ADVANTAGE CHIROPRACTIC CLINIC

Welcome to our office! We look forward to becoming your partner in evaluating and improving your health. Please take the time prior to your first visit to fill out all the forms included in this packet. Give yourself plenty of time to fill in everything as accurately and thoughtfully as possible. This may be the most important step in your health and recovery. Knowing the history and underlying aspects of your case ensures a more accurate assessment and efficient treatment recommendations. It is often the smallest, most seemingly insignificant detail that turns out to be an important factor in how you got to where you are now. Our patients often find it helpful to fill these questions out over several days, sometimes with the help of family members. To be as thorough as we need you to be it will require a good bit of "digging" into your past!

Chiropractic and Functional Medicine are a perfect match – a potent and effective combination that can change your health in profound and lasting ways.

Functional Medicine (FM) is different from "wellness" care or preventive wellness in that it addresses the patient who may be experiencing severe and/or chronic symptoms in addition to the 'well-patient". This is not to say that FM and wellness care are mutually exclusive by any means. In fact, a cornerstone of FM is teaching patients how to *stay healthy* and to strive for optimal health and function which is the best approach to avoiding disease. However, FM is more equipped to address serious health complaints. As practitioners we all know that an unfortunate reality of the human psyche is to resist change unless there is an immediate motivator such as pain or discomfort. This allows the Functional Medicine Practitioner (FMP) to get to the patient when they are most apt to adopt lifestyle changes that encourage healing and wellness, when they may have otherwise just sought drugs or another quick fix.

In my opinion, every patient deserves a thorough look into the whole of the body, not just musculoskeletal. How amazing is it that can go to your chiropractor, get your aches and pains addressed, get supported in maintaining optimal health, get your lab work done, have nutritional medicine alternatives that are scientifically based, and have a knowledgeable resource for any and all health issues that may arise for you or your family? This is what I strive to provide, by knowing everything I can about the human body and how to support it.

For Functional Medicine to succeed it requires a high degree of personal responsibility on the part of the patient. We will work together to develop a treatment plan that fits your lifestyle but you must be willing to follow the treatment plan if you expect to see results.

If you have any further questions after reading the enclosed information, please feel free to call our office. We will be happy to assist you. Please be sure to complete all forms and send them to us before your scheduled visit. We look forward to working with you!

Yours In Health,

Brad Adams, D.C., Fellow of the Academy of Chiropractic Orthopedists

2408 East University Drive Suite 101
Auburn, AL 36830
334-821-2552 office • 866-850-0983 fax

GENERAL INFORMATION *(If more space is needed when filling in certain sections, please feel free to provide separate sheet)*

Name: *First*_____ *Middle*_____ *Last*_____
Preferred Name:_____ Date:_____
Date of Birth: _____/_____/_____ Age: _____ Gender: □ Male □ Female
Primary Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Alternate Address: _____ Apt. No.: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Cell: _____ Work: _____
Best Phone and Times to Reach You: _____
Email: _____ Fax: _____
Emergency Contact: Name _____ Phone_____
Relationship to you_____ Address: _____
City: _____ State: _____ Zip: _____
Your Genetic Background: □ African □ Asian □ European □ Ashkenazi □ Native American
□ Middle Eastern □ Mediterranean □ Other _____
Job Title: _____
Nature of Business: _____
Primary Pharmacy: Name_____ Phone_____
Address: _____
City: _____ State: _____ Zip: _____
Email: _____ Fax: _____
Whom may we thank for referring you? _____
□ Existing Patient □ Website □ Media □ Other
_____

Health Concerns & Goals

Please list the top 5 Health concern you have: start with your highest concern first

1. _____
2. _____
3. _____
4. _____
5. _____

Please Elaborate on the top 3 health concerns:

Health Concern #1 *(Please describe as many details as you can)* _____
_____
When did you first notice symptoms appear? _____ Was there a trigger? _____
Is this condition getting: □ Better □ Worse □ About the same
What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____
_____
What makes it better? _____
What makes it worse? _____
If pain is associated with your condition, please check all that apply: *Type of pain*
□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning
□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____
How often do you experience this condition? _____
Is it constant or does it come and go? _____
Anything else you feel is important about this condition? _____

Health Concern #2 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

Health Concern #3 *(Please describe as many details as you can)* _____

_____

When did you first notice symptoms appear? _____ Was there a trigger? _____

Is this condition getting: □ Better □ Worse □ About the same

What treatments have you tried? *Please list everything - home remedies to medical interventions:* _____

_____

What makes it better? _____

What makes it worse? _____

If pain is associated with your condition, please check all that apply: *Type of pain*

□ Sharp □ Dull □ Throbbing □ Numbness □ Aching □ Shooting □ Burning

□ Tingling □ Cramps □ Stiffness □ Swelling □ Other _____

How often do you experience this condition? _____

Is it constant or does it come and go? _____

Anything else you feel is important about this condition? _____

In general, what do you hope to achieve with your visits here?

