leave streaks at the bottom of the toilet? **Do you?:** Wipe 1-2 times?_____Do you wipe 4-5 times?_____
Do you wipe more than >10 times?_____

Women: Vagina: Burning itch dry pain with intercourse discharge (color _____) bad odor:_____
Menses: Post menopausal Regular Irregular First day of last menstrual period _____
short cycle (less than 28 days) long cycle (over 28 days) spotting
Flow: heavy moderate light clots long brief Cramps: none mild medium severe menstrual back pain
Swelling: face hands feet breasts whole body **Hot flashes**: none mild moderate severe
PMS: None Mild Moderate Severe painful ovulation ovarian cysts uterine fibroids
Breast tissue is: smooth ropy or lumpy tender have cysts nipple discharge breast prosthesis have breast implants
Other: Decrease in energy irritable loss of stamina can not lose excess weight or tend to gain weight easily

Skin: Acne: face chest back shoulders Dry Itching Fungus Psoriasis Eczema Cellulite skin tags rash age spots small red moles
Hair: Excessive hair loss brittle / breaks easily finger nails break easily **Urination:** How often do you get up at night to urinate? _____
Do you have: Urgency burning pain Leak if you sneeze/cough Frequent bladder infections How many times do you urinate during the day? _____
Sleep: Hours a night _____ Difficulty falling asleep Wake up and cannot get back to sleep Sleep all night but do not feel rested
Wake up several times a night but go back to sleep each time Do not remember dreams Have nightmares Have night sweats
General restlessness at night Wake up between 1am and 3am Awaken suddenly (jolt) Aching or restless legs (especially at night)

Men: Low mood irritable pessimism discouragement loss of energy loss of strength and stamina loss of body hair
withdrawal from activities and people less productive at work decreased initiative loss of motivation or drive erectile dysfunction (ED)
decreased spontaneous morning erections increased fat in the breasts increased fat in the hips or waist difficulty staring urination dribbling
history of prostate problems losing interest in things in general (work, family, activities)

Circle any of the following that you experience often:
Sadness Grief Depression Moodiness Irritable Worry Anger Nervousness Frustration Anxiety Panic Crying Fear Guilt
Compulsive over-eater / under eater Like to eat something sweet after meals Feel energetic after meals Experience fatigue or get sleepy after you eat
Energy crash between 3 and 6 pm Crave sweets, pasta or bread Crave salt or salty foods Feel shaky, get headaches or grumpy if meals missed
Appetite: Good Fair Poor Energy: good low up and down Sex Drive: good low none hyper Healing: Good Slow
Pain / Stiffness: Face neck upper back mid back low back shoulders arms elbows wrist hands fingers sacroiliac hips buttocks
thighs lower legs ankles feet toes Other:_____

Consent to Evaluation and Treatment

Every type of health care is associated with some risk of a potential problem or may achieve less than the desired outcome for both the Doctor and the patient. This includes chiropractic care, nutritional therapy and the general area of what is referred to as holistic or functional medicine. We want you to be informed about the potential problems associated with chiropractic care and the other therapies we use before consenting to treatment. This is called an informed consent.

AUTHORIZATION TO EXAMINE AND TREAT

I, the undersigned party, request and authorize the performance upon myself of a physical examination / evaluation. I also consent to the performance of other tests such as blood and urine tests, gut tests procedures that are deemed necessary. **In giving this authorization, I understand that these tests or procedures may not actually be done. I also understand that I have the right to refuse any examination, test, or treatment procedure at any time.** These services will be performed by Dr. Catherine D. Seat, or by other qualified health care professionals or support staff that are selected by them and that act under their direction. Should it be determined that my condition may benefit from chiropractic care, nutritional therapy or from the other types of therapies provided at her office, I consent to treatment which may include, but is not limited to, chiropractic adjustments of the spine or other joints of the body, myofascial release, dry-needling, micro current electrotherapy, mechanical percussive therapy, various rehabilitation exercises and activities, nutritional, homeopathic or herbal therapy. I understand that any of the above therapies, except chiropractic adjustments may be administered by a staff member under the direction and supervision of the doctor. I also consent to the performance of other diagnostic and therapeutic procedures, in addition to or different from those stated above, whether or not arising from presently unforeseen conditions that Dr. Catherine Seat may consider necessary or advisable in the course of my health care.

Concerning Chiropractic Therapy:
I understand that **chiropractic adjustments** may involve risks of complications, injury or even death from both known and unknown causes. The known risks are as follows:

Stroke: This is the most serious potential complication associated with spinal adjustments, regardless of whether the provider is a chiropractor, medical or osteopathic doctor or other health professional. A stroke occurs when the blood supply to the brain is interrupted and an area of the brain does not receive enough oxygen from the blood stream which results in brain damage. The results of a stroke can be temporary or permanent and can cause temporary dizziness, nausea, paralysis, vision loss, locked in syndrome (complete paralysis of voluntary muscles in all parts of the body except for those that control eye movement), and death. Stroke concerns in relation to chiropractic treatment are focused on the vertebral artery in the neck. Two thirds of vertebral artery strokes occur spontaneously. One third are caused by traumatic events. Chiropractic adjustments of the neck can potentially cause a stroke because the vertebral artery in the neck may become injured by the adjustment. However, research studies have shown that strokes caused by a chiropractic adjustment are rare. The most recent studies estimate that the incidence of this type of complication occurs in 1 (one) in every 3,000,000 (three million) adjustments to the neck. When stroke has resulted from an adjustment, it has been associated with manual neck adjusting. **In Dr. Seat's office, she only uses this type of adjusting on individuals who are younger than 65, who do not smoke, who don't have vascular issues, and who do not have family or personal history of stroke.** If you smoke, have Ehlers Danlos or Down Syndrome, Rheumatoid or psoriatic arthritis, or Lupus please let Dr. Seat know as she will then use the Activator instrument for the neck. To the best of our knowledge, neck adjustments given by an instrument such as an Activator instrument, have never been documented to have caused a stroke. However, even though a stroke from a chiropractic adjustment of the neck is very unlikely to occur (and especially so when mechanical instruments are used), you need to be aware that it is possible.

