HOLISTIC HEALTH&NUTRITION

1164 S Roselle Rd • Schaumburg IL 60193 • office: 847-301-0433 • fax: 847-301-7304

Patient Information File#_____ Date: _____

Patient Name: (Last Name First)_____

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

Birth Date:_____ Age:_____

Address: _____City: _____

State/Zip_____

Email: _____

How did you find out about Holistic Health and Nutrition? _____

Have you ever been to a Chiropractor/Naturopath before? Yes No If yes, please describe:_____

_____

In Case of Emergency, who should we contact?

Name: _____ Phone: _____ Relationship: _____

PRIMARY CARE PHYSICIAN:

Name/Group: _____ Phone: _____

Address: _____Date Of Last Physical:_____

Date of Recent/last Lab Work:_____

FAMILY INFORMATION:

Marital Status: Single Married Partner Divorced Widow(er)

Spouses Name: _____ Children: Y N Number: _____

EMPLOYER INFORMATION:

Occupation: _____

Employer: _____ Employer Phone:_____

Employer Address: _____ City: _____ State/Zip:_____

INSURANCE INFORMATION:

Insurance Company Name: _____

Member Services Phone: _____ Group or Plan#: _____

Name of Insured: (if different from patient)_____ Phone: _____

Birth Date:_____ Age:_____

Address: _____ City: _____ State/Zip_____

Insured's Employer: (if different from patient)_____ Phone: _____

Address: _____ City: _____ State/Zip_____

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Health Holistic and Nutrition all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____ _____

Responsible Party Signature Relationship Date

ACCIDENT INFORMATION:

Is this condition due to an accident: Yes No Date of accident: _____

Type of accident: Auto Work Home Other_____

To whom have you made a report of your accident? _____

HEALTH HISTORY:

What treatment have you already received for your condition?

Medications _____ Surgery _____ Physical Therapy_____ Chiropractic Services _____ None _____ Other _____

Name and Address of other doctor(s) who have treated you for your condition: _____

_____

X-RAYS AND SPECIAL STUDIES: Please note when you have had each of the following and results:

X-Rays _____ Ultrasounds _____ TB Test _____ HIV _____ Last Dental Visit _____ DEXA Scan _____

Mammogram _____ MRI, CT-Scan _____ Electrocardiogram (ECG) _____ Electroencephalogram (EEG) _____

HCV _____ Last Eye Exam _____ Colonoscopy _____ PSA Level _____ Physical Exam _____

Spinal X-Ray _____ Blood Test _____ Spinal Exam _____ Chest X-Ray _____ Urine Test _____

Bone Scan _____ PAP Smear _____ Prostate Exam _____

IMMUNIZATIONS:

Diphtheria Y N Measles/Mumps/Rubella Y N Chicken Pox Y N Polio Y N

Tetanus Y N Influenza Y N Pertussis Y N Small Pox Y N Hepatitis Y N

Other _____Any Reactions to Immunizations? _____

EXERCISE:

5-7 days/wk _____ 3-4 days/wk _____ 1-2 days/wk _____ 45 min or more duration per work out _____

30-45 min _____ Less than 30 _____ Walk # days/wk _____ Run/aerobic # days/wk _____

Weights # days/wk _____ Stretching _____ Other _____

STRESS:

Circle the level of stress you are usually experiencing (1 is the lowest) 1 2 3 4 5 6 7 8 9 10

Indicate the causes of stress: Work _____ Family _____ Relationship _____ Financial _____

Residence _____ Legal Problems _____

WORK ACTIVITY:

Sitting _____ Standing _____ Light Labor _____ Heavy Labor _____

HABITS:

Smoking _____ packs/day _____ Alcohol _____ drinks/day _____ Coffee/Caffeine _____ cups/day_____

SLEEP HABITS:

How many hours per night? _____ Do you wake refreshed? _____ If not, why? _____

Do you have problems: Falling Asleep _____ Staying Asleep _____ Waking Up _____

Average energy level per week (1 is the lowest) 1 2 3 4 5 6 7 8 9 10

Average stress level per week (1 is the lowest) 1 2 3 4 5 6 7 8 9 10

How do you cope with stress? _____

Do you talk to anyone about your problems? _____

Who else might you confide in, or seek advice from? _____

What are things you do for fun and how often? _____

Are you Pregnant? Yes _____ No _____ Due Date: _____

HOSPITALIZATIONS, PROCEDURES, INJURIES, (Surgeries/special diagnostic studies):