_____

_____

_____

When was the last time you felt exceptionally well? _____

Medical History

Please list all other healthcare providers with whom you have received treatment within the last 10 years: Feel free to provide separate sheets

□ Doctor of Chiropractic *Name:* _____ *City:*_____

Treatment Focus: _____

□ M.D. / D.O. *Name:* _____ *City:*_____

Treatment Focus: _____

□ Physical Therapist *Name:* _____ *City:*_____

Treatment Focus: _____

□ *Other:* _____

Name: _____ *City:*_____

Treatment Focus: _____

Hospitalizations □ None

*Date*_____ - *Reason* _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

_____ - _____

Allergies

Medication/Supplement/Food	*Reaction*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Diagnostics with dates(i.e. Lab work, X-ray, imaging studies etc.)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Diseases/Diagnosis/Conditions: *Check appropriate box and provide Month/Year of onset* □ *Past Condition* □ *Ongoing Condition*

Gastrointestinal
- □ □ Irritable Bowel Syndrome ___ /____
- □ □ Inflammatory Bowel Disease ___ /____
- □ □ Crohn's ___ /____
- □ □ Ulcerative Colitis ___ /____
- □ □ Gastritis or Peptic Ulcer Disease ___ /____
- □ □ GERD *(reflux)* ___ /____
- □ □ Celiac Disease ___ /____
- □ □ Hemorrhoids ___ /____
- □ □ Other ___ /____ _____

Cardiovascular
- □ □ Heart Attack ___ /____
- □ □ Other Heart Disease ___ /____
- □ □ Stroke ___ /____
- □ □ Elevated Cholesterol ___ /____
- □ □ Arrhythmia *(irregular heart rate)* ___ /____
- □ □ Hypertension *(high blood pressure)* ___ /____
- □ □ Rheumatic Fever ___ /____
- □ □ Mitral Valve Fever ___ /____
- □ □ Other ___ /____ _____

Cancer
- □ □ Lung Cancer ___ /____
- □ □ Breast Cancer ___ /____
- □ □ Colon Cancer ___ /____
- □ □ Ovarian Cancer ___ /____
- □ □ Prostate Cancer ___ /____
- □ □ Skin Cancer ___ /____
- □ □ Other ___ /____ _____

Genital & Urinary Systems
- □ □ Kidney Stones ___ /____
- □ □ Gout ___ /____
- □ □ Interstitial Cystitis ___ /____
- □ □ Frequent Urinary Tract Infections ___ /____
- □ □ Frequent Yeast Infections ___ /____
- □ □ Erectile or Sexual Dysfunctions ___ /____
- □ □ Other ___ /____ _____

Metabolic/Endocrine
- □ □ Type 1 Diabetes ___ /____
- □ □ Type 2 Diabetes ___ /____
- □ □ Hypoglycemia ___ /____
- □ □ Metabolic Syndrome *(Insulin Resistance/ Pre-Diabetes)*___ /____
- □ □ Hypothyroidism *(low thyroid)* ___ /____
- □ □ Hyperthyroidism *(overactive thyroid)* ___ /____
- □ □ Endocrine Problems ___ /____
- □ □ Polycystic Ovarian Syndrome *(PCOS)* ___ /____
- □ □ Infertility ___ /____
- □ □ Weight Gain ___ /____
- □ □ Weight Loss ___ /____
- □ □ Frequent Weight Fluctuations ___ /____
- □ □ Bulimia ___ /____
- □ □ Anorexia ___ /____
- □ □ Binge Eating Disorder ___ /____
- □ □ Night Eating Syndrome ___ /____
- □ □ Eating Disorder *(non-specific)* ___ /____
- □ □ Other ___ /____ _____

Musculoskeletal/Pain
- □ □ Osteoarthritis ___ /____
- □ □ Fibromyalgia ___ /____
- □ □ Chronic Pain ___ /____
- □ □ Tendonitis ___ /____
- □ □ Tension Headaches ___ /____
- □ □ TMJ Problems ___ /____
- □ □ Foot Cramps ___ /____
- □ □ Joint Deformity ___ /____
- □ □ Joint Pain ___ /____
- □ □ Other ___ /____ _____

Inflammatory/Autoimmune
- □ □ Chronic Fatigue Syndrome ___ /____
- □ □ Autoimmune Disease ___ /____
- □ □ Rheumatoid Arthritis ___ /____
- □ □ Lupus SLE ___ /____
- □ □ Immune Deficiency Disease ___ /____
- □ □ Herpes-Genital ___ /____
- □ □ Cold Sores ___ /____
- □ □ Severe Infectious Disease ___ /____
- □ □ Poor Immune Function *(frequent infections)* ___ /____
- □ □ Food Allergies ___ /____
- □ □ Environmental Allergies ___ /____
- □ □ Multiple Chemical Sensitivities ___ /____
- □ □ Latex Allergy ___ /____
- □ □ Other ___ /____ _____

Respiratory Diseases
- □ □ Asthma ___ /____
- □ □ Chronic Sinusitis ___ /____
- □ □ Bronchitis ___ /____
- □ □ Emphysema ___ /____
- □ □ Pneumonia ___ /____
- □ □ Tuberculosis ___ /____
- □ □ Sleep Apnea ___ /____
- □ □ Other ___ /____ _____

