



COMPREHENSIVE HEALTH HISTORY

Thank you for choosing our office to assist with your health care. Our ability to draw effective conclusions about your current health and improve it to optimal capacity depends largely on the accuracy of the information you provide, including symptoms that you may consider minor. Health issues may be influenced by many factors; therefore, it is important that you carefully consider the questions asked in this form as well as those posed by the doctor during your consultation. Our goal is to provide you with an optimal health care plan and effectively utilize your scheduled appointment time. This form **must** be completed before the doctor will see you. ***PLEASE BRING PRIOR LABS TO YOUR APPOINTMENT or OBTAIN THEM WITH THE MEDICAL RELEASE FORM.**

Date: _____

First Name: _____ Middle: _____ Last: _____

Address _____ City _____ State _____ Zip Code _____

Home Phone (____) ____ - ____ Work (____) ____ - ____ Cell (____) ____ - ____

Email _____

Age _____ Date of Birth ____/____/____ Place of birth _____ Gender: Female ___ Male ___
City or town & country, if not US

Referred by: _____

Name, address, & phone number of primary care physician: _____

Marital Status:

Single ___ Married ___ Divorced ___ Widowed ___ Long Term Partnership ___

Emergency Contact: _____

Relationship

Name

Phone

Address

Occupation _____ Hours per week _____ Retired _____

Nature of Business _____

Genetic Background: Please check appropriate box(es):

- African American Hispanic Mediterranean Asian
 Native American Caucasian Northern European Other

CURRENT HEALTH STATUS/CONCERNS

Please provide us with current and ongoing problems

Problem	Date of Onset	Severity/Frequency	Treatment Approach	Success
Example: Headaches	May 2006	2 times per week	Acupuncture/Aspirin	Mild improvement

What diagnosis or explanation(s), if any, have been given to you for these concerns?

When was the last time that you felt well? _____

What seems to trigger your symptoms? _____

What seems to worsen your symptoms? _____

What seems to make you feel better? _____

What physician or other health care provider (including alternative or complimentary practitioners) have you seen for these conditions? _____

How much time have you lost from work or school in the past year due to these conditions? _____

PAST MEDICAL AND SURGICAL HISTORY

If you have experienced reoccurrence of an illness, please indicate when or how often under comments.

ILLNESSES	WHEN /ONSET	COMMENTS
Anemia		
Arthritis		
Asthma		
Bronchitis		
Cancer		
Chicken Pox		
Chronic Fatigue Syndrome		
Crohn's Disease or Ulcerative Colitis		
Diabetes		

ILLNESS	WHEN/ONSET	COMMENTS
Emphysema		
Epilepsy, convulsions, or seizures		
Gallstones		
German Measles		
Gout		
Heart Attack, Angina		
Heart Failure		
Hepatitis		
Herpes Lesions/Shingles		
High blood fats (cholesterol, triglycerides)		
High blood pressure (hypertension)		
Irritable bowel (or chronic diarrhea)		
Kidney stones		
Measles		
Mononucleosis		
Mumps		
Pneumonia		
Rheumatic Fever		
Sinusitis		
Sleep Apnea		
Stroke		
Thyroid disease		
Whooping Cough		
Other (describe)		
Other (describe)		
INJURIES	WHEN	COMMENTS
Back injury		
Broken bones or fractures (describe)		
Head injury		
Neck injury		
Other (describe)		
Other (describe)		

DIAGNOSTIC STUDIES	WHEN	COMMENTS
Blood Tests		
Bone Density Test		
Bone Scan		
Carotid Artery Ultrasound		
CAT Scan (Please indicate type)		
Colonoscopy		
EKG		
Liver Scan		
Mammogram		
Neck X-Ray		
MRI		
X-Ray (Please indicate type)		
Other (describe)		
Other (describe)		
SURGERIES	WHEN	COMMENTS
Appendectomy		
Dental Surgery		
Gall Bladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Tubes in Ears		
Other (describe)		
Other (describe)		

HOSPITALIZATIONS

WHERE HOSPITALIZED	WHEN	REASON

MEDICATIONS

How often have you taken antibiotics?	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

How often have you taken oral steroids? (e.g. Prednisone, Cortisone, etc)	Less than 5 times	More than 5 times	Comments
Infancy/Childhood			
Teen			
Adulthood			

List all medications. Include all over the counter non-prescription drugs.

Medication Name	Date started	Date stopped	Dosage

List all vitamins, minerals, and any nutritional supplements that you are taking now. If possible, indicate whether the dosage.

