San Antonio Family Alternative Medicine

Paperwork Instructions:

To offer you the best service and most complete care, we ask A LOT of information. There are an infinite number of often-overlooked factors that could have contributed to your current situation, and they take time and effort to identify and assess. The paperwork greatly speeds up this process. What we're trying to do is gain a perspective on the status of your health in terms of mind, body, and spirit, both currently and in the past. Basically, we're trying to assess your entire life very quickly and efficiently, which is not an easy task.

Completing the Paperwork:

- **You'll find that there are duplicate questions** in certain sections of the paperwork. This isn't a mistake; although these questions appear the same, they are actually interpreted differently.
- This packet typically takes 30 minutes to an hour to complete; please take your time so you can collect your thoughts and answer questions thoroughly.
- Please fill out this intake packet in ***blue*** ink as completely and honestly as you can.
- Please do not skip any questions, because each is relevant to your case. If a question clearly does not apply to your situation, please write "N/A", but do not leave it blank.
- Please try to avoid answering "I don't know"; take your best guess.
- Although some questions may seem similar, each question has a different, specific purpose.
- If you have downloaded this packet from our website, please be sure to select default regular size when printing (1 page of paperwork per piece of paper; double-sided is fine).
- Please make sure every question has been answered before submitting your packet.
- Incomplete paperwork can't be accepted.
- Please be sure to keep the Office Policies sheet (the last page of the packet) for yourself, in case you'd like to refer to it in the future.

Submitting the Paperwork:

- When your packet is complete, please submit it in person or via regular mail. Due to the volume of paperwork we receive, we cannot accept packets by fax or email. We apologize for the inconvenience!
- Once we receive your paperwork, we'll schedule your first appointment for at least 24-48 hours in advance.*

Please make sure you've read through all of the Informed Consents, Privacy Info, Office Protocols, and Financial Agreement very carefully; all patients are responsible for everything they sign. If you have any questions, please ask!

Please don't hesitate to call us if you have questions or you need clarification! We're here for you.

*Please note: Chiropractic emergencies can be handled differently; certain components of the packet are still required, but certain guidelines can be waived individually as needed.

Contact Info:

We're located at: 1931 NW Military Hwy, Suite #204
Castle Hills, TX, 78213

Please don't hesitate to email us at the email address below with any questions you have!

Phone: 340-2150
Email: safaminfo@gmail.com

San Antonio Family Alternative Medicine

1931 N.W. Military Highway Suite #204 Castle Hills, TX 78213 Phone: (210) 340-2150

The World Health Organization defines Health as a "state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmary."

Expect Different.

Date:_____ File:_____

Last Name:_____ First Name:_____ MI:_____

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

Street Address:_____ Apt #:_____

City:_____ State_____ ZIP:_____

Cell Phone:_____ Home Phone:_____ Work Phone:_____

Fax Number:_____ Email Address:_____ Newsletter? Y / N

Best way to contact (check all that apply): Work #____ Cell #____ Home #____ Email____

Occupation:_____ Stress Level from 1 (low), to 10 (high):_____

Emergency Contact:
Name:_____ Phone #: (____)_____ Relation:_____

Do you have any of the following:

- Family physician (MD/DC/DO/ND)? ☐ Yes ☐ No Name:_____
- Regular Chiropractic doctor? ☐ Yes ☐ No Name:_____
- Dentist?(Natural or conventional-minded?) ☐ Yes ☐ No Name:_____
- Licensed Massage Therapist? ☐ Yes ☐ No Name:_____
- Specialist (cardiac, endocrine, allergist)? ☐ Yes ☐ No Name:_____
- Pediatrician? ☐ Yes ☐ No Name:_____
- Acupuncturist? ☐ Yes ☐ No Name:_____
- (For Women) Midwife or doula? ☐ Yes ☐ No Name:_____
- (For Women) Ob-Gyn? ☐ Yes ☐ No Name:_____
- Other? Name_____ Title:_____

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Your Reason For Coming To See Us

Check as many that apply to you about your reason for visiting us today.