Head, Eyes, & Ears
- □ □ Conjunctivitis ___ /____
- □ □ Distorted Sense of Smell ___ /____
- □ □ Distorted Taste ___ /____
- □ □ Ear Fullness ___ /____
- □ □ Ear Pain ___ /____
- □ □ Hearing Loss ___ /____
- □ □ Hearing Problems ___ /____
- □ □ Headache ___ /____
- □ □ Migraine ___ /____
- □ □ Sensitivity to Loud Noises ___ /____
- □ □ Vision Problems *(other than glasses)* ___ /____
- □ □ Macular Degeneration ___ /____
- □ □ Vitreous Detachment ___ /____
- □ □ Retinal Detachment ___ /____
- □ □ Other ___ /____ _____

Nails
- □ □ Bitten ___ /____
- □ □ Brittle ___ /____
- □ □ Curve Up ___ /____
- □ □ Frayed ___ /____
- □ □ Fungus-Fingers ___ /____
- □ □ Fungus-Toes ___ /____
- □ □ Pitting ___ /____
- □ □ Ragged Cuticles ___ /____
- □ □ Ridges ___ /____
- □ □ Soft ___ /____
- □ □ Thickening of Finger Nails ___ /____
- □ □ Thickening of Toenails ___ /____
- □ □ White Spots/Lines ___ /____
- □ □ Other ___ /____ _____

Diseases/Diagnosis/Conditions: *continued*

Skin Diseases

□ □ Acne on Back ___ /____
□ □ Acne on Chest ___ /____
□ □ Acne on Face ___ /____
□ □ Acne on Shoulders ___ /____
□ □ Athlete's Foot ___ /____
□ □ Bumps on Back of Upper Arms ___ /____
□ □ Cellulite ___ /____
□ □ Dark Circles Under Eyes ___ /____
□ □ Ears Get Red ___ /____
□ □ Easy Bruising ___ /____
□ □ Lack of Sweating ___ /____
□ □ Hives ___ /____
□ □ Jock Itch ___ /____
□ □ Lackluster Skin ___ /____
□ □ Moles w/ Color/Size Change ___ /____
□ □ Oily Skin ___ /____
□ □ Pale Skin ___ /____
□ □ Patchy Dullness ___ /____
□ □ Rash ___ /____
□ □ Red Face ___ /____
□ □ Sensitive to Poison Ivy/Oak ___ /____
□ □ Shingles ___ /____
□ □ Skin Darkening ___ /____
□ □ Strong Body Odor ___ /____
□ □ Hair Loss ___ /____
□ □ Vitiligo ___ /____
□ □ Eczema ___ /____
□ □ Psoriasis ___ /____
□ □ Melanoma ___ /____
□ □ Skin Cancer ___ /____

Neurologic/Mood

□ □ Depression ___ /____
□ □ Anxiety ___ /____
□ □ Bipolar Disorder ___ /____
□ □ Schizophrenia ___ /____
□ □ Headaches ___ /____
□ □ Migraines ___ /____
□ □ ADD/ADHD ___ /____
□ □ Autism ___ /____
□ □ Mild Cognitive Impairment ___ /____
□ □ Memory Problems ___ /____
□ □ Parkinson's Disease ___ /____
□ □ Multiple Sclerosis ___ /____
□ □ ALS ___ /____
□ □ Seizures ___ /____
□ □ Other Neurological Problems _____

Blood Type

□ A □ B □ AB □ O □ Rh+ □ unknown

Injuries *Check box if yes and provide date/description*

□ Back Injury ___ /____ _____
□ Other ___ /____ _____
□ Head Injury ___ /____ _____
□ Neck Injury ___ /____ _____
□ Broken Bones ___ /____ _____

Female Reproductive

□ □ Breast Cysts ___ /____
□ □ Breast Lumps ___ /____
□ □ Breast Tenderness ___ /____
□ □ Ovarian Cysts ___ /____
□ □ Poor Libido ___ /____
□ □ Vaginal Discharge ___ /____
□ □ Vaginal Odor ___ /____
□ □ Vaginal Itch ___ /____
□ □ Vaginal Pain with Sex ___ /____
□ □ Other ___ /____ _____

Surgeries: *Check box if yes and provide date of surgery*

□ None
□ Appendectomy ___ /____
□ Hysterectomy +/- Ovaries ___ /____
□ Gall Bladder ___ /____
□ Hernia ___ /____
□ Tonsillectomy ___ /____
□ Dental Surgery ___ /____
□ Joint Replacement: Knee/Hip ___ /____
□ Heart Surgery: Bypass Valve ___ /____
□ Angioplasty or Stent ___ /____
□ Pacemaker ___ /____
□ Other ___ /____ _____

Male Reproductive

□ □ Discharge from penis ___ /____
□ □ Ejaculation Problem ___ /____
□ □ Genital Pain ___ /____
□ □ Impotence ___ /____
□ □ Prostate or Urinary Infection ___ /____
□ □ Lumps in Testicles ___ /____
□ □ Poor Libido *(Sex Drive)* ___ /____
□ □ Other ___ /____ _____

