

**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 \_\_\_/\_\_\_
- Hemocult 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? \_\_\_\_\_<sup>hrs</sup>/day   How often do you use your computer? \_\_\_\_\_<sup>hrs</sup>/day   \_\_\_\_\_<sup>hrs</sup>/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 <i>(Yoga, Pilates, Tai Chi, etc.)</i>			
Sports or Leisure Activities <i>(Golf, Tennis, pickle ball, etc.)</i>			

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? \_\_\_\_\_:\_\_\_\_\_ <sup>AM</sup>/<sub>PM</sub> 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



## 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)
- Bloating feeling or abdominal swelling
- Belching or passing gas
- Heartburn or 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 or 1.5% 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

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



### **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., F.A.C.O. 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. Many 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 "Herxheimer" 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: \_\_\_\_\_



## **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 - \$150
- 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 w/ urinalysis - \$350
- Super Panel II w/ urinalysis - \$200
- Comprehensive Stool Analysis with Parasitology x3 - \$369
- Food Sensitivity IgG, IgA, & IgG4 (*Blood*) - \$529
- Food Allergy \$200-\$469
- Hormone Testing- \$250-\$600
- In office draw fee - \$15

**\*\*We have negotiated discounts for comprehensive 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 you, the patient, cancels less than 24 hours before your scheduled appointment, you are responsible for the 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: \_\_\_\_\_

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