BEYER CHIROPRACTIC CENTER
CHIROPRACTIC · FUNCTIONAL NEUROLOGY · METABOLIC SOLUTIONS

Please fill out the following form in as much detail as possible. All your health information is kept confidential.

PATIENT INFORMATION:

Patient Name____ Today's Date: __________________________
Date of Birth_______________________________________ E-mail____
Address: _______________________________________City___________________________Zip Code_____________
Home Phone_________________________________ Cell Phone: ____
Gender: Female__________ Male_____________ Height_____________ Weight___________________________
How many children do you have? _________________ Any family members being treated here? ______________
Occupation________________________________ Marital Status ____
In case of emergency please contact:
Name____Relationship_______________________________
Phone Number_____________________________________ Cell Phone_____________________________________
Spouse's/Partner's Name____
Phone Number: ___________________________________Cell Phone_______________________________________

PATIENT CONDITION:
What is your major complaint (be as specific as possible)____
____
When did your condition(s) /symptoms/pain first appear? (Specific date, days ago, weeks ago, etc.)
____
When is it worse? _____ Morning ______ Afternoon _____ Evening ______Varies in time of day
Does it interfere with: _____Work ______ Sleep ______Daily routines _____ Recreation______ Other_________
How long has it been since you really felt good? ____
Other doctors seen for this condition ______MD ______DC_______DO______DDS_______Other______________
Does the condition/symptoms/pain radiate? _______ Yes _______No
If YES, where and how frequently? ____

Personal and Social Health History
Are you currently pregnant, or do you think you may be pregnant? ____Yes ___No If yes how many weeks? _______
How many hours per week do you typically work/attend school? ____
What are your typical duties and postures (sitting, standing, lifting, etc.)______________________________________
____
How would you rate your eating habits? ___Excellent___Pretty good___Could be better ___Needs improvement
How well do you sleep? ___Excellent ___Pretty good ___Restless___Cannot sleep ____Wake up often
How many hours of sleep do you get daily? ____Do you feel rested in the morning? ___Yes ____No
How is your energy overall? ____Excellent _____OK _____Low ____Sporadic/ Generally fatigued _____I depend on caffeine/ energy drinks for energy
How often do you get sick? ____Almost never ___I tend to catch what is going around_____I am constantly sick

What do you hope to achieve from our program?

____
____
____

HEALTH HISTORY

Do you have any allergies? (food, contact, environment)____
List any vitamins, herbs and supplements____
When was your last: Physical exam______________________Blood/lab _______________________________
X-ray study____
Injuries/Surgeries you have had and when:

____
____
____

Have you had or do you have any of the following conditions or diseases? Please check any that apply to indicate yes.

__ADHD	__ Connective tissue issues	__HIV/AIDS	__Adrenal Disorder
__COPD	__Kidney Disease	__Anxiety	__Depression
__Knee Surgery	__Arthritis	__Diabetes	__Liver Disease
__Asthma	__Digestive/bowel problems	__Marfan's syndrome	__Autoimmune disorder
__Dizziness or vertigo	__Multiple sclerosis	__Bleeding disorder	__Ear Infection
__ Osteoporosis/penia	__Blurred vision	__Fibromyalgia	__Parkinson's disease
__Bowel/bladder problems	__Food Sensitivities	__Rotator Cuff problem	__Buzzing in ear
__Fusions (spinal/joint)	__STI/STD	__Gout	__Cancer (type)_______________
__Shoulder injury	__Carpal Tunnel Syndrome	__Gall Bladder Issue	__Spinal injury
__Celiac disease (gluten)	__Immune compromise	__Stroke/TIA	__Heart Disease
__Tuberculosis	__Cold hands or feet	__Hepatitis (A,B,C,etc.)	__Colitis/diverticulitis
__High blood pressure	__Compression fractures	__Hip replacement	

__Other ____
__Other ____
Are there any conditions that run in your family? __Yes ___No If yes, what condition(s) and which family members?

____
____
____
____

MEDICATIONS

Name: ____ Date: _______/_________/_______

List the name of each current prescribed and OTC (over-the-counter) medications, its prescribed use and any side effects/reactions/positive responses. (Example: birth control pills can be used to prevent pregnancy, manage menopause or acne, etc.). (Example of side effect could be Tylenol caused liver enzymes to increase).