Preventive Tests: *Check box if yes and provide date of most recent test*

□ Blood Tests ___ /____
□ Full Physical Exam ___ /____
□ X-Ray ___ /____ *Body Part?*_____
□ Dental X-Ray ___ /____
□ Bone Density ___ /____
□ Colonoscopy ___ /____
□ Cardiac Stress Test ___ /____
□ EKG ___ /____
□ Hemoccult Test (stool test for blood) ___ /____
□ MRI ___ /____
□ CT Scan ___ /____
□ Upper Endoscopy ___ /____
□ Upper GI Series ___ /____
□ Ultrasound ___ /____
□ Other ___ /____ _____

Gynecologic History *(for women only)*

Obstetric History *Check box if yes and provide relevant quantity*

□ Pregnancy_____ □ Vaginal Delivery_____ □ Caesarean Delivery_____ □ Miscarriage_____ □ Abortion_____
□ Living Children_____ □ Post-Partum Depression_____ □ Toxemia_____ □ Gestational Diabetes_____
□ Baby over 8 lbs. _____ □ Premature_____ □ Low Birth Weight (< 6lbs) _____
□ Breast Feeding Your Child *How long?* _____ □ Oral Contraceptives_____ *How long?* _____

Menstrual History

Age at first period: _____ Menses Frequency: _____ Length between menses: _____ Pain: □ Yes □ No
Clotting: □ Yes □ No Has your period ever skipped? □ Yes □ No How long? _____
Last Menstrual Period: _____
Do you use contraception? □ Yes □ No
If yes: □ Condom □ Diaphragm □ IUD □ Partner Vasectomy □Pills □Other_____

Women's Disorders/Hormonal Imbalances

□ Fibrocystic Breasts □ Breast Cancer ___ /___ □ Endometriosis □ Fibroids □ Infertility
□ Painful Periods □ Heavy Periods □ PMS
Last Mammogram ____ /____ Anything Abnormal? _____ □ Breast Biopsy ____ /_____
□ Thermogram ____ /____ /____ Last PAP Test ___ / ___ / ___ □ Normal □ Abnormal
Date of Last Bone Density: ___ /___ /____ Results: □ High □ Low □ Within Normal Range
Are you in menopause? □ Yes □ No Age of onset of menopause: _____
Check box if you are experiencing
□ Hot Flashes □ Mood Swings □ Concentration/Memory Problems □ Vaginal Dryness
□ Decreased Libido □ Heavy Bleeding □ Joint Pains □ Headaches □ Weight Gain
□ Loss of Control of Urine □ Palpitations □ Painful Intercourse
□ Use of hormone replacement therapy *How Long?* _____ *What hormones and dosage?* _____
_____

Men's History *(for men only)*

Have you had a PSA done? □ Yes □ No Date of last test? ___ /___ /____ Highest PSA Level: □ 0-2 □ 2-4 □ 4-10 □ >10
Check all that apply:
Do you regularly have morning erections? □ Yes □ No
□ Increased fat accumulation □ Headaches
□ Emotional reactions □ Prostate enlargement □ Prostate infection □ Change in libido □ Impotence
□ Difficulty obtaining an Erection □ Difficulty maintaining an erection □ Prostate Cancer
□ Nocturia *(urination at night)* How many times a night? _____ □ Urgency/Hesitancy/Change in Urinary Stream
□ Loss of Control of Urine □ Testicular injury □ Testosterone replacement □ More fatigue and/or muscle soreness

Patient Birth History

□ Term □ Premature *Pregnancy Complications:* _____
Birth Complications: _____
□ Breast Fed *How long?* _____ □ Bottle-fed

GI History

Foreign travel? □ Yes □ No *Where?* _____
Wilderness Camping □ Yes □ No *Where?* _____
Have you had severe: □ Gastroenteritis □ Diarrhea □ Crohn's/Ulcerative colitis □ Parasites
Do you feel like you digest your food well? □ Yes □ No Do you feel bloated after meals? □ Yes □ No

Dental History

Dental Surgery? _____
□ Silver Mercury Fillings *How many?* _____ □ Gold Fillings □ Root Canals □ Implants □ Tooth Pain
□ Bleeding Gums □ Gingivitis □ Problems with Chewing
Do you floss regularly? □ Yes □ No Do you brush regularly? □ Yes □ No
Have you had Fluoride treatments? □ Yes □ No

Diet

Do you have known adverse food reactions, allergies, or sensitivities? □ Yes □ No *If yes, describe symptoms and list all foods:*

_____

_____

Do you have an adverse reaction to caffeine? □ Yes □ No

When you drink caffeine do you feel: □ Irritable or Wired □ Aches & Pains □ Headaches

Do you adversely react to: *Check all that apply*

□ Monosodium Glutamate *(MSG)* □ Aspartame *(NutraSweet)* □ Preservatives *(ex. sodium benzoate)*

□ Cheese □ Citrus foods □ Chocolate □ Alcohol □ Red Wine □ Caffeine □ Bananas □ Garlic □ Onion

□ Sulfite containing foods *(wine, dried fruit, salad bars)* □ Other: _____

Caffeine intake: □ Yes □ No

If yes: Cups/day: □ Coffee □ Tea - □ 1 □ 2 – 4 □ > 4 a day

Caffeinated sodas or diet sodas intake: □ Yes □ No

12 oz. soda per day: □ 1 □ 2 – 4 □ > 4 a day Favorite soda: _____

Nutrition History

Have you ever had a nutrition consultant? □ Yes □ No

Have you made any changes in your eating habits because of your health? □ Yes □ No *Describe* _____

