

Medical History

Arthritis
 Allergies/hay fever
 Asthma
 Alcoholism
 Alzheimer's disease
 Autoimmune disease
 Blood pressure problems
 Bronchitis
 Cancer
 Chronic fatigue syndrome
 Carpal tunnel syndrome
 Cholesterol, elevated
 Circulatory problems
 Colitis
 Dental problems
 Depression
 Diabetes
 Diverticular disease
 Drug addiction
 Eating disorder
 Epilepsy
 Emphysema
 Eyes, ears, nose, throat problems
 Environmental sensitivities
 Fibromyalgia
 Food intolerance
 Gastroesophageal reflux disease
 Genetic disorder
 Glaucoma
 Gout
 Heart disease
 Infection, chronic
 Inflammatory bowel disease
 Irritable bowel syndrome
 Kidney or bladder disease
 Learning disabilities
 Liver or gallbladder disease (stones)
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological problems (Parkinson's, paralysis)
 Sinus problems
 Stroke
 Thyroid trouble
 Obesity
 Osteoporosis
 Pneumonia
 Sexually transmitted disease
 Seasonal affective disorder
 Skin problems
 Tuberculosis
 Ulcer
 Urinary tract infection
 Varicose veins
 Other _____

Medical (Men)

Benign prostatic hyperplasia
 Prostate cancer
 Decreased sex drive
 Infertility
 Sexually transmitted disease
 Other _____

Medical (Women)

Menstrual irregularities
 Endometriosis
 Infertility

Fibrocystic breasts
 Fibroids/ovarian cysts
 Premenstrual syndrome (PMS)
 Breast cancer
 Pelvic inflammatory disease
 Vaginal infections
 Decreased sex drive
 Sexually transmitted disease
 Other _____
 Date of last GYN exam _____
 Mammogram q + q _____
 PAP q + q _____
 Form of birth control _____
 # of children _____
 # of pregnancies _____
 C-section _____
 Age of first period _____
 Date - last menstrual cycle _____
 Length of cycle _____ days
 Interval of time between cycles _____ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _____

Surgical menopause
 Menopause

Family Health History (Parents and Siblings)

Arthritis
 Asthma
 Alcoholism
 Alzheimer's disease
 Cancer
 Depression
 Diabetes
 Drug addiction
 Eating disorder
 Genetic disorder
 Glaucoma
 Heart disease
 Infertility
 Learning disabilities
 Mental illness
 Mental retardation
 Migraine headaches
 Neurological disorders (Parkinson's, paralysis)
 Obesity
 Osteoporosis
 Stroke
 Suicide

Other _____

Health Habits

Tobacco:
 Cigarettes: #/day _____
 Cigars: #/day _____
 Alcohol:
 Wine: #glasses/d or wk _____
 Liquor: #ounces/d or wk _____
 Beer: #glasses/d or wk _____
 Caffeine:
 Coffee: #6 oz cups/d _____
 Tea: #6 oz cups/d _____
 Soda w/caffeine: #cans/d _____
 Other sources _____
 Water: #glasses/d _____

Exercise

5-7 days per week
 3-4 days per week
 1-2 days per week
 45 minutes or more duration per

workout
 30-45 minutes duration per workout
 Less than 30 minutes
 Walk - #days/wk _____
 Run, jog, other aerobic - #days/wk _____

Weight lift - #days/wk _____
 Stretch - #days/wk _____

Other _____

Nutrition & Diet

Mixed food diet (animal and vegetable sources)
 Vegetarian
 Vegan
 Salt restriction
 Fat restriction
 Starch/carbohydrate restriction
 The Zone Diet
 Total calorie restriction
 Specific food restrictions:
 dairy
 wheat
 eggs
 soy
 corn
 all gluten

Other _____

Food Frequency

Number of servings per day:
 Fruits (citrus, melons, etc.) _____
 Dark green or deep yellow/orange vegetables _____
 Grains (unprocessed) _____
 Beans, peas, legumes _____
 Dairy, eggs _____
 Meat, poultry, fish _____

Eating Habits

Skip meals - which ones _____
 One meal/day
 Two meals/day
 Three meals/day
 Graze (small frequent meals)
 Generally eat on the run
 Eat constantly whether hungry or not

Current Supplements

Multivitamin/mineral
 Vitamin C
 Vitamin E
 EPA/DHA
 Evening Primrose/GLA
 Calcium, source _____
 Magnesium
 Zinc
 Minerals, describe _____
 Friendly flora (acidophilus)
 Digestive enzymes
 Amino acids
 CoQ10
 Antioxidants (e.g., lutein, resveratrol, etc.)
 Herbs
 Homeopathy
 Protein shakes
 Superfoods (e.g., bee pollen,

phytonutrient blends)

Liquid meals (Ensure)