Medication	**The name of the condition or purpose for taking this medication.** (i.e. birth control pills for acne or endometriosis) Note: We do not need the number of pills or the dosage-mg/day info)	Any Side-Effects

Metabolic Assessment Form

Name: ____________________ **Age:** ______ **Sex:** _____ **Date:** ______________

PART I

Please list your 5 major health concerns in order of importance:

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3

Category VI (continued)				
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes	No		
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

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SMGEMAF04(052212)

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

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beyerchirocenter@gmail.com

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_______ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? ________

Rate your stress level on a scale of 1-10 during the average week: ________

How many caffeinated beverages do you consume per day? ________

How many times do you eat fish per week? ________

How many times do you eat out per week? ________

How many times do you work out per week? ________

How many times do you eat raw nuts or seeds per week? ________

List the three worst foods you eat during the average week: ____________________ ____________________ ____________________

List the three healthiest foods you eat during the average week: ____________________ ____________________ ____________________

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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SMGEMAF04(052212)

Beyer Chiropractic Center

PATIENT E-MAIL CONSENT FORM

Patient name: ____________________________
E-mail: ________________________________
Practice Physician: Dr. Stephen Beyer

1. RISK OF USING E-MAIL

Transmitting patient information by E-mail has a number of risks that patients should consider before using E-mail. These include, but are not limited to, the following risks:

a) **The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") recommends that E-mail that contains protected health information be encrypted. E-mails sent from Dr. Stephen Beyer and Beyer Chiropractic Center so E-mails may not be secure.** Therefore it is possible that the confidentiality of such communications may be breached by a third party.
b) E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
c) E-mail senders can easily misaddress an E-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Backup copies of E-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to inspect E-mail transmitted through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
   Practice server could go down and E-mail would not be received until the server is back on-line.
i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

Practices cannot guarantee but will use reasonable means to maintain security and confidentiality of E-mail information sent and received. Practice and Physician are not liable for improper disclosure of confidential information that is not caused by Practice's or Physician's intentional misconduct. Patients must acknowledge and consent to the following conditions:

a) **E-mail is not appropriate for urgent or emergency situations. Practice and Physician cannot guarantee that any particular E-mail will be read and responded to within any particular period of time.**
b) **If the patient's E-mail requires or invites a response from Practice or Physician, and the patient has not received a response within two (2) business days, it is the patient's responsibility to follow-up to determine whether the intended recipient received the E-mail and when the recipient will respond.**
c) E-mail must be concise. The patient should schedule an appointment if the issue is too complex or sensitive to discuss via E-mail.
d) **All E-mail will usually be printed and filed in the patient's medical record.**
e) Office staff may receive and read your messages.
f) Practice will not forward patient identifiable E-mails outside of the Practice without the patient's prior written consent, except as authorized or required by law.
g) The patient should not use E-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, or substance abuse. Practice is not liable for breaches of confidentiality caused by the patient or any third party.
h) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.
i) This consent will remain in effect until terminated in writing by either the patient or Practice.
j) In the event that the patient does not comply with the conditions herein, Practice may terminate patient's privilege to communicate by E-mail with Practice.

3. INSTRUCTIONS

To communicate by E-mail, the patient shall:

a) Avoid use of his/her employer's computer.
b) Put the patient's name in the body of the E-mail.
c) Key in the topic (e.g., medical question, billing question) in the subject line.

d) Inform Practice of changes in his/her E-mail address.
e) Acknowledge any E-mail received from the Practice and/or Physician.
f) Take precautions to preserve the confidentiality of E-mail.
g) Protect his/her password or other means of access to E-mail.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of E-mail between the Practice, Physician and me, and consent to the conditions and instructions outlined, as well as any other instructions that the Practice may impose to communicate with patient by E-mail. If I have any questions, I may inquire with the Practice Privacy Officer.

I, for myself, my heirs, executors, administrators and assigns, fully and forever release and discharge **Beyer Chiropractic Center** and its affiliates, shareholders, officers, directors, physicians, agents and employees, from and against any and all losses, claims, and liabilities arising out of or connected with the use of such E-mail.

Patient signature________________________
Date________________________________

Witness signature ________________________
Date ________________________________

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