☐ Wellness Care:

- ☐ Nutritional Counseling
- ☐ Genomic (Gene) testing
- ☐ Neurotransmitter testing
- ☐ Spinal and Joint Health
- ☐ Lifestyle management
- ☐ Food allergy testing
- ☐ Stress management
- ☐ Physical Conditioning
- ☐ Weight Loss
- ☐ hormone testing
- ☐ Pain management
- ☐ Balance & Stability

☐ Motor Vehicle Accident: When did it occur?_____ *HxA-MVA*

☐ Recent fall: When did it occur?_____ *HxA-Fa*

☐ Another type of accident, trauma, or injury – was it:

- ☐ Less than 3 days ago?
- ☐ Between 3 days and 8 weeks ago?
- ☐ Between 8 weeks and 4 months ago?
- ☐ More than 4 months ago?
- ☐ At work?
- ☐ At home?
- ☐ Somewhere else?_____

What happened?_____

_____

☐ Neurological, Autoimmune, or Glandular problem or disease:

If yes, please explain and include any prior testing and diagnosis._____

_____

☐ Other problem:

Please explain and include any prior testing and diagnosis._____

_____

Important: Please list **ALL** medications, prescribed AND/OR over-the-counter, including **dosage**.

_____ _____ _____

_____ _____ _____

(If you're taking more than 6 medications, please let us know and we'll provide you with more paper!)

How were you referred to us?_____

What brings you to see us today?_____

How long have you been aware of this problem?_____

What was the last straw that made you decide to address it **today**?_____

_____

Did it come on gradually or suddenly?_____

Has this problem affected your: ☐ Work ☐ School ☐ Recreation ☐ Family ☐ Mood, YET?

If so, how?_____

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Is there pain associated with this problem? ☐ No. ☐ Yes.

If so, please rate your **pain** on a scale of 0-10. Mark "B" for at its best, and "W" for at its worst, by circling the appropriate number on the scale.

0 1 2 3 4 5 6 7 8 9 10

0 = no pain
1-2 = some pain
3-5 = affecting work
6-7 = can't work
8-9 = bad enough to go to the hospital
10 = worst pain I've ever felt in my life

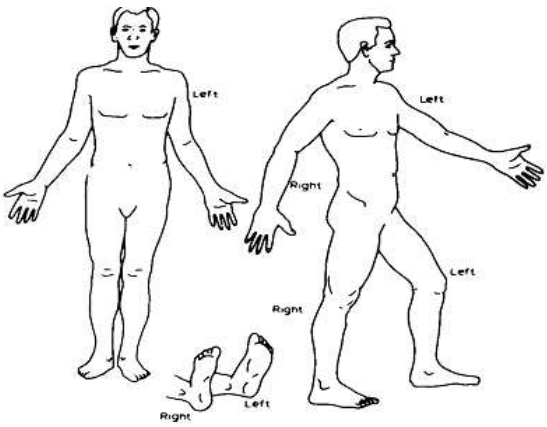
Please rate the intensity of your **symptoms other than pain** on a scale of 0-10, "B" and "W" as above, by circling the appropriate number on the scale.

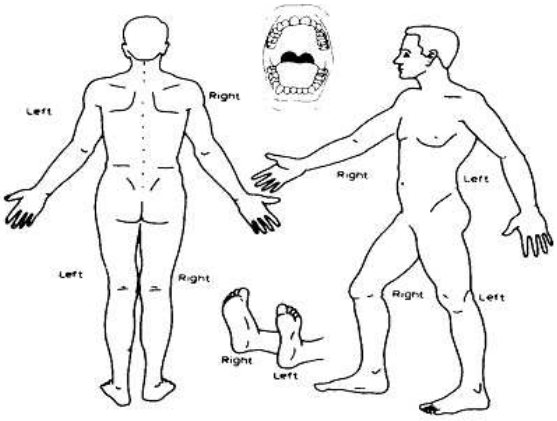
0 1 2 3 4 5 6 7 8 9 10

0 = no symptoms
1-2 = mild, annoying
3-5 = affecting extra activities
6-7 = affecting work
8-9 = can barely function
10 = can't function

Please mark the following symptoms, if you're experiencing them.