Rib Fracture, Joint Dislocations, Sprain Injury or Muscle Soreness: A ***manual*** chiropractic adjustment may crack (fracture) a rib, create a joint dislocation or sprain injury. Fractures occur only to those patients who have weakened bones from such things as osteoporosis, prolonged steroid use, or other bone weakening diseases. Sprains can happen to anyone. Because Dr. Seat uses manual adjustments these types of injures can be possible. This problem occurs so rarely that there are no statistics available to determine its probability. Sometimes a patient will experience soreness after any type of adjustment. This happens usually because muscles begin to engage better than prior to the treatment or because improvements in muscular synergy occur which make previously less functional muscles, more active. It is usually mild to moderate if it occurs at all, and usually only lasts anywhere from an hour or two up to a couple of days.

Nutritional Programs:
Before you sign this agreement, we want you to understand that our viewpoint concerning nutrition and the need for certain nutrients is not necessarily shared by the American Medical Association, the Food and Drug Administration and quite possibly other similar government agencies or professional organizations. Functional You LLC offers nutritional care for our patients. Since nutritional deficiency may or may not be associated with a specific disease, or may or may not be the cause of a disease, or may occur as a result of a disease, it is important for you to understand fully that Dr. Seat's sole concern in your case will be your nutritional status and your ability to metabolize and utilize the nutrients that you consume, either in your diet or as nutritional supplements, that may help to improve your body's general physiological function. **Dr. Seat's nutritional programs are not intended to cure or treat any specific disease.**

Medicare and Our Office: If you are 65 or older, you need to be aware that Dr. Seat does not provide any health care services that are covered by Medicare. If you are 65 or older, and desire chiropractic care, we ask that you obtain such care from some other chiropractor where such services are provided. We are happy to provide all other non-covered services to you, but you will have to pay for them yourself.

Please Note: While Dr. Seat does treat patients who have a wide range of health problems, ***the treatment methods she uses are not designed or intended to treat any specific disease.*** This is especially applicable to her nutritional / functional medicine programs. Our approach is holistic in that it acts to correct malfunctions and/or imbalances in the nervous system and biochemical/physiological systems of the body. When this is achieved, the body is best positioned to heal itself, regardless what type of health problem may be present. **If you have a serious health problem Dr. Seats recommends that you also consult an appropriate medical specialist.**

As your health improves, you may find that any prescription medications you are on may need to be adjusted. Do not change your medication without consulting your doctor first.

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I have read, or have had read to me, the above information and consent. I have also had an opportunity to ask questions. All of my questions have been answered to my satisfaction. By signing below, I consent to treatment. I intend this consent form to cover the entire course of treatment for my current condition or future preventive or maintenance care. I acknowledge that no promise or guarantee has been made to me regarding the results or outcome of any treatment provided by Dr. Catherine D. Seat or any office staff members. I do not expect the doctor to be able to anticipate and explain all risks and potential complications. Dr. Seat has explained the nature and purpose of the procedures she will be using, the risks involved, possible alternatives, as well as no treatment, possible consequences and the possibility of complications to me, to my satisfaction. I therefore elect to undergo examination and treatment from Dr. Catherine D. Seat, or their staff who act under their direction. I also verify that the Patient Privacy and Consent Policies form that govern federal HIPPA privacy laws has been made available to me.

Signature:_____ Date:_____
(patient or other responsible party or legal guardian)

I understand that I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved insurance carrier.

I grant permission to the Functional You LLC staff to call to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.

Financial Responsibility: **I understand that I am personally responsible for the payment of 100% of all services and products I receive from Functional You LLC, regardless of how much my, or any other insurance carrier, may or may not pay. Payment for all services or products is due when received.**

Return Policy**: You may return any unopened nutritional products or prepaid lab requisitions within 15 days of purchase for a full refund.**

Authorization of Payment by Insurance Carrier: I hereby assign, transfer and set over to Dr. Catherine D. Seat and Functional You LLC and / or its individual providers, all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy or any other third party policy, as they may apply to my treatment at Functional You LLC.

I authorize the release of any medical information needed to determine these benefits or to settle a claim. I understand and agree that this authorization shall remain valid and be irrevocable until any balance due on my account is paid in full.

I also give any other medical or health care provider, clinic or hospital, permission to release any information or medical records needed by Dr. Catherine D Seat, which they request, in relation to my being under their care.

Signature: _____ Date: _____

Print Name: _____

Consent to Treatment of a Minor Child

I hereby authorize Dr. Catherine Seat or their assistants to administer treatment and diagnostic exams or evaluations, as they deem necessary,

to my (relationship) _____named (name)_____.

Signature **(parent or legal guardian)**_____ Date:_____

Please read the following and sign below where indicated. If you have any questions or objections to any of the following, please speak with the staff member or the doctor before signing.

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