Type	Date Started	Date Stopped	Dosage

Are you allergic to any medication, vitamin, mineral, or other nutritional supplement? Yes ___ No ___

If yes, please list: _____

CHILDHOOD HISTORY

Please answer to the best of your knowledge.

	Yes	No	Don't Know	Comment
Where you a full term baby?				
A premature birth? ('preemie')				
Breast fed?				
Bottle fed?				
When pregnant with you, did your mother:				
Smoke tobacco?				
Use recreational drugs?				
Drink alcohol?				
Use estrogen?				
Other prescription or non-prescription medications?				

IMMUNIZATION HISTORY

Please indicate if you have been vaccinated against any of the following diseases:

	Yes	No	Don't Know	Comment
Smallpox				
Tetanus				
Diphtheria				
Pertussis				
Polio (oral)				
Polio (injection)				
Mumps				
Measles				
Rubella (German Measles)				
Typhoid				
Cholera				

CHILDHOOD DIET

Was your childhood diet high in:	Yes	No	Don't Know	Comment
Sugar? (Sweets, Candy, Cookies, etc)				
Soda?				
Fast food, pre-packaged foods, artificial sweeteners?				
Milk, cheeses, other dairy products?				
Meat, vegetables, & potato diet?				
Vegetarian diet?				
Diet high in white breads?				

As a child, were there foods that you had to avoid because they gave you symptoms? Yes___ No___

If yes, please explain: (Example: milk – diarrhea)_____

CHILDHOOD ILLNESSES

Please indicate which of the following problems/conditions you experienced as a child (ages birth to 12 years) and the approximate age of onset.

	YES	AGE
ADD (Attention Deficient Disorder)		
Asthma		
Bronchitis		
Chicken Pox		
Colic		
Congenital problems		
Ear infections		
Fever blisters		
Frequent colds or flu		
Frequent headaches		
Hyperactivity		
Jaundice		
Measles		

	YES	AGE
Mumps		
Pneumonia		
Seasonal allergies		
Skin disorders (e.g. dermatitis, etc)		
Strep infections		
Tonsillitis		
Upset stomach, digestive problems		
Whooping cough		
Other (describe)		
Other (describe)		

As a child did you:

Have a high absence from school? Yes___ No___

If yes, why?_____

Experience chronic exposure to second hand smoke within your home? Yes___ No___

FEMALE MEDICAL HISTORY

(For women only)

OBSTETRICS HISTORY

Check box if yes, and provide number of pregnancies and/or occurrences of conditions

- | | | |
|---|---|---|
| <input type="checkbox"/> Pregnancies _____ | <input type="checkbox"/> Cesarean _____ | <input type="checkbox"/> Vaginal deliveries _____ |
| <input type="checkbox"/> Miscarriage _____ | <input type="checkbox"/> Abortion _____ | <input type="checkbox"/> Living Children _____ |
| <input type="checkbox"/> Post partum depression ___ | <input type="checkbox"/> Toxemia _____ | <input type="checkbox"/> Gestational diabetes _____ |

GYNECOLOGICAL HISTORY

Age at first menses? _____

Frequency: _____ Length: _____

Painful: Yes ___ No ___ Clotting: Yes ___ No ___

Date of last menstrual period: ___/___/___

Do you currently use contraception? Yes ___ No ___ If yes, what please indicate which form:

Non-hormonal

- Condom
- Diaphragm
- IUD
- Partner vasectomy
- Other (non-hormonal-please describe) _____

Hormonal

- Birth control pills
- Patch
- Nuva Ring
- Other (please describe) _____

Even if you are *not* currently using conception, but have used hormonal birth control in the past, please indicate which type and for how long. _____

Do you experience breast tenderness, water retention, or irritability (PMS) symptoms in the second half of your cycle? Yes ___ No ___

Please advise of any other symptoms that you feel are significant. _____

Are you menopausal? Yes ___ No ___ If yes, age of menopause _____

Do you currently take hormone replacement? Yes ___ No ___ If yes, what type and for how long? _____

- | | | | | | |
|--------------------------------------|-------------------------------|----------------------------------|-----------------------------------|---------------------------------------|----------------------------------|
| <input type="checkbox"/> Estrogen | <input type="checkbox"/> Ogen | <input type="checkbox"/> Estrace | <input type="checkbox"/> Premarin | <input type="checkbox"/> Progesterone | <input type="checkbox"/> Provera |
| <input type="checkbox"/> Other _____ | | | | | |

DIAGNOSTIC TESTING

Last PAP test: ___/___/___ Normal: _____ Abnormal _____

Last Mammogram ___/___/___ Breast biopsy? Date: ___/___/___

Date of last bone density ___/___/___ Results: High ___ Low ___ Within normal range ___