"**//**" for stabbing pain"**B**" for burning pain
"**D**" for dull pain
"**A**" for aching pain
"**N**" for numbness
"**T**" for tingling
"**St**" for stiffness
"**Sw**" for swelling
"**Cr**" for cramps
"**Cl**" for chilly or cold
"**H**" for heat





Please tell us about any other symptoms you feel may be important: _____

_____

_____

_____

_____

_____

Is the problem getting Better / Worse / Not changing?_____

Is it constant? ☐ Yes. ☐ No. Or does it come and go? ☐ Yes. ☐ No. Please explain_____

If it comes and goes, how often does it come?_____

How long does it last?_____

Is it worse in the morning, or at night? Please explain:_____

Do pain or other symptoms wake you up at night? ☐ No. ☐ Yes.

Do pain or other symptoms change with position? ☐ No. ☐ Yes.

Have you seen anyone else for this issue? ☐ No. ☐ Yes. If yes, who?_____

Have you tried any home remedies or self care? ☐ No. ☐ Yes. If yes, what?_____

_____

Has anything/anyone **helped**? ☐ No. ☐ Yes. Who/what helped, and how?_____

_____

Did anything make things **worse**? ☐ No. ☐ Yes. (Please explain.)_____

_____

Have you ever been treated for a **similar** problem? ☐ No. ☐ Yes.

Please describe._____

Do you have any **other** complaints or concerns?_____

What do ***you*** think may be causing the problem?_____

Trauma and Illness History **(Functional Medicine patients may skip this section)**

Please list all operations or surgeries you've had, including dates:_____

_____

Please list any hospitalizations you may have had, with dates:_____

Please list any major illness you have had, with dates:_____

Have you had any recent infections, colds, or flu? ☐ No. ☐ Yes:_____

Please list any and ***all*** traumas or injuries you've ever had (broken bones, falls, sprained ankles, etc), with dates, from the simple to the serious:_____

_____

Have you ever been diagnosed with a tumor, cancer, neoplasia, or dysplasia? ☐ No. ☐ Yes.

Explain:_____

Have you ever been diagnosed with diabetes? ☐ No. ☐ Yes:_____

Have you ever been diagnosed with a cardiac (heart) condition, a blood vessel condition (like arteriosclerosis, atherosclerosis, or vasculitis), or hypertension (high blood pressure)? ☐ No. ☐ Yes:_____

Have you ever had a stroke or heart attack? ☐ No. ☐ Yes:_____

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Lifestyle Background

Please indicate your familial status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ In a relationship
☐ Living with someone ☐ Assisted Living facility

How many children do you have?_____ Do you plan to have children? ☐ No. ☐ Yes. If yes, when?_____

What do you do for a living?_____. How many hours/week?_____

Do you have a second job?_____. How many hours/week?_____

Describe your work environment:_____

How long have you been at this job?_____

What other jobs have you had in the **past**?_____

Describe your home life:_____

What is your highest level of education?_____. What are your hobbies?_____

_____

Do you exercise? ☐ No. ☐ Yes, then what type and how often:_____

Do you use any tobacco products? ☐ No. ☐ Yes.

If yes, what kind, how often, & how long:_____ Would you like to quit? ☐ Yes. ☐ No.

