# HEALTH FOR LIVING CHIROPRACTIC
# Dr. Loren Stockton, CCN, DACBN

**12400 Pillsbury Avenue South, Burnsville, MN 55337 PH 952.890.9055 FAX 952.890.7515**

## WELCOME TO HEALTH FOR LIVING CHIROPRACTIC

We are pleased you have chosen us to address your health and wellness needs and look forward to the opportunity to serve you. Below you will find information regarding our clinic services as well as a Patient Health Questionnaire, which will allow us to best serve you. Please take the necessary time to accurately and completely fill out all the pages enclosed.

## WHAT TO EXPECT

1. Your first appointment will be a consultation with the doctor to discuss your healthcare. We typically do not perform adjustments during the first appointment.
2. A diagnostic chiropractic, orthopedic and neurological examination will be performed to determine if chiropractic care is appropriate for you. The doctor will advise you if there is a need for any additional procedures, such as laboratory work or x-rays.
3. The front desk will inform you of your insurance coverage and what you will be financially responsible for at each visit. If using insurance please provide us with this information on the following page.
4. Your second visit will be a Report of Findings (ROF) and commencement of treatment.

## HEALTH SERVICES

- Skilled Spinal Care
- Acupuncture & Acupressure
- Nutritional Lab Profile Analysis
- Treatment for Auto & Job related Injuries
- Treatment for Sports Injuries
- Food Sensitivity Management
- Addressing:
  - Chronic Fatigue
  - Colic
  - Ear Problems
  - Headaches
  - Sinus Congestion
  - PMS
  - Candida
  - Fibromyalgia
  - Colon, Intestinal & Digestive Issues
- Nutritional Counseling/Detoxification
- Exercise Programs
- Custom Foot/Arch Supports
- Massage Therapy Referral
- Referral Network with top Medical Specialists

***Ask the doctor for more information regarding any condition you do not see listed here***

## MEDICARE PATIENTS!

In order for Medicare to pay for your treatment you must have a new incident or episode resulting in an acute neuromusculoskeletal injury or a re-injury to an old spinal problem. Our doctors are ready to address your health and wellness needs, however you must understand Medicare will not pay for injuries to areas other than the spine. This means care for injuries to toes, feet, ankles, knees, hips, fingers, hands, wrists, elbows, shoulders and everything in between are not covered.

## ATTENTION!

**For the health and safety of our patients with Allergies/Asthma/Emphysema, please refrain from wearing any of the following on the day of your office visit:**

***Cologne***
***Perfume***
***Scented Soaps***
***Scented Fabric Softeners***
***Hair Spray***
***Scented Lotions***

***THANK YOU FOR YOUR COOPERATION IN THIS VERY IMPORTANT MATTER***

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## INSURANCE INFORMATION

**Is your insurance purchased by you or your employer?** YES NO

If not, please provide us with the following:

Name of insured:_____

Date of birth of insured:_____/_____/_____

Patient's relationship to the insured (i.e. spouse, child, etc.)_____

**Please mark any and all insurance information:**

- o Blue Cross Blue Shield
- o Health Insurance
- o Medicare
- o MN Care/ Medical Assist.
- o Other: _____
- o None

**Name of Primary Insurance Co:**

_____

**Address:** _____

**ID #:** _____

**Group #:** _____

**Insurance Phone #:** _____

**Name of Secondary Insurance Co (if any):**

_____

**Address:** _____

**ID #:** _____

**Group #:** _____

**Insurance Phone #:** _____

**I authorize HEALTH FOR LIVING CHIROPRACTIC to release medical information to my insurance company.**

_____

Signature of Patient or Guardian Printed Name Date

## PERSONAL HISTORY

**Name:** _____ **Date:** _____

**Address:** _____**Apartment #:** _____

**City:** _____ **State:** _____ **Zip:** _____

**Home Phone: (_____)**_____ **Work: (_____)**_____ **Cell: (_____)**_____

**Email Address:** _____ **Sex: ( ) M ( ) F**

**Birth Date:**_____/_____/_____ **Age:** _____

**Employer:** _____ **Type of Work:** _____

**Check One: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed ( ) Life Partner**

**Emergency Contact:**

**Name:** _____**Phone: (____)**_____

**Relationship to Patient:** _____

**Spouse's Name:** _____**Phone: (____)**_____

**Number of Children:** _____

**Referred by:** _____

***Please initial here indicating your permission to thank the person(s) that referred you. _____

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**Preferred Language:**
**[ ]** ENGLISH
**[ ]** OTHER: _____

