Tavares Health and Wellness Center

Date_____

Name_____ Date of Birth_____

Address_____City/State_____

E-mail _____Zip Code_____

By documenting your email on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and Tavares Health and Wellness Center. While usually considered safe, email is not the most secure method of sharing personal information.

Telephone:
Home_____Cell_____

Marital Status_____Spouse's Name_____

Number of Children_____

In case of an emergency, who should we contact?

Name_____Phone_____

Relationship_____How did you hear about us?_____

Main Complaints:

1)_____ 2)_____

3)_____ 4)_____

How long have you suffered with this problem? _____

Any other complaints: _____

_____

List any past serious accidents with dates_____

_____

Would you like improvement with any of the following?

Digestion: Reflux, Gas, Constipation, Weight Gain
Sleep: Falling asleep or staying asleep
Sense of Well Being
Energy

What have you tried doing to resolve this problem that Did Not work?

_____
_____
__

Have you become discouraged or stressed about handling this problem?

_____
_____
__

When your problem is at its worst, how does it make you feel?

_____

How does this problem interfere with the following areas in your life?

Work: _____
Family: _____
Hobbies: _____
Life: _____

When it's at its worst, how much older does this make you feel? _____

Do you know how this problem may have started? _____

_____

What effect does this have on your body functions? _____

_____

Are you here visiting us to:

1 Resolve my immediate problem
2 Life style program for optimized living
3 Both
4 Other: _____

How have you taken care of your health in the past?

Medications
Routine medical
Exercise

Diet and Nutrition
Holistic
Vitamins

Chiropractic
Acupuncture
Other: _____

How did the previous methods work for you? _____

_____

What are you afraid this might be or will be affecting without change? Please circle

Job
Kids
Marriage
Sleep
Freedom
Future abilities
Finances
Time

Are there any health conditions you are afraid this might turn into?

Diminished Future abilities
Stress
Weight gain
Heart disease
Depression
Surgery
Arthritis
Cancer
Diabetes
Other: _____

Where do you picture yourself being in the next 3-5 years if this problem is not taken care of? Please be specific _____

_____

_____

What would be different or better without this problem? Please circle:

Diminished stress
More energy
Self esteem
Confidence
Sleep
Work
Outlook
Family

Do you have any specific cravings?

If we were to sit down and discuss your life 3 years from now and look back at today, what would have to have happened for you to be happy with your progress?
(Please take your time and don't sell yourself short! Include anything that is part of your happiness, whether health, family, work, finances, travel, marriage or bucket list)

_____
_____
_____
_____

What potential barriers do you foresee that would prevent these things from happening?

_____
_____
_____
_____
_____

Do you feel it is possible to eliminate or prevent these potential barriers?

_____
_____
_____
_____
_____
_____

What are your strengths that will enable you to accomplish your goals?

_____
_____
_____
_____
_____
_____

Rate on a scale of 1-10:

_____ How important is it for you to resolve your health concerns?
_____ Do you feel that you are coachable and would enjoy a mentor in helping you?
_____ Are you prepared to make the appropriate lifestyle changes that may be necessary in order to achieve your goals?