Have you used tobacco products in the past? ☐ No. ☐ Yes, then what, how long, & when did you quit?_____

Do you drink alcoholic beverages? ☐ No. ☐ Yes, then what kind and how many a week:_____

Have you had alcohol problems in the past? ☐ No. ☐ Yes, then how long ago & for how long:_____

Do you drink caffeinated beverages? ☐ No. ☐ Yes, then what kind and how many a day:_____

Do you drink sodas? ☐ No. ☐ Yes, then how many a day:_____ Diet or regular? (Please circle one)

Do you use recreational drugs? ☐ No. ☐ Yes, then which drugs, how long ago & for how long:_____

Have you used recreational drugs in the past? ☐ No. ☐ Yes, then what type, when, & for how long:_____

Do you have any special dietary restrictions? ☐ No. ☐ Yes, then what type:_____

Are you sexually active? ☐ No. ☐ Yes. If yes have you ever been diagnosed with an STD or VD:_____

When did you last see a chiropractor?_____

What were those visits for & how were the outcomes?_____

_____

Why have you changed chiropractors?_____

Family History

Does anyone in your immediate family (parent, grandparent, sibling, or child) have any of the following (either currently or in the past)?

☐ heart disease ☐ stroke ☐ diabetes ☐ back or neck pain
☐ depression ☐ anxiety ☐ schizophrenia ☐ cancer ☐ nerve diseases ☐ any other condition

Please explain any of the above:_____

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Health Screening

Are you currently experiencing any of the following symptoms, either now or recently?

- ☐ Chest pain
- ☐ Shortness of breath
- ☐ Blackouts
- ☐ Jaw pain
- ☐ Lightheadedness
- ☐ Swelling in your left arm
- ☐ Pain in your left arm
- ☐ Pale skin
- ☐ Excessive sweating w/o exertion
- ☐ Nausea
- ☐ Vomiting
- ☐ Double vision
- ☐ Numbness
- ☐ Difficulty talking
- ☐ Difficulty swallowing
- ☐ Severe headache
- ☐ Abnormal sweating
- ☐ Dizziness or vertigo
- ☐ Disequilibrium or feeling unsteady
- ☐ Abnormal eye movements
- ☐ Feel like you're going to fall

Have you experienced any change in bowel or bladder function, loss of control, or lack of sensation in that area? ☐ No. ☐ Yes. Please explain:_____

_____

Females only: is there ANY possibility that you could be pregnant? ☐ Yes ☐ No

Date of last period (**even if you are menopausal**)_____
Month / Year

_____

☞ Everyone: Is there ***anything*** preventing you from doing what it takes to get well? (Time / Money / Family obligations / family / peer resistance / lack of support / etc)_____

_____

Thank you for taking the time to fill out these forms!

Important: At this time, please review your form to make sure you did not skip or gloss over *any* questions; all questions are significant for the doctors to evaluate your condition, and every answer provided is important. Any question left incomplete or inaccurate could mean the difference between correct and incorrect diagnosis and treatment. A single detail may change an entire diagnosis and course of treatment. Your answers are critical to the doctors so that they may make an appropriate diagnosis and treatment plan.

Please sign below authorizing that the information in this form has been read & filled out **completely & accurately** to the best of your understanding. Also, please understand that the information in this form is considered confidential & for use by the doctors and other providers at San Antonio Family Alternative Medicine, as outlined in our privacy policies.

_____ _____
Patient's Signature Date:

_____ _____
Signature of parent or legal guardian Date:
(if under 18 or otherwise under another's care)

_____ _____
Doctor's Signature Date:

San Antonio Family Alternative Medicine – Functional Med.

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"The doctor of the future will give no medicine, but will instruct his patient in the care of the human frame, in diet and in the cause and prevention of disease." ~Thomas Edison

Patient Name:_____ File Number:_____

Review of Systems

Please mark **every** condition you've **ever** had, and let us know if it is "**C**" for Current or "**P**" for Past.