FAMILY HEALTH HISTORY

Please indicate current and past history to the best of your knowledge

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Age (if still living)									
Age at death (if deceased)									
Heart Attack									
Stroke									
Uterine Cancer									
Colon Cancer									
Breast Cancer									
Ovarian Cancer									
Prostate Cancer									
Skin Cancer									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Anemia									
Anxiety									
Arthritis									
Asthma									
Autism									
Autoimmune Diseases (such as Lupus)									
Bipolar Disease									
Bladder disease									
Blood clotting problems									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Flu									

Check Family Members that Apply	Father	Mother	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Genetic disorders									
Glaucoma									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Inflammatory Bowel Disease									
Insomnia									
Irritable Bowel Syndrome									
Kidney disease									
Multiple Sclerosis									
Nervous breakdown									
Obesity									
Osteoporosis									
Other									
Parkinson's									
Pneumonia/Bronchitis									
Psoriasis									
Psychiatric disorders									
Schizophrenia									
Sleep Apnea									
Smoking addiction									
Stroke									
Substance abuse (such as alcoholism)									
Ulcers									

REVIEW OF SYMPTOMS

Check (✓) those items that applied to you in the **past**. **Circle** those that **presently** apply.

GENERAL

- Fever
- Chills/Cold all over
- Aches/Pains
- General Weakness
- Difficulty sweating
- Excessive Sweating
- Swollen Glands
- Cold hands & Feet
- Fatigue
- Difficulty falling asleep
- Sleepwalker
- Nightmares
- No dream recall
- Early waking
- Daytime sleepiness
- Distorted vision

SKIN:

- Cuts heal slowly
- Bruise easily
- Rashes
- Pigmentation
- Changing Moles
- Calluses
- Eczema
- Psoriasis
- Dryness/cracking skin
- Oiliness
- Itching
- Acne
- Boils
- Hives
- Fungus on Nails
- Peeling Skin
- Shingles
- Nails Split
- White Spots/Lines on Nails
- Crawling Sensation
- Burning on Bottom of Feet
- Athletes Foot
- Cellulite
- Bugs love to bite you
- Bumps on back of arms & front of thighs
- Skin cancer
- Strong body odor

Is your skin sensitive to:

- Sun
- Fabrics
- Detergents
- Lotions/Creams

HEAD:

- Poor Concentration
- Confusion
- Headaches:
 - After Meals
 - Severe
 - Migraine
 - Frontal
 - Afternoon
 - Occipital
 - Afternoon
 - Daytime
 - Relieved by:
 - Eating Sweets
- Concussion/Whiplash
- Mental sluggishness
- Forgetfulness
- Indecisive
- Face twitch
- Poor memory
- Hair loss

EYES:

- Feeling of sand in eyes
- Double vision
- Blurred vision
- Poor night vision
- See bright flashes
- Halo around lights
- Eye pains
- Dark circles under eyes
- Strong light irritates
- Cataracts
- Floaters in eyes
- Visual hallucinations

EARS:

- Aches
- Discharge/Conjunctivitis
- Pains
- Ringing
- Deafness/Hearing loss
- Itching
- Pressure
- Hearing aid
- Frequent infections
- Tubes in ears
- Sensitive to loud noises
- Hearing hallucinations

NOSE/SINUSES

- Stuffy
- Bleeding
- Running/Discharge
- Watery nose
- Congested
- Infection
- Polyps
- Acute smell
- Drainage
- Sneezing spells
- Post nasal drip
- No sense of smell
- Do the change of seasons tend to make your symptoms worse? Yes/No

If yes, is it worse in the:

- Spring
- Summer
- Fall
- Winter

MOUTH:

- Coated tongue
- Sore tongue
- Teeth problems
- Bleeding gums
- Canker sores
- TMJ
- Cracked lips/ corners
- Chapped lips
- Fever blisters
- Wear dentures
- Grind teeth when sleeping
- Bad breath
- Dry mouth

THROAT:

- Mucus
- Difficulty swallowing
- Frequent hoarseness
- Tonsillitis
- Enlarged glands
- Constant clearing of throat
- Throat closes up

NECK:

- Stiffness
- Swelling
- Lumps
- Neck glands swell

CIRCULATION/RESPIRATION:

