Confidential Patient Health Record Date: ___/___/_____

Circle One: Divorced Married Single Separated Widowed

Birth Date: ___/___/_____ Age: _____ Gender: Male/ Female

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Social Security#:_____-_____-_____ Email Address: _____

Spouses Name: _____ Children (Ages):_____

***How did you hear about us*?**

_____

Employer

Business Name: _____Occupation/Job Title: _____

Business Phone: _____ Business Fax: _____

Primary Care Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Who is Responsible for Your Bill?

☐ Self ☐ Insurance ☐ Medicare ☐ Other (be specific)

_____

Insurance: _____ Insured person's name: _____

Ins. Person's Soc. Sec. #:_____ Ins. Person's Date of Birth: _____

Subscriber ID: _____ Group #:_____

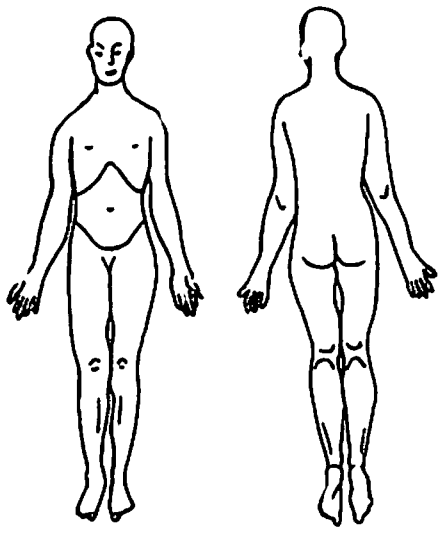
Contact Persons Name: _____ Phone Number: _____

Are you experiencing any pain or adverse sensations?

On the diagram to the right, use the letters below to indicate the type and location of any sensations you are feeling right now:

A= Ache **B**= Burning **N**= Numbness

S= Stabbing **P** =Pins and Needles **O**=Other



FEMALE HEALTH HISTORY QUESTIONNAIRE

Name _____ Age: _____ Today's date: _____

Birth Date: _____ Weight: _____ Height: _____ Occupation: _____

1. What is the reason for this visit?

_____

_____

2. List medications you are currently taking:

_____

_____

3. Any known drug allergies? _____

4. List natural supplements, herbs, remedies, including athletic performance supplements you are currently taking:

_____

_____

_____

5. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

_____

_____

_____

6. Date of last pelvic/gynecological exam: _____ Last Pap Test: _____ Last mammogram: _____
7. Last thermography? _____ Unusual results? _____
8. List significant non-GYN health issues (diabetes, surgeries, etc.):

_____

_____

LIFESTYLE INDICATORS **< = less than > = greater than**

1. Do you use any of the following? (circle responses)

Alcohol	None	<2 drinks/day	>2 drinks/day
Coffee	None	<2 cups/day	>2 cups/day
Soda	None	<2 cans/day	>2 cans/day
Sweets/refined carbs		<twice/day	>twice/day

2. Do you smoke cigarettes/cigars or use nicotine gum? Yes No When/How often? _____
3. How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10
4. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10
5. How often do you exercise? never rarely sometimes regularly competitively

INSTRUCTIONS: Check either "Ongoing" or "Just w/ Period" for each problem that applies to you. Check both if the problem is ongoing and worse with your period. Then rate the severity.