_____

Do you currently follow a special diet or nutritional program? □ Yes □ No *Check all that apply*

□ Low Fat □ Low Carbohydrate □ High Protein □ Low Sodium □ Diabetic □ No Dairy □ No Wheat

□ Gluten Restricted □ Vegetarian □ Vegan □ Ultrametabolism □ Macrobiotic □ Paleo

□ Specific Program for Weight Loss/Maintenance Type: _____ □ Other _____

How often do you weigh yourself? □ Daily □ Weekly □ Monthly □ Rarely □ Never

Have you ever had your metabolism *(resting metabolic rate)* checked? □ Yes □ No *If Yes, what was it?* _____

Do you avoid any particular foods? □ Yes □ No If yes, types & reason _____

_____

If you could only eat a few foods a week, what would they be? _____

_____

Do you grocery shop? □ Yes □ No If no, who does the shopping? _____

Do you eat organic foods? □ Yes □ No

What percentage of your food is organic (pesticide free, non-GMO, etc.)? _____

How many meals do you eat out per week? □ 0 – 1 □ 1 – 3 □ 3 – 5 □ >5 meals per week

Check all factors that apply to your current lifestyle and eating habits

□ Fast Eater
□ Erratic eating pattern
□ Eat too much
□ Late night eating
□ Dislike healthy food
□ Time constraints
□ Eat more than 50% meals away from home
□ Travel frequency
□ Non-availability of healthy foods
□ Do not plan meals or menus
□ Reliance on convenience
□ Poor snack choices
□ Significant other or family members don't like healthy foods
□ Significant other or family members have special dietary needs or food preferences
□ Love to eat
□ Eat because I have to
□ Have a negative relationship to food
□ Struggle with eating issues
□ Emotional eater *(eat when sad, lonely, depressed, bored)*
□ Eat too much under stress
□ Eat too little under stress
□ Don't care to cook
□ Eating in the middle of the night
□ Confused about nutrition advice

The most important thing I should change about my diet to improve my health is: _____

_____

What foods would be the hardest to reduce or eliminate? _____

Environmental & Detoxification Assessment Which of these significantly affect you? *Check all that apply*

□ Cigarette Smoke □ Perfumes/Colognes □ Auto Exhaust Fumes □ Other: _____
In your home or work environment, are you exposed to: □ Chemicals □ Electromagnetic Radiation □ Mold
How often do you use your cell phone? ____ hrs/day How often do you use your computer? ____ hrs/day ____ hrs/wk
Have you ever turned yellow *(jaundiced)*? □ Yes □ No
Have you ever been told you have Gilbert's syndrome or a liver disorder? □ Yes □ No
If yes, explain _____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
□ Herbicides □ Insecticides *(frequent visits of exterminator)* □ Pesticides □ Organic Solvents
□ Heavy Metals □ Other _____
Chemical *Name/Date/Length of Exposure (if known)* _____
Do you dry clean your clothes frequently? □ Yes □ No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposure? □ Yes □ No
Do you have any pets or farm animals? □ Yes □ No

Social History

Height _____*ft.* _____*in.* Current Weight _____ Usual Weight Range (+/- *5lbs)* _____
Desired Weight Range (+/- *5lbs)* _____ Highest Adult Weight _____ Lowest Adult Weight _____
Have you experienced weight fluctuations greater than 10 lbs? □ Yes □ No Body fat % _____
Is your weight, in the recent past, increasing, decreasing, or staying the same? *If changing describe* _____
_____

Smoking

Currently smoking? □ Yes □ No *How many years?* _____ *Packs per day:* _____ *Attempts to quit:* _____
Previous smoking? *How many years?* _____ *Packs per day:* _____ *Date quit:* _____
Secondhand smoke exposure? _____ *From where?* _____

Alcohol Intake

How many drinks currently per week? *1 Drink = 5 oz. wine, 12 oz. beer, or 1 oz. spirit*
□ None □ 1 -3 □ 4 – 6 □ 7 – 10 □ > 10 If 'None' – Skip to 'Other Substances'
Most common beverage? _____

Other Substances

Are you currently using any recreational drugs? □ Yes □ No *Type* _____
Have you ever used IV or inhaled recreational drugs? □ Yes □ No

Exercise

Current exercise program

Activity	Type	Frequency Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other *(Yoga, Pilates,Tai Chi , etc.)*			
Sports or Leisure Activities *(Golf, Tennis, pickle ball, etc.)*			

Rate your level of motivation for including exercise in your life? □ Low □ Medium □ High
List your problems that limit activity: _____
_____
Do you feel unusually fatigued after exercise? □ Yes □ No *If yes, please describe:* _____
_____
Do you usually sweat when exercising? □ Yes □ No

Psychosocial

Do you feel significantly less vital than you did a year ago? □ Yes □ No
Are you happy? □ Yes □ No Do you feel your life has meaning and purpose? □ Yes □ No
Do you believe stress is presently reducing the quality of your life? □ Yes □ No
Do you like the work you do? □ Yes □ No Have you ever experienced major losses in your life? □ Yes □ No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? □ Yes □ No
Would you describe your experience as a child in your family as happy and secure? □ Yes □ No