- Swollen ankles
- Sensitive to hot
- Sensitive to cold
- Extremities cold or clammy
- Hands/Feet go to sleep/numbness/tingling
- High blood pressure
- Chest pain
- Pain between shoulders
- Dizziness upon standing
- Fainting spells
- High cholesterol
- High triglycerides
- Wheezing
- Irregular heartbeat
- Palpitations
- Low exercise tolerance
- Frequent coughs
- Breathing heavily
- Frequently sighing
- Shortness of breath
- Night sweats
- Varicose veins/spider veins
- Mitral valve prolapse
- Murmurs
- Skipped heartbeat
- Heart enlargement
- Angina pain
- Bronchitis/Pneumonia
- Emphysema
- Croup
- Frequent colds
- Heavy/tight chest
- Prior heart attack ? When ___/___/___
- Phlebitis

GASTROINTESTINAL

- Peptic/Duodenal Ulcer
- Poor appetite
- Excessive appetite
- Gallstones
- Gallbladder pain
- Nervous stomach
- Full feeling after small meal
- Indigestion
- Heartburn
- Acid Reflux
- Hiatal Hernia
- Nausea
- Vomiting
- Vomiting blood
- Abdominal Pains/Cramps
- Gas
- Diarrhea
- Constipation
- Changes in bowels
- Rectal bleeding

- Tarry stools
- Rectal itching
- Use laxatives
- Bloating
- Belch frequently
- Anal itching
- Anal fissures
- Bloody stools
- Undigested food in stools

KIDNEY/URINARY TRACT:

- Burning
- Frequent urination
- Blood in urine
- Night time urination
- Problem passing urine
- Kidney pain
- Kidney stones
- Painful urination
- Bladder infections
- Kidney infections
- Syphilis
- Bedwetting
- Have trichomonas

WOMEN'S HISTORY (for women only)

- Fibrocystic breasts
- Lumps in breast
- Fibroid Tumors/Breast
- Spotting
- Heavy periods
- Fibroid Tumors/Uterus
- Painful periods
- Change in period
- Breast soreness before period
- Endometriosis
- Non-period bleeding
- Breast soreness during period
- Vaginal dryness
- Vaginal discharge
- Partial/total hysterectomy
- Hot flashes
- Mood swings
- Concentration/Memory Problems
- Breast cancer
- Ovarian cysts
- Pregnant
- Infertility
- Decreased libido
- Heavy bleeding
- Joint pains
- Headaches
- Weight gain
- Loss of bladder control
- Palpitations

MEN'S HISTORY (for men only)

Have you had a PSA done?

Yes _____ No _____

PSA Level:

- 0 – 2
- 2 – 4
- 4 – 10
- >10

- Prostate enlargement
- Prostate infection
- Change in libido
- Impotence
- Diminished/poor libido
- Infertility
- Lumps in testicles
- Sore on penis
- Genital pain
- Hernia
- Prostate cancer
- Low sperm count
- Difficulty obtaining erection
- Difficulty maintaining an erection
- Nocturia (urination at night)
 - How many times at night? _____
- Urgency/Hesitancy/Change in Urinary Stream
- Loss of bladder control

JOINT/MUSCLES/TENDONS

- Pain wakes you
- Weakness in legs and arms
- Balance problems
- Muscle cramping
- Head injury
- Muscle stiffness in morning
- Damp weather bothers you

EMOTIONAL:

- Convulsions
- Dizziness
- Fainting Spells
- Blackouts/Amnesia
- Had prior shock therapy
- Frequently keyed up and jittery
- Startled by sudden noises
- Anxiety/Feeling of panic
- Go to pieces easily
- Forgetful
- Listless/groggy
- Withdrawn feeling/Feeling 'lost'
- Had nervous breakdown
- Unable to concentrate/short attention span
- Vision changes
- Unable to reason
- Considered a nervous person by others
- Tends to worry needlessly
- Unusual tension

EMOTIONAL (CONTINUED)

- Frustration
- Emotional numbness
- Often break out in cold sweats
- Profuse sweating
- Depressed
- Previously admitted for psychiatric care
- Often awakened by frightening dreams
- Family member had nervous breakdown
- Use tranquilizers
- Misunderstood by others
- Irritable/
- Feeling of hostility/volatile or aggressive
- Fatigue
- Hyperactive
- Restless leg syndrome
- Considered clumsy
- Unable to coordinate muscles
- Have difficulty falling asleep
- Have difficulty staying asleep
- Daytime sleepiness
- Am a workaholic
- Have had hallucinations
- Have considered suicide
- Have overused alcohol
- Family history of overused alcohol
- Cry often
- Feel insecure
- Have overused drugs
- Been addicted to drugs
- Extremely shy

PAIN ASSESSMENT

Are you currently in pain? Yes ___ No ___

Is the source of your pain due to an injury? Yes ___ No ___

If yes, please describe your injury and the date in which it occurred: _____

If no, please describe how long you have experienced this pain and what you believe it is attributed to: _____