**Smoking Status – Age 13+**
**[ ]** Current/Every day smoker
**[ ]** Current/Some days smoker
**[ ]** Former Smoker
**[ ]** Never Smoked

**Race:**
**[ ]** American Indian or Alaska Native
**[ ]** Asian
**[ ]** Black or African American
**[ ]** Hispanic or Latino
**[ ]** Multi-racial
**[ ]** Native Hawaiian / Pacific Islander
**[ ]** White
**[ ]** Other _____

**Current Prescription Drugs Taken:**
**[ ]** NONE
**[ ]** _____
_____

**Current Nutritional Supplements Taken:**
**[ ]** NONE
**[ ]** _____
_____

**Allergies:**
**[ ]** No Known Drug Allergies (NKDA)
**[ ]** Drug Allergy: _____
**Reaction: [ ]** Mild **[ ]** Moderate **[ ]** Severe
**[ ]** Food Allergy: _____
**Reaction: [ ]** Mild **[ ]** Moderate **[ ]** Severe
**[ ]** Environmental: _____
**Reaction: [ ]** Mild **[ ]** Moderate **[ ]** Severe

**VITAL STATISTICS:**

**Height: _____ Weight: _____ Blood Pressure: _____/_____**

WE ARE ***FEDERALLY REQUIRED*** TO RECORD INFORMATION ON ***AT LEAST ONE*** OF YOUR FAMILY MEMBERS (PARENT, SIBLING OR CHILD) WITH A MEDICAL CONDITION.

PLEASE FILL IN THEIR NAME, DATE OF BIRTH, WHAT CONDITION THEY HAVE (IF ANY), WHEN THEY WERE DIAGNOSED, THEIR RELATIONSHIP TO YOU AND IF THE CONDITION IS STILL ACTIVE.

THEIR NAME: _____ THEIR DATE OF BIRTH: _____
RELATIONSHIP: ☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ SON ☐ DAUGHTER
CONDITION:_____ IS THIS CONDITION ACTIVE: YES ☐ NO ☐
WHAT AGE WERE THEY DIAGNOSED WITH THIS CONDITION? : _____

## HEALTH CONDITIONS

Please list your #1 most important health concern below and others on the next page.

| Describe the problem/injury, what you think is wrong, describing each one separately | Date of Onset |
|---|---|

**1.** _____

On the scale below circle the **severity/intensity** of your main complaint at its worst.

1 2 3 4 5 6 7 8 9

No Pain — Moderate Pain — Unbearable Pain

On the scale below circle the **percentage of time/frequency** you experience your main complaint.

0-10 10-20 20-30 30-40 40-50 50-60 60-70 70-80 80-90

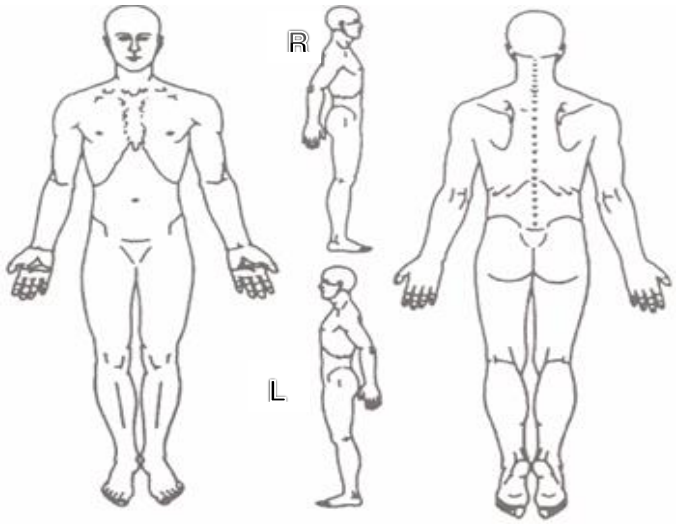
Occasional — Intermittent — Frequent — Constant