Stress / Coping

Have you ever sought counseling? □ Yes □ No *Describe* _____
Are you currently in therapy? □ Yes □ No *Describe* _____
Do you feel you have an excessive amount of stress in your life? □ Yes □ No
Do you feel you can easily handle the stress in your life? □ Yes □ No
How do you deal with stress? _____
Daily Stressors: *Rate on a scale of 1 – 10* Work ____ Family ____ Social ____ Finances ____ Health ____ Other ____
Do you practice meditation or relaxation technique? □ Yes □ No *How often?* _____
Check all that apply □ Yoga □ Meditation □ Imagery □ Breathing □ Tai Chi □ Prayer
□ Other: _____
Have you ever been abused, a victim of a crime, or experienced a significant trauma? □ Yes □ No
If yes, please explain _____
How would you describe your overall attitude towards life? _____

Sleep / Rest

Average number of hours you sleep per night: □ > 10 □ 8 -10 □ 6 – 8 □ < 6
What time do you typically go to sleep? _____:_____ $^{AM}/_{PM}$ Do you have trouble going to sleep? □ Yes □ No
Do you feel rested upon awakening? □ Yes □ No Do you have problems with insomnia? □ Yes □ No
Do you snore? □ Yes □ No Do you use sleeping aids? □ Yes □ No *Explain:* _____

Roles / Relationship

Marital status: □ Single □ Married □ Divorced □ Long Term Partnership □ Widow/ Widower

Resources for emotional support?

Check all that apply□ Spouse □ Family □ Friends □ Religious/Spiritual □ Pets □ Other: _____

How many people are in your house hold by age: 0-5_____ 6-11_____ 12-17 _____ 18+_____

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At School				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your spouse/boyfriend/girlfriend				
With your children				
With your parents				

Medications

Current Medications *(Both prescription and over-the-counter)*

Medication	Dose	Frequency	Start Date (month/year)	Reason For Use

Previous Medications*: Last 10 Years*

Medication	Dose	Frequency	Start Date (month/year)	End Date (month/year)	Reason For Use

Nutritional Supplements: *(Vitamins, Minerals, Herbs, &Homeopathy)* *If more space is needed, please write on separate sheet.*

Supplement & Brand	Dose	Frequency	Start Date (month/year)	Reason For Use

Have your medications or supplements ever caused you unusual side effects or problems? □ Yes □ No

Describe: _____

Have you had prolonged *(3 days or longer)* or regular use of NSAIDS *(i.e. Advil, Aleve, Motrin, Aspirin, etc.)*? □ Yes □ No

Have you had prolonged or regular use of Tylenol? □ Yes □ No

For what reason, and for how long, did you use pain relievers? _____

How much do you use NSAIDS now? Daily _____ Weekly _____ Monthly _____

Have you had prolonged or regular use of Acid Blocking Drugs *(i.e. Tagamet, Zantac, Prilosec, etc.)*? □ Yes □ No

Have you taken antibiotics **more than** 1 x per year? □ Yes □ No

Have you had long-term use of antibiotics? *(More than 10 days.)* □ Yes □ No

How many times have you taken antibiotics throughout your lifetime? _____

Have you ever used steroids *(i.e. prednisone, nasal allergy inhalers, skin/joint creams, etc.)*? □ Yes □ No

Family History

Check family members that apply	**Mother**	**Father**	**Brother(s)**	**Sister(s)**	**Children**	**Maternal Grandmother**	**Maternal Grandfather**	**Paternal Grandmother**	**Paternal Grandfather**	**Aunts**	**Uncles**
Age *or Age at Death (please place a D if deceseased*											
Cancers											
Colon Cancer											
Heart Disease											
Hypertension											
Obesity											
Diabetes											
Stroke											
Inflammatory Arthritis *(Rheumatoid, Psoriatic, Ankylosing Spondylitis)*											
Inflammatory Bowel Disease											
Multiple Sclerosis											
Auto Immune Diseases *(such as Lupus)*											
Irritable Bowel Syndrome											
Celiac Disease											
Asthma											
Eczema / Psoriasis											
Food Allergies, Sensitivities, or Intolerances											
Environmental Sensitivities											
Dementia											
Parkinson's											
ALS or other Motor Neuron Diseases											
Genetic Disorders											
Substance Abuse *(such as Alcoholism)*											
Psychiatric Disorders											
Depression											
Schizophrenia											
ADHD											
Autism											
Bipolar / Mood Disorder											
Other:											

Readiness Assessment

In order to improve your health, how willing are you to: *Rate on a scale of: 5 (very willing) to 1 (not willing)*

Significantly improve your diet _____ □ 5 □ 4 □ 3 □ 2 □ 1
Take several nutritional supplements each day _____ □ 5 □ 4 □ 3 □ 2 □ 1
Start preparing your own meals _____ □ 5 □ 4 □ 3 □ 2 □ 1
Modify your lifestyle _____ □ 5 □ 4 □ 3 □ 2 □ 1
Practice a relaxation technique _____ □ 5 □ 4 □ 3 □ 2 □ 1
Engage in regular exercise _____ □ 5 □ 4 □ 3 □ 2 □ 1
Have periodic lab tests to assess your progress _____ □ 5 □ 4 □ 3 □ 2 □ 1
Get regular bodywork such as chiropractic or massage _____ □ 5 □ 4 □ 3 □ 2 □ 1
Setting regular appointments _____ □ 5 □ 4 □ 3 □ 2 □ 1
Read books or articles to learn about your health and solutions _____ □ 5 □ 4 □ 3 □ 2 □ 1
Be fully responsible for your own healing _____ □ 5 □ 4 □ 3 □ 2 □ 1