Please use the area(s) and illustration below to describe the severity of your pain.
(0= no pain, 10= severe pain)

Example: Neck

0 1 2 3 4 5 6 7 8 9 10

Area 1. _____

1 2 3 4 5 6 7 8 9 10

Area 2. _____

1 2 3 4 5 6 7 8 9 10

Area 3. _____

1 2 3 4 5 6 7 8 9 10

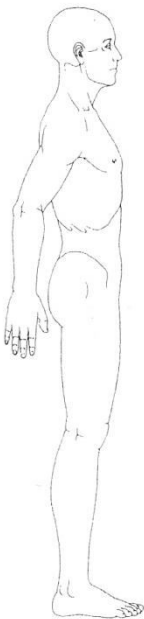
Area 4. _____

1 2 3 4 5 6 7 8 9 10

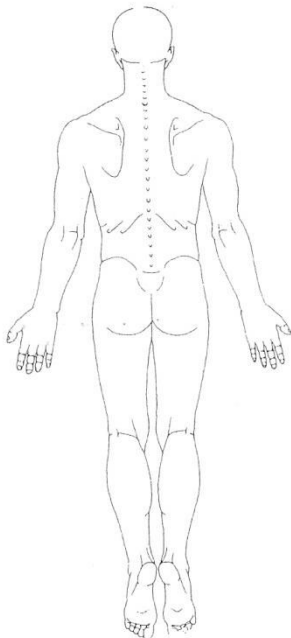
Use the letters provided to mark your area(s) of pain on the illustration.

A = ache **B**= burning **N**=numbness **S**= stiffness **T**=tingling **Z**=sharp/shooting

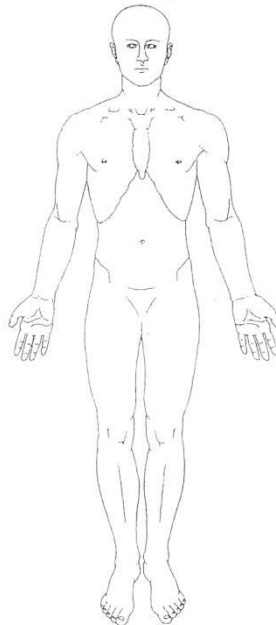
Right Side



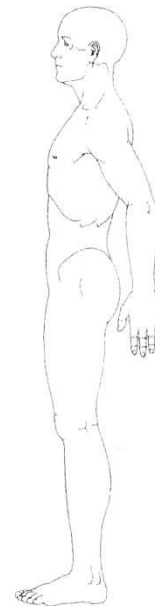
Back



Front



Left side



DENTAL HISTORY

	<u>Yes</u>	<u>No</u>
Problem with sore gums (gingivitis)?	_____	_____
Ringing in the ears (tinnitus)?	_____	_____
Have TMJ (temporal mandibular joint) problems?	_____	_____
Metallic taste in mouth?	_____	_____
Problems with bad breath (halitosis) or white tongue (thrush)?	_____	_____
Previously or currently wear braces?	_____	_____
Problems chewing?	_____	_____
Floss regularly?	_____	_____
Do you have amalgam dental fillings? How many?	_____	_____
Did you receive these fillings as a child?	_____	_____

List your approximate age and the type of dental work done from childhood until present:

Age	Type of dental work:	Health Problems following dental work? (describe)

NUTRITIONAL HISTORY

Have you made any changes in your eating habits because of your health? Yes ____ No ____

FOOD DIARY

Place a check mark next to the food/drink that applies to your current diet. (List continues on next page.)