- **Have your symptoms:** Decreased Not changed Increased
- **Symptoms are worse in the:** Morning Afternoon Evening Increases during the day Constant
  How long does it last? ___ Minutes ___ Hours
- **Does the pain move/travel?** No Yes **To Where:** _____
- **Any sensation or change in bodily function felt around same time as your health condition:** _____
  _____
- **What makes it feel better?** (circle all that apply)
  standing sitting walking movement/exercise inactivity ice heat manipulation drugs rest support electrical therapy nothing other:_____
- **What makes it feel worse?** (circle all that apply)
  standing sitting walking movement/exercise inactivity ice heat manipulation drugs rest support electrical therapy nothing other:_____
- **Have you had this problem in the past?** Circle one: No Yes When:_____
  a. If yes, check: [ ] I have been hospitalized [ ] I have seen another chiropractor
  [ ] I have seen another provider [ ] Never been seen for this problem
- **Have you lost time from work because of it?** Circle one: No Yes (list when below)
  a. Dates from _____ to _____

- Comments:_____
  _____

- Mark on the diagram to the right where you experience each condition using the number of your condition and the letters below on the left. Example: place a '1A' on the neck if you have aching neck pain.

**Description:**
**A=** ache
**B=** burning
**C=** cramping
**D=** dull pain
**R=** throbbing
**N=** numbness
**T=** tingling
**S=** stiffness



## HEALTH CONDITIONS CONTINUED

| Describe the problem/injury, what you think is wrong, describing each one separately | Date of Onset |
|---|---|
| **2.** _____ | |

On the scale below circle the **severity/intensity** of your main complaint at its worst.

1 2 3 4 5 6 7 8 9

No Pain — Moderate Pain — Unbearable Pain

On the scale below circle the **percentage of time/frequency** you experience your main complaint.

0-10 10-20 20-30 30-40 40-50 50-60 60-70 70-80 80-90

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- **Does the pain move/travel?** No Yes **To Where:** _____
- **What makes it feel better?** (circle all that apply)

standing sitting walking movement/exercise inactivity ice heat manipulation drugs rest support electrical therapy nothing other:_____

- **What makes it feel worse?** (circle all that apply)

standing sitting walking movement/exercise inactivity ice heat manipulation drugs rest support electrical therapy nothing other:_____

- **Have you had this problem in the past?** Circle one: No Yes When:_____
  a. If yes, check: [ ] I have been hospitalized [ ] I have seen another chiropractor
  [ ] I have seen another provider [ ] Never been seen for this problem
- **Have you lost time from work because of it?** Circle one: No Yes (list when below)
  a. Dates from _____ to _____

| | |
|---|---|
| **3.** | |
| **4.** | |

## PAST HEALTH HISTORY

**Please check and/or describe all that apply:**

Major Surgery/Operations: [ ] Appendectomy [ ] Tonsillectomy [ ] Gall Bladder [ ] Hernia
[ ] Gastric Bypass [ ] Broken Bones [ ] Hysterectomy [ ] Thyroid

[ ] Other: _____

[ ] Major Falls: _____

[ ] Car Accidents **(any)**: _____

[ ] Concussions/Knocked out: _____

[ ] Other Hospitalizations: _____

Have you been x-rayed in the last year? YES NO

If yes, Date and Place: _____ [ ] Spine [ ] Extremity [ ] Chest

Have you had any extreme Mental, Chemical (toxic), or Physical stress in the past or presently? If yes, explain

Mental: _____

Chemical: _____

Physical: _____

Previous Chiropractic Care: ONCE INFREQUENT ON-GOING NEVER

Doctor's name and approximate date of last visit: _____

Have you been treated for any health condition in the last year? NO YES - Please explain below.

_____

## SOCIAL HISTORY

*Choose the best answer that applies to you*:

Do you smoke? [ ] Never Smoked [ ] Former Smoker [ ] Current/Some days
[ ] Current/every day

Do you drink alcohol? [ ] Never drink [ ] 1-2 times /month [ ] 3-4 times/month
[ ] 2-3 times/weekly [ ] Daily [ ] Used to drink

Do you drink coffee? [ ] Never [ ] 1-3 cups / week [ ] 4 or more cups per week
[ ] Daily (how many cups? _____) [ ] Used to drink coffee

Do you drink pop? [ ] Never [ ] 1-3 cans / week [ ] 4 or more cans per week
[ ] Daily (how many cans? _____) [ ] Used to drink pop

Do you use recreational drugs? [ ] Not applicable [ ] Marijuana [ ] Molly [ ] Ecstasy
[ ] Methamphetamine [ ] LSD/Heroin [ ] Speed/PCP [ ] Cocaine

If YES, how often? [ ] Daily [ ] 1-2 times /month [ ] 1-2 times/year
[ ] 2-3 times/weekly [ ] 3-4 times/month [ ] less than 1 time/year

Are you now or have you been on birth control in the past? [ ] Yes [ ] No

## FAMILY HISTORY

Do any of your family members have (or have they had) any of the following diseases or conditions?