Comments: _____
_____

How confident are you of your ability to organize and follow through on the above health related activities?
Rate on a scale of: 5 (very confident) to 1 (not confident at all) □ 5 □ 4 □ 3 □ 2 □ 1 *If you are not confident of your ability, what aspects of yourself or your life lead you to question your capacity to fully engage in the above activities?* _____
_____

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?
Rate on a scale of: 5 (very supportive) to 1 (very unsupportive) □ 5 □ 4 □ 3 □ 2 □ 1 *Comments:* _____
_____
_____

How much ongoing support and contact *(office visits)* from the Doctor would be helpful to you as you implement your personal health program? *Rate on a scale of: 5 (very frequent) to 1 (very infrequent contact)* □ 5 □ 4 □ 3 □ 2 □ 1
Please list how often you would be willing to make appointments if needed _____
Comments: _____
_____
_____

4-Day Diet Diary Instructions

There is a 4-day diet diary at the end of this packet. It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 4 consecutive days including one weekend day. Please feel free to carry it with you as it is often easier to write down what you consume shortly after you consume it, rather than wait until the end of the day.

- **Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.**
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, or nonfat); toast – (whole wheat, white, buttered); chicken - (fried, baked, or breaded); coffee – (decaffeinated w/ sugar & ½ 'n' ½)
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, **including water**, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits in this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc.)
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

Diet Diary: *Name* _____ *Date* _____

Day 1

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 2

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 3

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

Day 4

Meal	Time	Food / Beverage / Amount	Comments
Breakfast			
Lunch			
Dinner			
Snacks & Other			

Bowel movements *(#, form, color)* _____

Stress/Mood/Emotions _____

Other Comments _____

ASQ – Appraisal and Symptom Questionnaire – (Abbreviated)

Name: _____ *Date:* _____

The Health Appraisal and Symptom Questionnaire is designed to elucidate symptoms that help to identify the underlying causes of illness, as well as help track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days.

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

Digestive Tract
___ Nausea or vomiting
___ Diarrhea (loose stools or >3x/day)
___ Constipation (not going everyday)
___ Bloated feeling or abdominal swelling
___ Belching or passing gas
___ Heartburn of GERD
___ Intestinal/stomach pain
___ Reactions to foods
___ Gallstones or pain after fatty meals
___ Bad breath
___ Blood or mucous in stool
___ Other_____
Total _____

Ears
___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
Total _____

Emotions
___ Mood swings
___ Anxiety, irritability
___ Anger or emotional outbursts
___ Depression
Total _____

Energy/Activity
___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
___ Restless legs
___ General feeling of ill health
Total _____

Eyes
___ Watery or itchy eyes
___ Swollen, reddened or sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel vision *(does not include near-or-far-sightedness)*
Total _____

Head
___ Headaches
___ Faintness
___ Dizziness or vertigo
Total _____

Heart
___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
Total _____

Joints/Muscles
___ Pain or aches in joints
___ Arthritis
___ Stiffness or limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
___ Muscle cramping
Total _____

Lungs
___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
___ Inability to take deep breaths
Total _____

Mind
___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Stuttered speech
___ Slurred speech
___ Insomnia
___ Learning disabilities
Total _____

Nose
___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
Total _____

Skin
___ Acne
___ Hives
___ Hair loss/thinning
___ Rash or reddened skin

___ Excessive sweating
___ Edema
___ Dry or oily skin (circle which)
___ Dry, cracked nails
___ Body odor offensive or strong
Total _____

Weight
___ Binge eating
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
Total _____

Mouth/Throat
___ Chronic coughing
___ Gagging, frequent throat clearing
___ Sore throat, hoarseness, loss of voice
___ Swollen/discolored tongue, gums, lips
___ Canker sores
___ Sticky coating on tongue
___ Dry, cracked lips
Total _____

Immune
___ Frequent illness
___ Teeth infection/bleeding
___ Frequent or urgent urination
___ Urinary tract infections
___ Genital itch/discharge or STD outbreak
Total _____

Hormones
___ Awake feeling un-refreshed/tired
___ Craving salty/sweet foods (circle which)
___ Low or High Libido (circle)
___ Facial or unusual hair growth
___ Flushing or hot flashes
___ Painful/abnormal periods (females)
___ Cold hand/feet
___ Frequent thirst
___ Dizziness when standing
*Total*_____

ADVANTAGE CHIROPRACTIC CLINIC, P.C.
Financial Agreement and TCPA

Regarding Financial Arrangements: Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff. We accept cash, checks, MasterCard, Visa, and Discover. Returned checks and balances older than thirty (30) days may be subject to interest charges at the rate of 18% annually or1.5% monthly and subject to additional collection fees of 33.33%, bank fees, attorney's fees and court costs.