Date	Procedure	Reason	Outcome
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

MEDICATIONS AND SUPPLEMENTS:

Y=Yes, you take now				**N=No, you never have**				**P=you have taken in past**			
Laxatives	Y	N	P	Pain Relievers	Y	N	P	Hormones	Y	N	P
Blood Pressure Pills	Y	N	P	Insulin	Y	N	P	Antacids	Y	N	P
Birth Control	Y	N	P	Antibiotics	Y	N	P	Sleeping Pills	Y	N	P
Appetite Suppressants	Y	N	P	Thyroid Pills	Y	N	P	Cortisone	Y	N	P
Tranquilizers	Y	N	P	Sedatives	Y	N	P				

CURRENT MEDICATIONS:

Name of Drug	Reason for Taking	Dose	Date Started	Prescribed By

CURRENT SUPPLEMENTS, VITAMINS & HERBS:

Name of Drug	Reason for Taking	Dose	Date Started	Prescribed By

ALLERGIES TO DRUGS, ENVIROMENTAL, FOOD, ETC. (state reaction):

_____

_____

_____

_____

_____

_____

INJURIES/SURGERIES:

Falls _____ date_____

Head Injuries _____ date_____

Broken Bones _____ date_____

Dislocations _____ date_____

Surgeries _____ date_____

CHIEF COMPLAINT:

What is the reason for your visit today? _____

_____

_____

_____

_____

_____

_____

When did your symptoms appear? _____

Is the condition getting progressively worse? Yes No Unknown

Describe how it feels (circle all that apply) Numbness Pins & Needles Aching Burning Stabbing Sharp Dull

Throbbing Cramps Stiffness Other_____

Have you had anything like this before? Yes No If yes, when? _____

How often do you have this pain? _____

Please circle the best description of your symptoms: (please circle)

Constant or On & Off usually lasting ___ min ___days ___weeks

Does it interfere with your: (please circle) Work Sleep Daily Routine Recreation Other _____

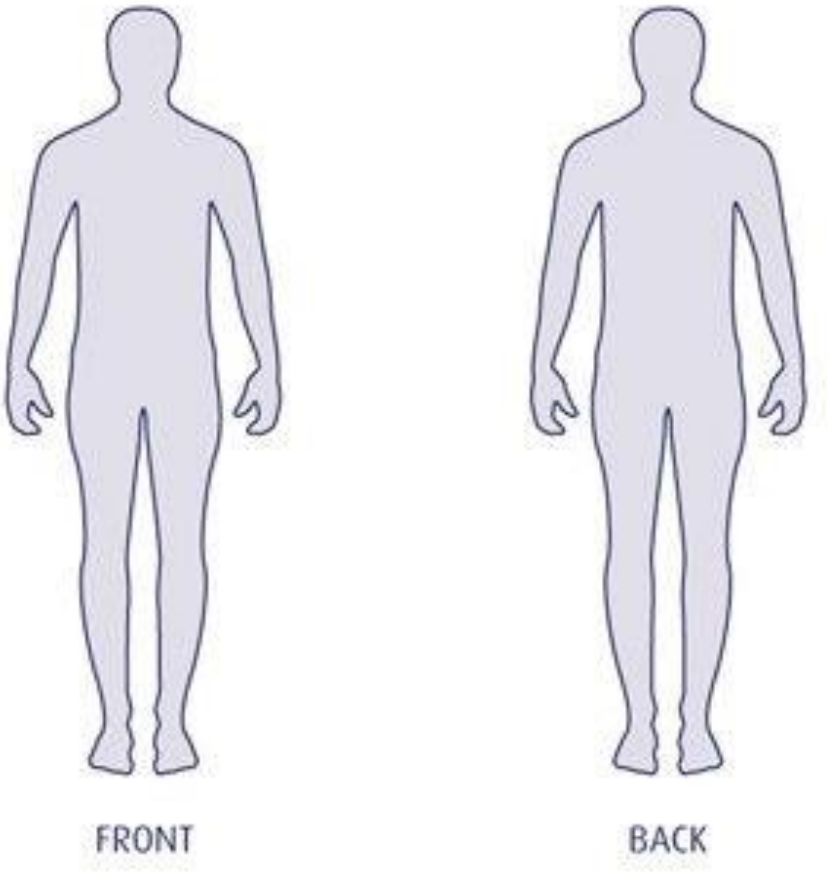
Activities that are painful to perform: Sitting Standing Walking Bending Lying Down Other _____