Check all that apply.

[ ] Abnormal Bleeding/Hemophilia
[ ] Anemia
[ ] Arthritis
[ ] Asthma/Hay Fever
[ ] Bone Disorders
[ ] Cancer
What type:_____
[ ] Chronic Back Pain
[ ] Chronic Headaches
[ ] Congenital Heart Defect
[ ] Diabetes
[ ] Dizziness/Vertigo
[ ] Epilepsy
[ ] Gastrointestinal Disorders
[ ] Heart Problems
[ ] Heart Murmur
[ ] Hepatitis/ Liver Problems
[ ] High/Low BP
[ ] Tuberculosis
[ ] Kidney Problems
[ ] Lupus
[ ] Nervous Disorders
[ ] Obesity
[ ] Multiple Sclerosis
[ ] Major Surgeries _____
[ ] Other _____

Please provide 3 goals (NOT including relieving pain) that you hope to accomplish through our care:

1. _____
2. _____
3. _____

*If you have ever had a listed condition in the past, please check it in the Past column. If you are presently troubled by a particular condition, check it in the Present column. The information you provide; concerning past and present conditions and diseases assists your doctor in more thoroughly understanding your state of health.*

**Past Present**

[ ] [ ] Neck Pain (723.1)
[ ] [ ] Upper Back Pain (724.1)
[ ] [ ] Lower Back Pain (724.2)
[ ] [ ] Shoulder Pain (719.41)
[ ] [ ] Pain in Upper Arm or Elbow (719.42)
[ ] [ ] Wrist Pain (719.43)
[ ] [ ] Hand Pain (719.44)
[ ] [ ] Pain in Upper Leg or Hip (719.45)
[ ] [ ] Pain in Lower Leg or Knee (729.5)
[ ] [ ] Pain in Ankle or Foot (719.47)
[ ] [ ] Jaw Pain (526.9)
[ ] [ ] Swelling/Stiffness of Joints (719.5)
[ ] [ ] Arthritis (716.9)
[ ] [ ] Rheumatoid Arthritis (714.0)
[ ] [ ] Fainting (780.2)
[ ] [ ] Visual Disturbances (368.9)
[ ] [ ] Convulsions (780.3)
[ ] [ ] Diabetes (250.0)
[ ] [ ] Dizziness (780.4)
[ ] [ ] Headache (784.0)
[ ] [ ] Muscular Incoordination (781.3)
[ ] [ ] Tinnitus (388.30)
[ ] [ ] Rapid Heart Beat (785.0)
[ ] [ ] Chest Pain (786.50)
[ ] [ ] Loss of Appetite (783.0)
[ ] [ ] Anorexia (307.1)
[ ] [ ] Abnormal Weight Gain (783.1) Loss (783.2)
[ ] [ ] Excessive thirst (783.5)
[ ] [ ] Chronic Cough (786.2)
[ ] [ ] Chronic Sinusitis (473.9)
[ ] [ ] General fatigue (780.7)
[ ] [ ] Irregular Menstrual Flow (626.4)
[ ] [ ] Profuse Menstrual Flow (626.7)
[ ] [ ] Breast Soreness/Lumps (611.72)
[ ] [ ] Endometriosis (617.9)
[ ] [ ] PMS (625.4)
[ ] [ ] Loss of Bladder Control (788.30)
[ ] [ ] Painful Urination (788.1)
[ ] [ ] Frequent Urination (788.41)
[ ] [ ] Abdominal Pain (789.0)
[ ] [ ] Constipation/Irregular Bowel Habits (564.0)
[ ] [ ] Difficulty Swallowing (787.2)
[ ] [ ] Heartburn/Indigestion (787.1)
[ ] [ ] Dermatitis/Eczema/Rash (692.9)