Agreement to Pay: I willingly allow the release of medical information to insurance carriers for the purpose of expediting claim benefits from the insurance company. I also understand that if I suspend treatment or terminate my schedule of care as determined by my treating doctor, any fees for professional services will be due & payable at once. **I, the undersigned, accept the fee(s) charged as a legal and lawful debt and agree to pay said fees, including any/all collection agency fees, (33.33%), attorney fees and /or court costs, if such be necessary. I understand the fee(s) charged are due at the time of service. I waive now and forever, my right of exemption under the laws of the Constitution of the State of Alabama and any other state.**

Patient Signature _____ Date _____

PRINT Patient Name _____

Telephone Consumer Protection Act (TCPA): You agree, in order for us to service your account or to collect monies you may owe, **Advantage Chiropractic Clinic,** and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded / artificial voice messages and /or use of automatic dialing device, as applicable. **I / We have read this disclosure and agree that Advantage Chiropractic Clinic,P.C., its employees and/ or agents may contact me/us as described above.**

Responsible Party Signature _____

Date _____

2408 East University Drive Suite 101
Auburn, AL 36830
334-821-2552 office • 866-850-0983 fax

Patient Health Information Notice

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 HIPAA NOTICE that is available to you at the front desk before signing this consent.**

1. The patient understands and agrees to allow Advantage Chiropractic Clinic to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow Advantage Chiropractic Clinic 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 clinic 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 clinic 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 clinic.
4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff members have 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.
8. The patient has the right to request their medical records in an electronic format.
9. The patient has the right to restrict the disclosure of PHI to a health plan where the patient has paid out of pocket in full for a health care item or service.

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

_____ _____

Signature of Patient Date

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Informed Consent and Mutual Understanding

TO THE PATIENT: Please read it in its entirety prior to signing it. It is important that you understand the information contained in this document. Please ask questions before you sign if there is anything that is unclear.
It is NOT necessary or encouraged to discontinue treatments with other physicians or healthcare providers. If you are on any current medication or nutritional supplementation- it is your responsibility to inform changes in your condition, symptoms, contact information, or treatments between visits.
You are encouraged to contact Dr. Adams at any time with health related questions as this is a team effort and every effort will be made to keep you focused on your ultimate goal of optimal health. Dr. Adams, D.C., FACO holds a Doctor of Chiropractic Degree and is currently licensed in the state of Alabama; each procedure/lifestyle modification/treatment holds both risks and benefits. Your case will be thoroughly evaluated to avoid some of these negative reactions and customized to your unique health status; but no guarantees can be assured regarding the outcomes of treatment(s) or procedure(s) nor are they implied.

Nutrition Informed Consent

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."
A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support overall health and well-being. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking. Adverse reactions are rare, and may include, but are not limited to: bloating, nausea, vomiting, rash, fatigue, diarrhea, constipation, headaches and dizziness. If any of these or other symptoms appear, please discontinue immediately and talk to Dr. Adams or in case of emergency, go to your local urgent care facility/Hospital. May times adjustments in dosages and or timing is all that is needed to alleviate these symptoms. Keep in mind also; there is often an initial "Herxhiemer" reaction. This was first described by a German physician of the same name. He observed that as patients started to fulfill a need nutritionally, or emotionally, often a "detox" would start to happen as the body adjusts to metabolic pathways becoming functional again. This is usually temporary and may last a few days to several weeks. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, 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 biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

By signing below, I state that I have weighed the risks involved in undergoing treatment and have decided that it is my best interest to undergo treatment. Having been informed of the risks, I hereby give my consent to that treatment.

Patient Name (print) _____

Patient/Guardian Signature_____ Date:_____

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Services and Fees

- New Patient Exam (first hour, pro-rated thereafter) $300/hr.
- Interpretation of previous labs (time is pro-rated)-$250/hr.
- Consultation in office, phone or email (time is pro-rated) - $250/hr.
- Annual Physical Exam (includes Super Panel II with Urinalysis) $350
- Focused Office Visit (15 min) - $ 65
- Regular Office Visit (35 min) -$130
- Comprehensive Office Visit (60 min) - $250

****Please keep in mind, your office visit charge may include the time given to your case outside of the office visit, such as laboratory test interpretation, review of history, etc. by our doctors.**

Testing:

- Super Panel I -$350
- Super Panel II (*includes Urinalysis*)-$200
- Urinalysis-$ 12
- Comprehensive Stool Analysis with Parasitology x3-$300
- Food and Environmental Allergy Testing (*Blood)*-$368
- DUTCH Complete (Urine -Hormone)-$325
- DUTCH Plus (Hormone and Cortisol Awakening Response) - $400
- DUTCH Cycle Mapping- $ 400

****We have negotiated discounts for testing with these labs; however fees for testing conducted by outside facilities must be collected by our office prior to the testing. Health Insurance does not cover testing for "Investigative Purpose".**

Missed Appointment Fee - If cancelled less than 24 hours, the patient is responsible for full price of appointment.

We cannot accept returns on any products once they are opened. Thank you for understanding.

By my signature, I agree to the terms listed above.

Patient Name (print) _____

Patient/Guardian Signature_____ Date:_____

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