SIGNS & SYMPTOMS	ONGOING	JUST W/ PERIOD	MILD	MODERATE	SEVERE	MORE INFORMATION
Mood swings						
Anxiety/Nervousness						
Overly Reactive/Short fuse						
Irritability						
Depression						
Lowered self-esteem/self-image						
Caretake others before yourself						
Sadness/Crying						
Foggy thinking						
Memory difficulties						
Fatigue						
Constant hunger						
Sweet cravings (carbs/chocolate)						
Caffeine/Stimulant cravings						
Salt cravings						
Headaches/Migraines						
Body/Joint Aches/Backache						
Weight gain						
Weight loss						
Water Retention						
Bloating						
Irritable Bowel						
Constipation						
Light colored stool						
Loose stool/Diarrhea						
Nausea/vomiting						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered libido						
Heightened libido						
Hot flashes						
Night sweats						
Breast tenderness/swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency						
Incontinence						
Vaginal dryness						
Painful intercourse						

Any other symptoms? _____

_____

REPRODUCTIVE HEALTH HISTORY *(please fill in or circle the appropriate answer)*

1. Age at onset of menarche (first period): _____ Approximate date of onset: _____
2. Are you currently using a method of birth control? Yes No
   If yes, what method? _____
3. Are you, or have you used *(please circle)* oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No
   When and for how long? _____
4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____
   What type of IUD did you use? copper hormone other _____
5. Please describe problems that you may have experienced associated with the use of any and all birth control methods *(such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)*

   _____

   _____

   _____
6. Have you used, or are you currently using fertility or treatment? Yes No
   If yes, please explain. _____
7. Have you used, or are you currently using, bioidentical hormones (such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.)? Yes No If yes, what hormone(s), dosage, & for how long? _____

   _____

8. Have you been pregnant before? Yes No Age(s) of children: _____
   Number of pregnancies? _____ Details/ Complications: _____
   Number of live births: _____ _____
   Miscarriages: _____ _____
   Premature births: _____ _____
   Cesarean births: _____ _____
   Stillbirths: _____ _____
   Abortions: _____ _____
   Ectopic pregnancies _____ _____
9. If you have had a miscarriage, how many weeks pregnant were you? _____
10. Have you had an abnormal Pap Test? Yes No Diagnosis/Reason: _____
    Treatment and/or Medication: _____
11. Have you had a vaginal infection? Yes No If yes, what? _____
    Treatment and/or Medication: _____
12. Any history of... Ovarian cysts? Yes No Uterine fibroids? Yes No
    Fibrocystic Breasts? Yes No Endometriosis? Yes No
    Polycystic Ovarian Syndrome (PCOS)? Yes No

FOR CYCLING-AGE WOMEN *(please fill in or circle the appropriate answer)*

1. First day of last menstrual period (LMP): _____ Have you had a tubal ligation? Yes No When? _____
2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No
   If yes, please give details. _____
3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period)
   <20 _____ 20-30 _____ 30-40 _____ 40-50 _____ >50 _____
4. How many days does menstruation typically last? _____
5. Is your cycle regular? Yes No Not Always Details: _____
6. Typical menstrual flow: Light Medium Heavy Details: _____
7. How many *pads* and/or *tampons* (circle) are used on heavy days? _____
8. Do you pass clots? Yes No How often? _____
9. Do you spot? Yes No At what point in your cycle? _____
10. Do you experience cramping? None Mild Moderate Severe
    At what point in your cycle? _____
11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____
12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____
13. Do you experience breast tenderness? None Mild Moderate Severe
    At what point in your cycle? _____ Change in breast size? Yes No
14. Do experience nipple discharge? Yes No If yes, when? _____ Color? _____

FOR MENOPAUSAL WOMEN *(please fill in or circle the appropriate answer)*

1. Your age at the onset of menopause: _____ Year of onset: _____
2. Have you had a hysterectomy? complete *(ovaries AND uterus)* partial *(uterus only)*
3. Date of hysterectomy: _____ Reason for hysterectomy: _____
4. List any other GYN related surgeries: _____
5. Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.)*

MENOPAUSAL WOMEN, CONT'D

6. Have you used, or are you currently using, conventional hormone replacement therapy (HRT)? Yes No

   If yes, what were you prescribed? _____

   What dosage? _____ For how long? _____

7. Have you used, or are you currently using bioidentical hormone creams/gels/sublingual, troche, oral? Yes No

   If yes, what? _____

   What dosage? _____ For how long? _____

8. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No

   If yes, what? _____

   For how long? _____

9. Have you had, or do you have any vaginal spotting or bleeding since menopause? Yes No

   If yes, when? _____ Were you evaluate and/or treated by a GYN? Yes No

   Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY.