**Past Present**

[ ] [ ] Depression (311)
[ ] [ ] Aortic Aneurysm (441.5)
[ ] [ ] High Blood Pressure (401.9)
[ ] [ ] Angina (413.9)
[ ] [ ] Heart Attack (410.9)
[ ] [ ] Stroke (436)
[ ] [ ] Asthma (493.9)
[ ] [ ] Cancer (199.1)
[ ] [ ] Tumor (229.9)
[ ] [ ] Anemia
[ ] [ ] Thyroid Disorder
[ ] [ ] Prostate Problems (601.9)
[ ] [ ] Blood Disorder (790.6)
[ ] [ ] Emphysema (COPD) (492.8)
[ ] [ ] Epilepsy (349.5)
[ ] [ ] Ulcer (556.9)
[ ] [ ] Liver (573.9) / Gallbladder (575.9) problems
[ ] [ ] Hepatitis (573.3)
[ ] [ ] Kidney Stones (592.0)
[ ] [ ] Kidney Disorders (by condition)
[ ] [ ] Bladder Infection (595.9)
[ ] [ ] Colitis (558.9)
[ ] [ ] Irritable Colon (564.1)
[ ] [ ] HIV/AIDS (042)
[ ] [ ] Pregnant (V22.2)
[ ] [ ] Birth Control Pills
Other _____
[ ] [ ] Articular hypermobility/joint instability
[ ] [ ] Severe demineralization of bone
[ ] [ ] Benign bone tumors of the spine
[ ] [ ] Bleeding disorders and anticoagulant therapy
[ ] [ ] Radiculopathy with progressive neurological signs
[ ] [ ] Acute rheumatoid arthritis
[ ] [ ] Acute ankylosing spondylitis
[ ] [ ] Acute fracture or dislocation
[ ] [ ] Healed fracture or dislocation
[ ] [ ] Unstable os odontoideum
[ ] [ ] Vertebral column: malignancies
[ ] [ ] Infection of joint/bone in vertebral column
[ ] [ ] Symptoms of myelopathy
[ ] [ ] Cauda Equina Syndrome
[ ] [ ] ANY arterial aneurysm
[ ] [ ] Cervical spine: vertebrobasilar insufficiency syndrome

Do you have a permanent disability? YES [ ] NO [ ]
Location:_____
Date Received: _____
Rating Percentage:_____%

# MEDICAL SYMPTOM/TOXICITY QUESTIONNAIRE

**NAME:** _____ **DATE:** ____/____/____

Rate each of the following symptoms based upon your typical health profile for the **specified duration you choose:**

[ ] Past Month [ ] Past week [ ] Past 48 Hours

***POINT SCALE*** *0 = Never or almost never have the symptom 1 = Occasionally have it, effect is not severe 2 = Occasionally have it, effect is severe 3 = Frequently have it, effect is not severe 4 = Frequently have it, effect is severe*

## Medical Symptoms Questionnaire (MSQ)

**Head**
___Headaches
___Insomnia
___Faintness
___Dizziness Total_____

**Eyes**
___Watery or Itchy
___Bags or dark circles under eyes
___Swollen, reddened, or sticky eyelids
___Blurred or tunnel vision Total_____

**Ears**
___Itchy ears
___Earaches/Infections
___Drainage from ear
___Ringing in ears Total_____

**Nose**
___Stuffy nose
___Sinus problems
___Hay Fever
___Sneezing attacks
___Excessive mucus Total_____

**Mouth/Throat**
___Chronic coughing
___Gagging, frequent need to clear throat
___Sore throat, hoarseness, loss of voice
___Swollen or discolored tongue, gums, lips
___Canker sores Total_____

**Skin**
___Acne
___Hives, rashes, dry skin
___Hair loss
___Flushing, hot flashes
___Excessive sweating Total_____

**Energy/ Activity**
___Fatigue, sluggishness
___Apathy, lethargy
___Hyperactivity
___Restlessness Total_____

**Other**
___Frequent Illness
___Frequent/Urgent urination
___Genital itch/discharge Total_____

**Joints/ Muscle**
___Pain or aches in joints
___Arthritis
___Feeling of weakness or tiredness
___Stiffness or limitation of movement
___Pain or aches in muscles Total_____

**Heart**
___Chest Pain
___Irregular or skipped beat
___Rapid pounding heartbeat Total_____

**Lungs**
___Chest congestion
___Asthma, bronchitis
___Shortness of breath
___Difficulty breathing Total_____

**Digestive**
___Nausea, Vomiting
___Diarrhea
___Constipation
___Bloated feeling
___Belching, passing gas
___Heartburn
___Intestinal/stomach pain Total_____

**Weight**
___Underweight
___Binge eating/drinking
___Craving certain foods
___Excessive weight gain
___Water retention
___Compulsive eating Total_____

**Mind**
___Poor concentration
___Confusion, poor comprehension
___Poor memory
___Learning disabilities
___Difficulty in making decisions
___Stuttering or stammering
___Slurred speech
___Poor physical coordination Total_____

**Emotions**
___Mood swings
___Anxiety, fear, nervousness
___Anger, irritability, aggressiveness
___Depression Total_____

**GRAND TOTAL: _____**

Approximately how many servings of the following foods do you consume each **week**?