Please rate your pain on the scales below: 0=No Pain and 10=Severe Pain

Pain Currently	Pain at its Worst	Pain Typically
0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10	0 1 2 3 4 5 6 7 8 9 10

Please mark area(s) of injury or discomfort as shown in the example below

NN=Numbness PP=Pins & Needles AA=Aching BB=Burning SS=Stabbing



Additional Information:_____

_____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

PATIENT SYMPTOM SURVEY

DATE_____
PATIENT'S NAME_____ **AGE**_____
WEIGHT_____ **HEIGHT**_____ **BLOOD PRESSURE**_____ **PULSE**_____ **O_2**_____

This is a confidential patient symptom survey. Please check each condition which is true for you. If the condition does not apply to you or you do not understand a term or if you are not sure if a condition applies to you, then do not check the box. Use common sense. For example, Insomnia once in the last month probably isn't that important and would not be marked. However, Insomnia occurring 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 175.9male
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
▢ Pacemaker
038 ▢ High Cholesterol 272.0
039 ▢ High Blood Pressure 401.9
040 ▢ Low Blood Pressure458.9
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 Gehrig's disease 335.20
145 ▢ Polymyalgia Rheumatica 725
146 ▢ Scleroderma 710.1
171 ▢ Goiter 240.9
178 ▢ Raynaud's Syndrome 433.8
179 ▢ Hemochomatosis 275.0
180 ▢ Thalassemia 282.49
181 ▢ Brain aneurysm 431
▢ Stroke

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
148 ☐ Had radiation therapy in the last year
149 ☐ Had chemotherapy in the last year
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 weight loss of over 20lbs within the 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 Habits

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 more than 3 cups of coffee per day
378 ☐ Drinks more than 3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks 1 or more 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 more than 5 alcoholic drinks per week
☐ Recovering Alcoholic
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in the last 5 years
384 ☐ Smoked for more than 5 years
385 ☐ Smokes more than 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
715 ☐ Radiated thyroid
708 ☐ Cancer
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy

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
☐ Whooping Cough
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 fascitis
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
☐ Fractures

☐ Herniated Disc
where?:
_____

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
☐ Suicide Attempt

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
☐ Nipple discharge
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
explain:
_____
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
☐ Abnormal PAP

INFORMED CONSENT TO CHIROPRACTIC TREATMENT

The Nature of Chiropractic Treatment:
The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a “click” or “pop”, such as the noise made when a knuckle is “cracked”, and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, therapeutic ultrasound, dry hydrotherapy, or photo light therapy may also be used.

Possible Risks:
As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves, or spinal cord.
Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns, or minor complications.

Probability of Risks Occurring:
The risks of complications due to chiropractic treatment have been described as “rare”, about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered “rare”.
OTHER TREATMENT OPTIONS WHICH COULD BE CONSIDERED MAY INCLUDE THE FOLLOWING:

Over the counter analgesics, the risks of these medications include irritation to stomach, liver, and kidneys as well as other side effects in a significant number of cases.

Medical care, typically anti- inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.

Hospitalization, In conjunction with medical care adds risks of exposure to virulent communicable disease in a significant number of cases.

Surgery, in conjunction with medical care adds risk to adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of Remaining Untreated:
Delay of treatment allows formation of adhesions, scar tissue, and other degenerative changes. These changes can further reduce skeletal mobility and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make further rehabilitation more difficult.

Unusual Risks: I have had the following risks of my case explained to me.

I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment and hereby give my full consent to treatment.

I have read and understand the above:
Print name:_____
Signature _____ Date _____

CONSENT TO TREAT A MINOR

I, the undersigned, hereby attest that I am the parent or legal guardian of (child’s name) _____
and give my consent to such examinations and treatments as may be deemed necessary by Dr. _____
for the evaluation and treatment of the condition for which this minor child has been presented.

Signature Parent/Guardian: _____ Date _____

Witness:
Print name:_____
Signature _____ Date _____

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 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 Holistic Health and Nutrition, 847-301-0433.

Thank you,
Holistic Health and Nutrition

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, 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 and understand the above:

Signature _____ Date _____