10. How would you have described your menstruation?

    Easy Uncomfortable Difficult Debilitating

11. What was your typical menstrual flow? Light Medium Heavy

12. When you were cycling would you consider your cycle regular? Yes No

    If no, explain. _____

Please describe any 'treatment' ever received for cycle issues. _____

_____

_____

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

   How long has this been happening? _____

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? *(no night light, street lamp, TV, etc.)* Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

I _____, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this consent.

2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is available upon request. I may also request a copy from this office at anytime via US mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

_____ _____
Printed name of Patient Date

_____ _____
Signature of Patient, Parent, or legal guardian Witness

Payment Policy

___ **CASH:** Payment in full is expected at the time the service is done.

___ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment of benefits to this office for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance.

___ **ALL INSURANCE AND MEDICARE:** I hereby authorize this office to release any medical or incidental information that may be necessary for medical care or processing applications for financial benefits. If I receive payment from my insurance carrier during the period which the clinic has accepted assignment of benefits, I will bring the check into this office within 3 days of receipt and endorse it over to the office. Failure to do this may result in collection action. If I discontinue care for any reason other than discharge by the doctor, I will be responsible for any unpaid balance regardless of any claims submitted to my insurance company, at the time I discontinue care. This office does not promise that any insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be my responsibility to pay all the charges and pursue reimbursement from the insurance company on my own.

___ **CANCELLATION POLICY:** 24 hour notice must be given to cancel an appointment. In case of a short notice or no notice cancellation, a $25.00 cancellation fee will be charged.

___ **PAST DUE ACCOUNT POLICY:** After 60 days of non-payment, a $25.00 late fee will be added to my account to be compounded monthly. If necessary, my account will be turned over to a collections agency. As a last resort, the office will take legal action and all reasonable attorney and court fees incurred to collect fees due to this office will be added to my account and I will be responsible.

****I have read and understand the above and hereby agree to abide by the provisions as specified. Thank you for your cooperation and understanding.**

Patient Name:_____

_____ _____

Signature of Patient, Parent, or Legal Guardian Date

Information Release Form

Name: _____ Date: _____

Contact Preferences

By signing below I give permission to Whole Health Chiropractic to leave messages regarding my appointments, nutrition, or other health information via the following methods unless otherwise specified (strike through any methods you wish to not receive).

- Voice Message on Home Number / Cell Number / Business Number
- Text Message to provided number
- Email Message to provided email address
- Demand Force – email/text appointment reminders, newsletters, birthday wishes, etc.
    - Contact settings can be changed by following the instructions in an email or text.

Sign: _____ Date: _____

Digital Contact Release

I understand that Whole Health Chiropractic seeks to be available for questions and further clarification that may be required through email, texting, Facebook messages, or other digital outlets. I also understand that many of these forms may not be compliant with HIPAA (health information portability and accountability act) privacy standards for medical information. By signing I agree to allow Whole Health Chiropractic staff and doctors to discuss my health information with me via these non-secure forms. Nothing will be intentionally made public.

Sign: _____ Date: _____

*By refusing signature, you are declining contact through these forms and all health information questions must be addressed by appointment or phone call.