**1. Glasses of:**
Whole milk _____
Skim milk _____
Cream _____
Buttermilk _____
Soy milk _____

**1a. Servings of:**
Cheese _____
What kind _____
Yogurt _____

**2. Servings of:**
Eggs _____
Beef _____
Pork _____
Veal _____
Liver _____
Bacon _____
Fowl _____
Fish _____
Shell fish _____
Lunch meat _____
Canned meat _____

**3. Servings of:**
Cereals (hot) _____
Cereals (cold) _____
Sugar-coated _____
Pancakes _____
Waffles _____
Crackers _____
Rice (brown) _____
Rice (white) _____
Rice (wild) _____
Macaroni _____
Spaghetti _____
Soup (canned) _____
Soup (fresh) _____

**4. Servings of:**
Pie _____
Cake _____
Jell-O/pudding _____
Candy _____
Candy bars _____
Doughnuts _____
Ice cream _____
Chips _____

**5. Glasses of:**
Juice _____
What kind _____
Soda/Pop _____
Spring water _____
Water (city) _____
Water (well) _____

**6.** Servings **of:**
Potatoes _____
Carrots _____
Beans (yellow) _____
Beans (green) _____
Beans (dried) _____
Corn _____
Squash _____
Spinach _____
Lettuce _____
Celery _____
Green peas _____
Broccoli _____
Cauliflower _____
Asparagus _____
Onions _____
Tomatoes _____
Green pepper _____
Cabbage _____
Turnips _____
Beets _____
Others _____

**7. Servings of:**
Oranges _____
Grapefruit _____
Pineapple _____
Melon _____
Apples _____
Pears _____
Bananas _____
Grapes _____
Raisins _____
Apricots _____
Peaches _____
Plums _____
Strawberries _____
Raspberries _____
Blueberries _____
Others _____

**8. Servings of:**
Peanuts _____
Peanut butter _____
Other nuts _____
Jellies _____
Mayonnaise _____

**9.** What vegetable oils do you use in cooking?
_____ in salads _____

**10.** Do you use any fats or compounds when cooking? _____ What kind?_____

**11. Pats of:**
Butter _____
Margarine _____

**12. Slices of:**
Wheat Bread _____
White Bread _____
Rye Bread _____
Corn Bread _____
Sweet Bread _____
Others _____

**13. Glasses of:**
Water _____
Beer _____
Wine _____
Alcohol drink _____
Others _____

**14. Cups of:**
Coffee (regular) _____
Coffee (decaf) _____
Tea _____
Herbal _____

**15. Do you use Salt**:
Freely _____
Moderately _____
Sparingly _____
Never _____

**16. Do you use Vinegar:**
Freely _____
Moderately _____
Sparingly _____
Never _____

**17.** About how many teaspoons of sugar do you add to your food/drinks each day? _____

**18.** Has this been your average diet for the past three years? _____

**19.** What, if any, foods disagree with you? _____

**20.** Do you have indigestion? _____

**21.** What did you eat for breakfast yesterday? _____

**22.** What did you eat for lunch yesterday? _____

**23.** What did you eat for supper yesterday?_____

**24.** What beverages did you have yesterday? _____

**25.** What food or beverages did you have between meals? _____

**26.** Are you fond of:

| | | | | | |
|---|---|---|---|---|---|
| Meat | ____yes ____no | Cereals | ____yes ____ no | Sweets | ____yes ____no |
| Fruits | ____yes ____no | Vegetables | ____yes ____no | Butter | _____yes ____no |
| Fats | ____yes ____no | Breads | ____yes ____no | | |

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## PATIENT BILLING ACKNOWLEDGEMENT FORM

### Non-Covered/Reduced Fees

Under your health plan/auto insurance you are financially responsible for co-payments, co-insurance, deductibles and auto reductions for covered services. You are also financially responsible for all non-covered services, including care determined to be elective or maintenance.