Usual Breakfast	Usual Lunch	Usual Dinner
<input type="checkbox"/> None	<input type="checkbox"/> None	<input type="checkbox"/> None
<input type="checkbox"/> Bacon/Sausage	<input type="checkbox"/> Butter	<input type="checkbox"/> Beans (legumes)
<input type="checkbox"/> Bagel	<input type="checkbox"/> Coffee	<input type="checkbox"/> Brown rice
<input type="checkbox"/> Butter	<input type="checkbox"/> Eat in a cafeteria	<input type="checkbox"/> Butter
<input type="checkbox"/> Cereal	<input type="checkbox"/> Eat in restaurant	<input type="checkbox"/> Carrots
<input type="checkbox"/> Coffee	<input type="checkbox"/> Fish sandwich	<input type="checkbox"/> Coffee
<input type="checkbox"/> Donut	<input type="checkbox"/> Fried foods	<input type="checkbox"/> Fish
<input type="checkbox"/> Eggs	<input type="checkbox"/> Hamburger	<input type="checkbox"/> Green vegetables
<input type="checkbox"/> Fruit	<input type="checkbox"/> Hot dogs	<input type="checkbox"/> Juice
<input type="checkbox"/> Juice	<input type="checkbox"/> Juice	<input type="checkbox"/> Margarine
<input type="checkbox"/> Margarine	<input type="checkbox"/> Leftovers	<input type="checkbox"/> Milk
<input type="checkbox"/> Milk	<input type="checkbox"/> Lettuce	<input type="checkbox"/> Pasta
<input type="checkbox"/> Oat bran	<input type="checkbox"/> Margarine	<input type="checkbox"/> Potato
<input type="checkbox"/> Sugar	<input type="checkbox"/> Mayo	<input type="checkbox"/> Poultry
<input type="checkbox"/> Sweet roll	<input type="checkbox"/> Meat sandwich	<input type="checkbox"/> Red meat
<input type="checkbox"/> Sweetener	<input type="checkbox"/> Milk	<input type="checkbox"/> Rice
<input type="checkbox"/> Tea	<input type="checkbox"/> Pizza	<input type="checkbox"/> Salad
<input type="checkbox"/> Toast	<input type="checkbox"/> Potato chips	<input type="checkbox"/> Salad dressing
<input type="checkbox"/> Water	<input type="checkbox"/> Salad	<input type="checkbox"/> Soda
<input type="checkbox"/> Wheat bran	<input type="checkbox"/> Salad dressing	<input type="checkbox"/> Sugar
<input type="checkbox"/> Yogurt	<input type="checkbox"/> Soda	<input type="checkbox"/> Sweetener
<input type="checkbox"/> Oat meal	<input type="checkbox"/> Soup	<input type="checkbox"/> Tea
<input type="checkbox"/> Milk protein shake	<input type="checkbox"/> Sugar	<input type="checkbox"/> Vinegar
<input type="checkbox"/> Slim fast	<input type="checkbox"/> Sweetener	<input type="checkbox"/> Water
<input type="checkbox"/> Carnation shake	<input type="checkbox"/> Tea	<input type="checkbox"/> White rice
<input type="checkbox"/> Soy protein	<input type="checkbox"/> Tomato	<input type="checkbox"/> Yellow vegetables
<input type="checkbox"/> Whey protein	<input type="checkbox"/> Vegetables	<input type="checkbox"/> Other: (List below)
<input type="checkbox"/> Rice protein	<input type="checkbox"/> Water	
<input type="checkbox"/> Other: (List below)	<input type="checkbox"/> Yogurt	
	<input type="checkbox"/> Slim fast	
	<input type="checkbox"/> Carnation shake	
	<input type="checkbox"/> Protein shake	

How much of the following do you consume each week?

Candy	
Cheese	
Chocolate	
Cups of coffee containing caffeine	
Cups of decaffeinated coffee or tea	
Cups of hot chocolate	
Cups of tea containing caffeine	
Diet soda	
Ice cream	
Salty foods	
Slices of white bread (rolls/bagels, etc)	
Soda with caffeine	
Soda without caffeine	

Do you currently follow a special diet or nutritional program? Yes____ No____

- | | |
|--|--|
| <input type="checkbox"/> Ovo-lacto | <input type="checkbox"/> Vegetarian |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Vegan |
| <input type="checkbox"/> Dairy restricted | <input type="checkbox"/> Blood type diet |
| <input type="checkbox"/> Other (describe)_____ | |

Please tell us if there is anything special about your diet that we should know. _____

Do you have symptoms *immediately after* eating, such as belching, bloating, sneezing, hives, etc?

Yes____ No____

If yes, are these symptoms associated with any particular food or supplement?

Yes____ No____

If yes, please name the food or supplement and symptom(s). _____

Do you feel that you have *delayed* symptoms after eating certain foods, such as fatigue, muscle aches, sinus congestion, etc? (symptoms may not be evident for 24 hours or more)

Yes____ No____

Do you feel **worse** when you eat a lot of:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other _____ |

Do you feel **better** when you eat a lot of:

- | | |
|--|--|
| <input type="checkbox"/> High fat foods | <input type="checkbox"/> Refined sugar (junk food) |
| <input type="checkbox"/> High protein foods | <input type="checkbox"/> Fried foods |
| <input type="checkbox"/> High carbohydrate foods (breads, pasta, potatoes) | <input type="checkbox"/> 1 or 2 alcoholic drinks |
| | <input type="checkbox"/> Other _____ |

Does skipping meals greatly affect your symptoms? Yes _____ No _____

Has there ever been a food that you have craved or 'binged' on over a period of time?