☐ C ☐ P Swollen/painful joints
☐ C ☐ P Neck pain/stiffness
☐ C ☐ P Upper back pain/ stiffness
☐ C ☐ P Mid-back pain/stiffness
☐ C ☐ P Low back pain/stiffness
☐ C ☐ P Hip or pelvis pain
☐ C ☐ P Auto accident
☐ C ☐ P Machine/industrial/farm accident
☐ C ☐ P Pain in the foot, elbow, knee, ankle, or toes
☐ C ☐ P Pain in the shoulder, elbow, wrist, hand, or fingers
☐ C ☐ P Jaw pain or click
☐ C ☐ P Chronic headaches
☐ C ☐ P Sprain, strain, or sports injury
☐ C ☐ P Trouble with prolonged sitting, standing, or lying down
☐ C ☐ P Trouble with walking, bending, twisting, or lifting
☐ C ☐ P Osteoporosis
☐ C ☐ P Dislocated joints
☐ C ☐ P Fractured bones
☐ C ☐ P Torn ligament or muscle
☐ C ☐ P Bone infection (osteomyelitis)
☐ C ☐ P Herniated/bulging disc
☐ C ☐ P Scoliosis or spinal curve
☐ C ☐ P Osteoarthritis or DJD
☐ C ☐ P Rheumatoid arthritis
☐ C ☐ P Gout
☐ C ☐ P Ankylosing spondylitis

☐ C ☐ P Migraine headaches
☐ C ☐ P Cluster headaches
☐ C ☐ P Tension/stress headaches
☐ C ☐ P Blood pressure headache
☐ C ☐ P Allergy/Sinus headaches
☐ C ☐ P TMJ headache
☐ C ☐ P Other headache

☐ C ☐ P Balance problems
☐ C ☐ P Mental or emotional disorder

☐ C ☐ P Convulsion, epilepsy, or other seizures
☐ C ☐ P Losing time, memory, or blacking out
☐ C ☐ P Paralysis
☐ C ☐ P Stroke, or mini-stroke/TIA
☐ C ☐ P Trouble sleeping
☐ C ☐ P Trouble with focus
☐ C ☐ P Fainting spells
☐ C ☐ P Tire easily
☐ C ☐ P Blurred or double vision
☐ C ☐ P Recent lack of coordination
☐ C ☐ P Head and/or arms feel heavy and/or tired
☐ C ☐ P Concussion
☐ C ☐ P Other Head injury
☐ C ☐ P Spontaneous jerking or movement
☐ C ☐ P Persistent headache

☐ C ☐ P Lost muscle tone
☐ C ☐ P Muscle cramping
☐ C ☐ P Tremors or shaking (while resting or while moving?_____)
☐ C ☐ P Muscle twitching or weakness

☐ C ☐ P ADD/ADHD/behavior problems – as (circle one or both) child or adult
☐ C ☐ P Dyslexia
☐ C ☐ P Autism Spectrum (including Asperger's)

☐ C ☐ P Ear infections or earaches
☐ C ☐ P Tinnitus or Ringing in the ears
☐ C ☐ P Hearing loss
☐ C ☐ P Sinus problems

☐ C ☐ P Irregular heartbeats
☐ C ☐ P Heart murmur
☐ C ☐ P Leg pain with physical activity
☐ C ☐ P Dizziness/lightheaded with exercise
☐ C ☐ P High blood pressure
☐ C ☐ P Atherosclerosis or arteriosclerosis
☐ C ☐ P Heart attack

☐ C ☐ P Difficulty or painful breathing
☐ C ☐ P Chronic/frequent cough
☐ C ☐ P Snoring
☐ C ☐ P Other lung problems

☐ C ☐ P Ulcers
☐ C ☐ P Abdominal pain
☐ C ☐ P Celiac disease
☐ C ☐ P Irritable bowl syndrome
☐ C ☐ P Ulcerative colitis or Crohn's Disease