These non-covered services may include exams, manipulation, muscle testing, therapies, taping and nutritional supplements.

**********

I _____, acknowledge that I have been told in advance by my provider that the services listed above are not covered/or may be reduced by my health insurance/auto insurance. I agree to pay for these non-covered/reduced services.

Patient/Guardian Name – Please Print

_____ _____

Patient/Guardian Signature Date

## ATTENTION!

Metagenics medical foods are true human researched dietary supplements and thus are eligible for FSA, HSA, and HRA reimbursement. These include: UltraMeal 360, GlycemX 360, UltraInflamX 360, UltraClear Renew, etc. Please keep the prescription sheet provided by the doctor, the purchase receipt and follow claims process provided by your health insurance for reimbursement. This reimbursement is an added bonus to getting the full health benefits of the medical foods therapeutic action while maintaining the highest state of wellbeing.

# HEALTH FOR LIVING CHIROPRACTIC

## INFORMED CONSENT TO HEALTH CARE TREATMENT

**Natural Chiropractic Treatment:** The doctor uses his/her hands or a mechanical device in order to facilitate movement of your body's joints that are functioning abnormally. You may hear and feel a "click" or "pop", such as the noise when a knuckle is "cracked" and you may feel movement of the joint. Various ancillary procedures, such as electrical muscle stimulation, electrical needle-less acupuncture, other non-needle acupuncture devices, needle acupuncture, manual muscle and soft tissue release techniques, and traction may be used as well. Nutritional and herbal supplements may also be recommended. The doctors of chiropractic in this office have received extensive training in the use of Applied Kinesiology (AK or muscle testing) and Reflex Analysis to assist in evaluating your body's neuromusculoskeletal system. AK was developed by George Goodheart, DC in 1964. While there is a growing body of peer reviewed research and publications about AK, some of the techniques have not been supported by a body of evidence using standard scientific research and methods. This office will use AK testing as well as standard evaluation procedures as indicated.

**Possible Risks:** As with any health care procedure, complications are possible following chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocation of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. The estimates of this occurring are 6.4 per 10 million manipulations of the upper spine, and can be further reduced with screening procedures. In other words, the probability is extremely rare. Compare that with if you drive 10,000 miles per year, your chance of dying in a car wreck in any given year is something like 1 in 6,000. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, redness/minor bruises from needle insertions, or minor digestive upset from a nutritional product. Some patients can react to food compounds as an allergy, or be sensitive to specific nutrient compounds.

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

**Nutritional Informed Consent:** Vitamin, mineral, amino acid, fatty acid, antioxidant, herb or homeopathic remedies may have an effect on any disease process or symptoms. A drug is defined as "articles intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease" as tested by the Food, Drug, and Cosmetic Act. Therefore, please be advised that any suggested nutritional or dietary advice is not intended as primary treatment and/or therapy for any disease or particular body symptom. Nutritional counseling, recommendations, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biochemical processes of the human body.

**Cancer Informed Consent:** This is applicable to those patients with a diagnosis of cancer seeking health care advice from this office. The doctors and this clinic cannot be held responsible for the reversal, cure, or amelioration of your cancer condition. It is further understood that the doctor/clinic are not communicating a guarantee or implied "cure" of your cancer status. The advice and/or treatment the doctor/clinic is providing me is for general health care support, self-healing, and not for a specific disease or diagnosis. Some of the nutritional, herbal, metabolic supplements and ancillary procedures may be classified as experimental and developmental in nature, and that there may be no scientific proof that these suggestions will create the desired effect(s). There could be side effects/symptoms as a result of a suggested treatment(s).

**I have read the explanation above of health care treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I hereby give my full consent to diagnostic testing and treatment. I understand that treatment and results are not guaranteed.**

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Printed Name Signature Date

# PATIENT HEALTH INFORMATION CONSENT FORM (HIPPA)

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you in the reception area before signing this consent. If you would like a copy of our HIPPA policy please ask our receptionist and they will provide you with a copy to take home.

1. The patient understands and agrees to allow this chiropractic office to use their (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

3. A patient's written consent need only be obtained one time for all subsequent care given to the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but could apply to any care given after the request has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.

7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information (PHI) will be used and I agree to these policies and procedures.

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Signature of Patient Printed Patient Name Date