SYMPTOM SURVEY

WEIGHT_____ HEIGHT_____ BLOOD PRESSURE_____
PULSE_____ O_2_____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder 692.9
002 ☐ Acne 706.1
003 ☐ Psoriasis 696.1
004 ☐ Urticaria (Hives) 708.9
005 ☐ ADD/ADHD 314.00/314.01
006 ☐ Allergies, Unspecified 477.9
007 ☐ Allergic Rhinitis from food 477.1
008 ☐ Sinusitis 461.9
009 ☐ Alzheimer's 331.0
010 ☐ Poor Concentration/Memory 310.1
011 ☐ Parkinson's Disease 332.0
012 ☐ Anemia 285.9
013 ☐ Arthritic Disorder 716.90
014 ☐ Osteoporosis 733.00
015 ☐ Asthma 493.90
016 ☐ Emphysema 492.8
017 ☐ Cancer
018 ☐ Breast 174.9 female 175.9 male
019 ☐ Prostate 185
020 ☐ Lung 162.9
021 ☐ Colon and Rectal 153.9
022 ☐ Skin 173.9
023 ☐ Leukemia w/o remission 208.90 Leukemia w/ remission 208.91
024 ☐ Lymphoma, malignant 202.8
025 ☐ Brain Tumor, malignant 191.9
027 ☐ Anxiety Disorder 300.00
028 ☐ Autism 299.00
033 ☐ Edema 782.3
034 ☐ Eczema 692.9
035 ☐ Chronic Fatigue 780.71
036 ☐ Circulatory Disorder 459.9
037 ☐ Heart Disease 429.9
038 ☐ High Cholesterol 272.0
039 ☐ High Blood Pressure 401.9
040 ☐ Low Blood Pressure 458.9
041 ☐ Tachycardia (High Heart Rate) 785.00
042 ☐ Numbness 782.0
043 ☐ Constipation 564.0
044 ☐ Indigestion 536.8
045 ☐ Ulcerative Colitis 556.9
046 ☐ Depression 311
047 ☐ Diabetes Mellitus 250.0
030 ☐ Diabetes Type I 250.01
031 ☐ Diabetes Type II 250.02
029 ☐ Hyperglycemia [high blood sugar] 790.29
048 ☐ Hypoglycemia [low blood sugar] 251.2
049 ☐ Dizziness/Balance Problem 780.4
050 ☐ Ear Infection 381.4
051 ☐ Epstein Barr 075
052 ☐ Eye Problems 379.91
053 ☐ Cataracts 366.9
054 ☐ Glaucoma 365.9
055 ☐ Macular Degeneration 362.50
056 ☐ Fever 780.6
057 ☐ Fibromyalgia 729.1
058 ☐ Gallbladder Disorder 575.9
059 ☐ Gout 274.9
060 ☐ Headaches 784.0
061 ☐ Hearing Loss 389.9
062 ☐ Infertility, male 606.9
064 ☐ Liver Disease 571.9
065 ☐ Hepatitis 573.3
066 ☐ Hepatitis B 070.30
067 ☐ Hepatitis C 070.51
068 ☐ Kidney Disorder 593.9 or Bladder Disorder 596.9
063 ☐ Prostate Disorder 602.9
069 ☐ Hyperthyroidism 242.90
070 ☐ Hypothyroidism 244.9
071 ☐ Systemic Lupus 710.0
072 ☐ Infertility, female 628.9
073 ☐ Interstitial Cystitis 595.1
074 ☐ Irregular Menstrual Cycle 626.4
075 ☐ Menopausal Symptoms 627.2
076 ☐ Hot Flashes 627.2
077 ☐ Mental Disorder 300.9
078 ☐ Insomnia 780.52
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores 528.2
081 ☐ Overweight 278.02
082 ☐ Underweight 783.22
083 ☐ Sexual Disorder 302.89
084 ☐ Spinal Problems 724.9
085 ☐ Obesity 278.00
086 ☐ GERD 530.81
087 ☐ HIV 042
088 ☐ Crohn's Disease 555.9
089 ☐ Irritable Bowel Syndrome 564.1

092 ☐ Normal Pregnancy v22.2

****only applicable if *currently* pregnant**

093 ☐ Shingles 053.9
140 ☐ Migraines 346.90
141 ☐ Rheumatoid Arthritis 714.0
142 ☐ Non-Systemic Lupus 695.4

143 ☐ Multiple Sclerosis 340

144 ☐ ALS (Lou Gerigs) 335.20

145 ☐ Polymyalgia Rheumatica 725

146 ☐ Scleroderma 710.1

171 ☐ Goiter 240.9

178 ☐ Raynaud's Syndrome 443.8

179 ☐ Hemochromatosis 275.0

180 ☐ Thalassemia 282.49

181 ☐ Brain aneurysm 431

If necessary, please state your most significant concern…

General Health

100 ☐ Fingernail base is pink

101 ☐ Fingernail base is purple

102 ☐ Fingernails have ridges or white spots

103 ☐ Fingernails are soft

104 ☐ Fingernails are splitting

105 ☐ Fingernails peel

106 ☐ Pale fingernail beds

107 ☐ Blacks out easily

108 ☐ Balance problems

109 ☐ Difficulty walking

110 ☐ Has tattoos

111 ☐ Brittle hair

112 ☐ Dry hair

113 ☐ Thin hair

114 ☐ Hair loss

115 ☐ Drinks alcoholic beverages daily

116 ☐ Drinks less than 8 glasses of water per day

117 ☐ Currently on Chemotherapy

118 ☐ Currently on radiation treatment

119 ☐ Had chemotherapy in the past

120 ☐ Has had radiation treatments in the past

121 ☐ Gained over 20 lbs in the last 12 months

122 ☐ Somewhat Overweight

123 ☐ Somewhat Underweight

124 ☐ Unexplained loss of >20lbs in last 4 months

125 ☐ Energy level is worse than it was 5 years ago

127 ☐ Sleeps less than 6 hours per night

128 ☐ Unable to recall dreams the next day

129 ☐ Sensitive to chemicals, paint, fumes, cologne

130 ☐ Had blood transfusion in the past

131 ☐ Had transplant in the past

138 ☐ Takes anti-rejection drugs

132 ☐ Had a major accident or injury

137 ☐ Sleep Apnea

139 ☐ Toxic chemical exposure

175 ☐ Has been out of the country recently

176 ☐ Had childhood vaccines

177 ☐ Had a vaccine in the last 12 months

147 ☐ Had a flu shot last year

182 ☐ Had a pneumonia vaccine last year

183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:

184 ☐ Cancer

185 ☐ Heart Disease

186 ☐ Diabetes

187 ☐ Alcoholism

188 ☐ Depression

189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type?