Yes _____ No _____ If yes, what food(s) _____

Do you have an aversion to certain foods? Yes _____ No _____

If yes, what food(s) _____

Please complete the following chart as it relates to your bowel movements:

Frequency	√	Color	√
More than 3x/day		Medium brown consistently	
1-3x/ day		Very dark or black	
4-6x/week		Greenish color	
2-3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
Consistency	√	Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often floats			
Difficult to pass			
Diarrhea			
Thin, long or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

Intestinal gas:

- Daily
- Occasionally
- Excessive
- Present with pain
- Foul smelling
- Little odor

LIFESTYLE HISTORY

TOBACCO HISTORY

Have you ever used tobacco? Yes ____ No ____

If yes, what type? Cigarette ____ Smokeless ____ Cigar ____ Pipe ____ Patch/Gum ____

How much? _____

Number of years? _____ If not a current user, year quit _____

Attempts to quit: _____

Are you exposed to 2nd hand smoke regularly? If yes, please explain: _____

ALCOHOL INTAKE

Have you ever used alcohol? Yes ____ No ____

If yes, how often do you now drink alcohol?

- No longer drink alcohol
- Average 1-3 drinks per week
- Average 4-6 drinks per week
- Average 7-10 drinks per week
- Average >10 drinks per week

Do you notice a tolerance to alcohol (can you "hold" more than others?) Yes ____ No ____

Have you ever had a problem with alcohol? Yes ____ No ____

If yes, indicate time period (month/year) From _____ to _____

OTHER SUBSTANCES

Do you currently or have you previously used recreational drugs? Yes ____ No ____

If yes, what type(s) and method? (IV, inhaled, smoked, etc) _____

To your knowledge, have you ever been exposed to toxic metals in your job or at home? Yes ____ No ____

If yes, indicate which

- Lead
- Arsenic
- Aluminum
- Cadmium
- Mercury

SLEEP & REST HISTORY

Average number of hours that you sleep at night? Less than 10 ____ 8-10 ____ 6-8 ____ less than 6 ____

Do you:

- Have trouble falling asleep?
- Feel rested upon waking?
- Have problems with insomnia?
- Snore?
- Use sleeping aids?

EXERCISE HISTORY

Do you exercise regularly? Yes ____ No ____

If yes, please indicate:

Type of exercise	Times/week				Length of session			
	1x	2x	3x	4x/+	≤15	16-30 min	31-45 min	>45
Jogging/Walking								
Aerobics								
Strength Training								
Pilates/Yoga/Tai Chi								
Sports (tennis, golf, water sports, etc)								
Other (please indicate)								

If no, please indicate what problems limit your activity (e.g., lack of motivation, fatigue after exercising, etc)

SOCIAL HISTORY

Because stress has a direct effect on your overall health and wellbeing that often leads to illness, immune system dysfunction, and emotional disorders, it is important that your health care provider is aware of any stressful influences that may be impacting your health. Informing your doctor allows him/her to offer you supportive treatment options and optimize the outcome of your health care.

STRESS/PSYCHOSOCIAL HISTORY

Are you overall happy? Yes ____ No ____

Do you feel you can easily handle the stress in your life? Yes ____ No ____

If no, do you believe that stress is presently reducing the quality of your life? Yes ____ No ____

If yes, do you believe that you know the source of your stress? Yes ____ No ____

If yes, what do you believe it to be? _____

Do you practice meditation or relaxation techniques? Yes ____ No ____

If yes, how often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other

Hobbies and leisure activities:

Is there anything that you would like to discuss with the doctor today that you feel you cannot indicate here? Yes ____ No ____

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify your diet	5 _____	4 _____	3 _____	2 _____	1 _____
Take nutritional supplements each day	5 _____	4 _____	3 _____	2 _____	1 _____
Keep a record of everything you eat each day	5 _____	4 _____	3 _____	2 _____	1 _____
Modify your lifestyle (e.g. work demands, sleep habits)	5 _____	4 _____	3 _____	2 _____	1 _____
Practice relaxation techniques	5 _____	4 _____	3 _____	2 _____	1 _____
Engage in regular exercise	5 _____	4 _____	3 _____	2 _____	1 _____
Have periodic lab tests to assess progress	5 _____	4 _____	3 _____	2 _____	1 _____

Comments _____

Thank you for taking the time to complete this health history medical questionnaire. The information derived from all of these forms will provide invaluable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms alone.

We look forward to helping you achieve lifelong health and well being.