Others _____

I Would Like To:**ENERGY - VITALITY**

Feel more vital
 Have more energy
 Have more endurance
 Be less tired after lunch
 Sleep better
 Be free of pain
 Get less colds and flu
 Get rid of allergies
 Not be dependent on over-the-counter medications like aspirin, ibuprofen, anti-histamines, sleeping aids, etc.
 Stop using laxatives and stool softeners

BODY COMPOSITION

Lose weight
 Burn more body fat
 Be stronger
 Have better muscle tone
 Be more flexible

STRESS, MENTAL, EMOTIONAL

Learn how to reduce stress
 Think more clearly and be more-focused

Improve memory

Be less depressed

Be less moody

Be less indecisive

Feel more motivated

LIFE ENRICHMENT

Reduce my risk of degenerative disease

Slow down accelerated aging

Maintain a healthier life longer

Change from a "treating-illness"

orientation to creating a

wellness lifestyle

TERMS OF ACCEPTANCE

VERTEBRAL SUBLUXATION: A misalignment of one or more of the 24 vertebra in the spine, or within the extremities, which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer to diagnose or treat any disease or condition other than vertebral and extremity subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic or unusual findings, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of a health care provider who specializes in that area.

**** Possible Adverse Reactions to an Adjustment:**

Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.

Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare.

Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.

Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments.

Nutritional Supplements: If I have a medical condition and taking prescription medication, I agree to discuss with my medical doctor any nutritional supplement that has been prescribed or taken from Natural Elements.

I, have read and fully understand the above statements.

All questions regarding the doctor's objectives pertaining to the care in this office have been answered to my complete satisfaction.

I, therefore, accept chiropractic care on this basis.

Signature

Date: ____/____/____

HIPPA Regulations Natural Elements will Follow to Ensure your Protection

Your Rights

- The right to request restrictions on certain uses and disclosure of your protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree to a requested restriction.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

In 2009 all healthcare professionals are required by law to send their bills, correspondence, and related billing information electronically. Natural Elements uses the billing services of **Medical Business Consulting**, a company also required to follow HIPPA regulations noted by the Dept. Of Health and Human Services (federal level). Information that will be electronically submitted is:

Beneficiary's name, date of birth, address, Beneficiary's health insurance identification and claim number, Date(s) of service, Diagnosis/nature of illness, Procedure/services performed

Contact Information

If you think your privacy rights have been violated by us, or disagree with a decision we made about access to your personal health information, you may contact: The U.S. Department of Health & Human Services Office of Civil Rights, 200 Independence Ave. S.W., Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-696-9775

I have received a read copy of the notice of privacy practices. This acknowledgement applies to:

Signed: _____ Date: _____

Natural Elements Chiropractic & Massage Cancellation Policy

NEW PATIENTS: Must give a 24 hour notice to cancel your appointment. If a 24 hour notice is not given you will be charged the rate of service for the appointment scheduled, \$125.00 for chiropractic and \$60.00 for massage.

ESTABLISHED PATIENTS:

Morning appointments must be called in by 4:30 pm the day before your appointment.

Afternoon appointments must be called in by 9:00 am on the day of your appointment.

If you do not call in by the designated times or "no show" for your appointment, you will be charged the rate of service for the appointment and will be required to pay for the missed appointment before scheduling another.

Exceptions: Medical Emergencies, illness & funeral

Signature: _____ **Date:** _____

FINANCIAL POLICY

Natural Elements Health Center is a cash based practice. Payment is due at the time of service.

Payment Plan: If you are suffering a financial hardship and need to set up a payment plan, please speak to our office manager at the front desk.

Returned Check Policy: All returned check's will be a \$30.00 non-sufficient funds charge.

Signature of Patient: _____ **Date:** ____/____/____

Client Bill of Rights for Massage

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, or prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Please check the box indicating that you have read this policy and sign.

Client

Signature: _____ **Date:** _____

****For Doctor Use Only****

PATIENT STATUS AT TIME OF INFORMED CONSENT AND TERMS OF ACCEPTANCE PROCESS

Based on my personal observations, medical history and direct conversation with the patient, I conclude that throughout the consent process the patient was:

- | | | | | | |
|--------------------------|---|--------------------------|--------------|--------------------------|--------------------|
| <input type="checkbox"/> | Of legal age | <input type="checkbox"/> | Oriented x 3 | <input type="checkbox"/> | Coherent and lucid |
| <input type="checkbox"/> | Proficient in understanding the English language | | | | |
| <input type="checkbox"/> | Assisted in understanding by an interpreter (Interpreter's name: _____) | | | | |
| <input type="checkbox"/> | Unable to give legal consent | | | | |
| <input type="checkbox"/> | Consent given thru legal guardian _____ | | | | |

Name

Relationship

I certify that the above accurately describes the above named patient's status during the informed consent process.

Date

Signature of Doctor