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? _____

Do Not Write In This Space

If 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 many milligrams do you use? _____ How often are you using this? ☐Daily ☐Weekly ☐Monthly

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

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: _____

_____ 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

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? _____

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. Dr. Seat wants 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 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 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, cupping, 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 (this includes vascular EDS), and who do not have family or personal history of stroke.** If you smoke, have Ehlers Danlos Syndrome, 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 injuries can be possible. However, 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 of what type of health problem may be present. **If you have a serious health problem Dr. Seats will recommend that you also consult an appropriate medical specialist.**

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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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