_____

What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other _____

What year was your home built? _____ Any renovations in the past year?

_____

Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No

Explain:

_____

Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No

Explain:

_____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks >1 pop/sodas per day
I had 4 alcoholic drinks in one day:
172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago
381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing

288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate
202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear

168 ☐ Under considerable emotional stress
169 ☐ Unhappy when other are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night
556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are <u>currently</u> taking on a <u>daily basis</u>.

<u>DRUG</u> ***<u>PRESCRIBED FOR:</u>*** ***<u>HOW LONG</u>***

_____ _____
_____

_____ _____
_____

_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____

Please list all drugs taken <u>within the last year and/or you take as needed</u> including over the counter drugs, antibiotics, aspirin, inhalers, etc.

<u>DRUG</u> ***<u>PRESCRIBED FOR:</u>*** ***<u>HOW LONG</u>***

_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____
_____ _____
_____

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

☐ Dairy ☐ Eggs ☐ Garlic ☐ Gluten ☐ Mold ☐ Peanut ☐ Ragweed ☐ Shellfish ☐ Soy ☐ Sulfa drugs ☐ Tree nuts ☐ Wheat

☐ Other

_____
_____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u> ***<u>BRAND</u>*** ***<u>DOSAGE</u>***

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

- We invite you to discuss with us any questions regarding our services. The best services are based on a friendly, mutual understanding between provider and patient.
- Payment is due at the time services are rendered. Cash, check, or credit cards are acceptable forms of payment.
- For all HMO/PPO insurance groups that we are contracted with, co-pays, co-insurance, deductibles, and non-covered services are due at the time services are rendered. If an overpayment results based on an explanation of benefits, refunds will be issued. Any balance which is determined to be the patient responsibility on the explanation of benefits will be due immediately.
- For all insurance groups that we are not under contract with, assignment acceptance will be determined at the time the benefits are verified. If assignment is accepted, all co-pays, co-insurance, deductibles and non covered services will be due at the time the service is rendered. If we do not accept assignment, payment is due at the time services are rendered.
- For all discount plans that we participate in, payment is due at the time services are rendered.
- We allow a reasonable amount of time for claim processing. If claims are not processed within the state mandated time allowance, the account balance will be the patients financial responsibility.
- Any and all account balances which are 90 days overdue will be sent to collections, and a surcharge will be applied to the account balance.
- Personal and business checks that are returned from the bank will incur a $25 check return charge and will no longer be a valid form of payment.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment.
- I authorize the release of any medical or other information necessary to process claims. I also request payment of benefits either to myself or to the party who accepts assignment.
- I authorize payments of medical benefits to David L. Frerking, D.C., D.A.B.C.I.

- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

DISCLOSURE & CONSENT FOR CHIROPRACTIC ADJUSTMENT AND CARE

TO THE PATIENT: You have a right as a patient to be informed about your condition and the recommended chiropractic adjustments and other physical procedures to be used so that you may make the decision whether or not to undergo the procedure after knowing the potential risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so you may give or withhold your consent to the procedure.

I hereby request and consent to the performance of chiropractic adjustments and other procedures, including various modes of physical therapy and diagnostic X-rays, on me (or the patient named below, for whom I am legally responsible) by the Doctor of Chiropractic named below and/or other licensed Doctors of Chiropractic or those working at the clinic or office who now or in the future treat me while employed by, working or associated with, or serving as a backup for the Doctor of Chiropractic named below.

I have had the opportunity to discuss with the Doctor of Chiropractic named below, my diagnosis, the nature and purpose of chiropractic adjustments and other procedures and alternatives.

I understand and I am informed that, in the practice of chiropractic there are some risks to exam and treatment including, but not limited to, fractures, disc injuries, strokes, dislocations, sprains and increased symptoms and pain or no improvement of symptoms or pain. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest. I further acknowledge that no guarantees or assurances have been made to me concerning the results intended from the treatment.

Nutritional Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A vitamin is not a drug, NEITHER is a Mineral, Enzyme, Probiotic, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions, and all my questions have been answered fully and satisfactorily. By signing below, I consent to the treatment plan. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

To be completed by the patient:	To be completed by the patients' representative, if Necessary, e.g, if the patient is a minor or Physically or legally incapacitated:
_____	_____
print name	print name of patient
_____	_____
signature of patient representative	print name of patient's
_____	_____
date signed	signature of patient's representative as:_____ relationship or authority of patient's representative

_____

date signed

To be completed by doctor or staff

witness to patient's signature

date