Sincerely,

Dr. Katherine Kubovy, DC, DABCI

Medical Records Release

Healing Arts Center of Lenexa
15545 W. 87th St. Pkwy. Lenexa, KS 66219-1434
Phone: (913) 894-4428 * Fax (913) 894-4427

Date: _____

I,

(Patient's Name)

have requested the release of medical records which are a part of the records of:

(Doctor/Hospital/ Health Care Facility)

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports or x-rays in your possession concerning the undersigned to:

Dr. Katherine Kubovy

The type and amount of information to be used or disclosed is as follows:



All blood work & labs for past two years.

Patient: _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Guardian: _____ Date of Birth: _____

Guardian Signature: _____ Date: _____

HEALING ARTS CENTER OF LENEXA

FINANCIAL POLICY

Last Revised 8/13/2018

It is the policy of Healing Arts Center to provide our patients with access to the highest quality chiropractic care available. We ask that you read, understand, and sign our Financial Policy prior to receiving treatment.

INSURANCE PARTICIPATION STATUS

While our providers are in network with a large number of insurance carriers, they are not in-network with all insurance carriers. Network participation status can sometimes vary from provider to provider within the practice. If you have questions regarding whether or not your provider is in network with your insurance plan, please contact our office.

INSURANCE PRIOR AUTHORIZATION AND REFERRALS FROM PRIMARY CARE PROVIDERS

Some require a referral from a primary care provider in order to be seen by a specialist. Some insurance plans require prior authorization from the insurance carrier before we may treat you. This is important because if the referral or prior authorization has not been received, your insurance carrier may not provide coverage for your visit. If your insurance plan requires a referral and/or prior authorization, it is your responsibility to obtain the referral and/or pre-authorization before your first visit. If we have not received your referral and/or prior authorization, we will ask that you reschedule your appointment.

SUBMISSION OF INSURANCE CLAIMS AND INSURANCE POLICY COVERAGE

If you provide us with your current insurance information, we will submit your claim to your insurance carrier for services rendered during your visit. Please understand that the health insurance policy that you select is a contract between you and your insurance carrier. You are financially responsible for all charges that are not paid by your insurance carrier. Wherever possible, we can work together with you to help you understand your insurance benefits, but ultimately you as the patient are responsible for understanding your policy benefits and limitations. If you have specific questions regarding your insurance policy coverage that our office cannot answer, please contact your insurance carrier directly using the customer service number on the back of your insurance card prior to your visit.

PAYMENT AT TIME SERVICE

We require all patients to provide payment for services rendered on the day of your visit. For patients utilizing insurance benefits, this payment includes any applicable copayment, co-insurance, or deductible for covered services and payment in full for any non-covered services. Insurance carriers refer to this cost as "patient responsibility." For self-pay patients, we require payment for the full cost of services rendered during your visit.

PAYMENT OPTIONS

You will receive paper statements by mail if you have an account balance. Your financial obligation will be clearly listed in the area marked "Please Pay." It is due and payable upon receipt. For your convenience, we accept payment in the form of cash, check, Visa, MasterCard, American Express, and Discover. Payments may be called in at (913) 894-4428, or mailed to 15545 West 87th Street, Lenexa, Kansas 66219. If you are submitting payment by mail, please cut and include the applicable portion of the statement with your payment so that our office can post your payment to the proper patient account.

OUTSTANDING BALANCES REFERRED TO COLLECTIONS

We urge you to keep your account current. If your account balance becomes more than 90 days past due, it will be referred to collections. You will then need to contact the collections company directly to pay your outstanding balance. If you need to make special payment arrangements due to an unforeseen circumstance, it is your responsibility to contact our billing manager before your account is sent to collections. If a patient account is turned over to collections, we reserve the right to discharge that patient from the practice.

NO-SHOW FEE

Appointments cancelled without 24 hours' notice will be assessed a no-show fee.

- \$50.00-New Patient Exam/Functional Medicine/Office Visit/Consultation/Physical Exam
- \$25.00-Adjustment/Treatment

Patient Full Name

Patient Signature

Date

Healing Arts Center of Lenexa

15545 W 87th St., Lenexa, KS 66219 ♦ Phone (913) 894-4428 Fax (913) 894-4427

Last revised 08/13/2018

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review it carefully.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- HIV/AIDS-related information*
- Communicable disease information*
- Genetic information*
- Sexually transmitted diseases and reproductive health information*

*unless otherwise required by law

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see:

<https://www.hhs.gov/hipaa/for-individuals/>.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

My signature below indicates that I have been offered a copy of Healing Arts Center of Lenexa's Model Notice of Privacy Practices.

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/notice.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Other Instructions for Notice

You may contact the privacy officer with questions via phone at (913) 894-4428, or by mail at ATTN: Privacy Officer, Healing Arts Center, 15545 W. 87th St., Lenexa, KS 66219.

Patient Full Name (Printed)

Patient Signature

Date