☐ C ☐ P Excessive thirst
☐ C ☐ P Diabetes
☐ C ☐ P (Circle) Over or under active thyroid
☐ C ☐ P Night sweats
☐ C ☐ P (Circle) Adrenal or Thyroid problem

☐ C ☐ P Acne
☐ C ☐ P Eczema
☐ C ☐ P Dermatitis
☐ C ☐ P Psoriasis
☐ C ☐ P Change in hair pattern
☐ C ☐ P Shingles
☐ C ☐ P Warts
☐ C ☐ P Bruise easily
☐ C ☐ P Pits, dents, weakness in fingernails
☐ C ☐ P Change in fingernail appearance

☐ C ☐ P Nervousness
☐ C ☐ P Depression
☐ C ☐ P Mania
☐ C ☐ P Phobias
☐ C ☐ P Risk taking behavior
☐ C ☐ P Mood changes

☐ C ☐ P Panic attacks
☐ C ☐ P Post-Traumatic Stress
☐ C ☐ P Irritability
☐ C ☐ P Anger easily
☐ C ☐ P Excessive or chronic stress

☐ C ☐ P Prostate problems
☐ C ☐ P Erectile dysfunction
☐ C ☐ P Premature Ejaculation

☐ C ☐ P PMS or menstrual problems
☐ C ☐ P Breast or vaginal discharge
☐ C ☐ P Breast lumps or soreness

☐ C ☐ P Kidney problems or disease
☐ C ☐ P Difficult, or frequent urination
☐ C ☐ P Feelings of urgency to urinate
☐ C ☐ P Frequent or infrequent urination

☐ C ☐ P Bleeding disorder
☐ C ☐ P Anemia
☐ C ☐ P Slow to clot
☐ C ☐ P Excessive clotting
☐ C ☐ P Varicose veins
☐ C ☐ P Bruise easily
☐ C ☐ P Blood vessel/vascular disease

☐ C ☐ P Seasonal allergies
☐ C ☐ P Food allergies
☐ C ☐ P Autoimmune disease
☐ C ☐ P Immunodeficiency
☐ C ☐ P Frequent cold or flu

☐ C ☐ P Alcoholism
☐ C ☐ P Cancer (Location? Stage? Treatment?

Please feel free to use this space to explain or expand on any of the above._____

_____

_____

_____

_____

Printed Patient Name:_____ Patient Signature_____

Doctor Signature:_____ Date:_____

NECK DISABILITY INDEX QUESTIONNAIRE

Patient Name _____ Date_____

Please read carefully:

This questionnaire has been designed to enable us to understand how your neck pain has affected your ability to manage everyday life. Please answer every section, and mark in each section only ***ONE CHOICE*** *which applies to you. We realize that you may consider that two of the statements in any one section relate to you, but please just* ***mark the one box which most closely describes your problem right now.***

SECTION 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is very mild at the moment.
C. The pain is moderate at the moment.
D. The pain is fairly severe at the moment.
E. The pain is very severe at the moment.
F. The pain is the worst imaginable at the moment.

SECTION 2 – Personal Care (washing, dressing, etc.)

A. I can look after myself without causing extra pain.
B. I can look after myself normally but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help but manage most of my personal care.
E. I need help every day in most aspects of self care.
F. I do not get dressed, wash with difficulty and stay in bed.

SECTION 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it gives extra pain.
C. Pain prevents me from lifting heavy objects off the floor, but I can manage if they are conveniently positioned, e.g. on a table.
D. Pain prevents me from lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
E. I can lift very light weights.
F. I cannot lift or carry anything at all.

SECTION 4 – Reading

A. I can read as much as I want with no pain in my neck.
B. I can read as much as I want with slight pain in my neck.
C. I can read as much as I want with moderate pain in my neck.
D. I cannot read as much as I want because of moderate pain in my neck.
E. I can hardly read at all because of severe pain in my neck.
F. I cannot read at all.