Testimonial Release

Whole Health Chiropractic enjoys using testimonials to aid in patient awareness and education. I understand that by becoming a patient, my story may be told in written or oral form including online media. I understand that I have the right to determine the level of information revealed that connects me to the testimony personally including my name, initials, location, etc.
I am aware that I can request the removal of my identifying information at any time.
By signing below I give Whole Health Chiropractic the authority to use my:
(Please select all that apply)

- My initials
- My name
- Nothing (pseudonym)
- Picture (if provided)

Sign: _____ Date: _____

Informed Consent to Chiropractic and Associated Care

SERVICES

–Chiropractic & Manual Therapy: Chiropractic treatment will involve the doctor using their hands or an instrument to move your joints in order to impact the nervous system, which regulates the entire body. This may or may not result in a harmless "pop" sound, depending on the various techniques used. Manual therapies, such as myofascial reconfiguration and trigger point release, will involve the use of hands or tools to break up adhesions and impact the nervous system. *Risks:* The risks of Chiropractic and manual therapies include mild skin irritation, soreness or bruising. Extremely rare risks can include fracture, strain, sprain, stroke, or possible injury to intervertebral discs, nerves, the spinal cord or arteries in the neck. These risks are diminished by performing a thorough history, risk assessment, and examination.

–Acupuncture & Meridian Therapy: Acupuncture involves the use of needles to stimulate points on the body known to produce certain effects. Meridian therapy is the study of the energy systems in the body as it pertains to Traditional Chinese and other Eastern medicine practices, which includes acupressure, auriculotherapy, and some use of traditional herbal principles. *Risks:* The risks of Acupuncture therapy include bruising, numbness or tingling near needle sites for a few days, dizziness or fainting. Rare risks include organ puncture or infection. These risks are diminished by using sterile, disposable needles and practicing in a clean and safe environment.

–Functional Nutrition & Supplementation: Nutritional evaluation may include history, signs and symptoms analysis, laboratory testing (serum, skin, hair, urine, stool, saliva, etc), muscle testing, and bio-resonance testing. Recommendations may include lifestyle modification, dietary changes, and supplement suggestions. *Risks*: The risks of dietary and certain supplemental care may result in diarrhea, constipation, nausea, gas, headache, rashes or allergic response, toxicities, and deficiencies. These are diminished by taking ownership of the foods eaten and supplements taken, following general recommendations, and informing my medical and other doctors of any nutritional supplements or dietary changes. A full history, including medications, family and social history, is taken.

–Bio-resonance Testing: Bio-resonance testing is a form of bio-feedback that allows deeper analysis of the human body. It is not licensed by the FDA to diagnose or treat any condition and is not employed by most practitioners in this way. All decisions are ultimately made based on clinical and laboratory information regarding therapies or nutritional recommendations.

Alternatives: Alternatives to Chiropractic and these associated methods include medical care (including medications and/or surgical procedures), massage therapy, physical therapy, over-the-counter medication, and other self-care.

Risks of Non-Treatment: Delay of treatment may allow for progression of the current condition or reduction in healing with greater likelihood of formation of chronic pain or lifestyle limitations.

CONSENT TO TREATMENT

I hereby desire and request care via the methods above from Whole Health Chiropractic for myself or the patient, named below, for whom I am legally responsible. I have been informed of the risks, benefits and alternatives to Chiropractic, manual therapy, acupuncture, nutritional and herbal modification, and biofeedback testing. I am aware it is my sole responsibility to inform my physician to the best of my knowledge any health history or risk information so that my care plan may be adjusted accordingly. I also accept responsibility for seeking appropriate care for any conditions that arise before or after beginning care, including but not limited to pregnancy, diabetes, and any communicable diseases.

I understand that my doctor at Whole Health Chiropractic cannot make any promises or guarantees regarding a cure or improvement of my condition. I understand they will share their professional opinion regarding potential results from Chiropractic care and will discuss treatment options with me, but it is my responsibility to remain informed and in charge of the direction of my care.

I have been given the opportunity to ask pertinent questions regarding the above information. I understand that I am responsible for payment at time of service. My signature signifies that I have read this document and understand its purpose. I release Whole Health Chiropractic and its employed or affiliated practitioners from any liability.

Patient Name (print): Legal Guardian (required to sign if patient under 18):

_____ _____

Sign: Date: Witness: Date:

_____ _____ _____ _____