SECTION 5 – Headaches

A. I have no headaches at all.
B. I have slight headaches which come infrequently.
C. I have moderate headaches which come infrequently.
D. I have moderate headaches which come frequently.
E. I have severe headaches which come frequently.
F. I have headaches almost all the time.

SECTION 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

SECTION 7 – Work

A. I can do as much work as I want to.
B. I can only do my usual work, but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

SECTION 8 – Driving

A. I can drive without any neck pain.
B. I can drive as long as I want with slight pain in my neck.
C. I can drive as long as I want with moderate pain in my neck.
D. I cannot drive as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

SECTION 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hr. sleepless).
C. My sleep is mildly disturbed (1-2 hrs. sleepless).
D. My sleep is moderately disturbed (2-3 hrs. sleepless).
E. My sleep is greatly disturbed (3-5 hrs. sleepless).
F. My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – Recreation

A. I am able to engage in all my recreation activities with no neck pain at all.
B. I am able to engage in all my recreation activities with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
D. I am able to engage in a few of my usual recreation activities because of pain in my neck.
E. I can hardly do any recreation activities because of pain in my neck.
F. I cannot do any recreation activities at all.

OTHER COMMENTS:

_____

_____

_____

_____
Examiner

Oswestry Low Back Pain Scale

Please rate the severity of your pain by circling a number below:

No pain | 0 1 2 3 4 5 6 7 8 9 10 | *Unbearable pain*

Name _____ **Date** _____

Instructions: Please circle the **ONE NUMBER** in each section which most closely describes your problem.

Section 1 – Pain Intensity
0. The pain comes and goes and is very mild.
1. The pain is mild and does not vary much.
2. The pain comes and goes and is moderate.
3. The pain is moderate and does not vary much.
4. The pain comes and goes and is severe.
5. The pain is severe and does not vary much.

Section 2 – Personal Care (Washing, Dressing, etc.)
0. I would not have to change my way of washing or dressing in order to avoid pain.
1. I do not normally change my way of washing or dressing even though it causes some pain.
2. Washing and dressing increase the pain but I manage not to change my way of doing it.
3. Washing and dressing increase the pain and I find it necessary to change my way of doing it.
4. Because of the pain I am unable to do some washing and dressing without help.
5. Because of the pain I am unable to do any washing and dressing without help.

Section 3 – Lifting
0. I can lift heavy weights without extra pain.
1. I can lift heavy weights but it gives extra pain.
2. Pain prevents me lifting heavy weights off the floor.
3. Pain prevents me lifting heavy weights off the floor, but I can manage if they are conveniently positioned, e.g., on a table.
4. Pain prevents me lifting heavy weights but I can manage light to medium weights if they are conveniently positioned.
5. I can only lift very light weights at most.

Section 4 – Walking
0. I have no pain on walking.
1. I have some pain on walking but it does not increase with distance.
2. I cannot walk more than 1 mile without increasing pain.
3. I cannot walk more than ½ mile without increasing pain.
4. I cannot walk more than ¼ mile without increasing pain.
5. I cannot walk at all without increasing pain.

Section 5 – Sitting
0. I can sit in any chair as long as I like.
1. I can sit only in my favorite chair as long as I like.
2. Pain prevents me from sitting more than 1 hour.
3. Pain prevents me from sitting more than ½ hour.
4. Pain prevents me from sitting more than 10 minutes.
5. I avoid sitting because it increases pain immediately.

Section 6 – Standing
0. I can stand as long as I want without pain.
1. I have some pain on standing but it does not increase with time.
2. I cannot stand for longer than 1 hour without increasing pain.
3. I cannot stand for longer than ½ hour without increasing pain.
4. I cannot stand for longer than 10 minutes without increasing pain.
5. I avoid standing because it increases the pain immediately.

Section 7 – Sleeping
0. I get no pain in bed.
1. I get pain in bed but it does not prevent me from sleeping well.
2. Because of pain my normal nights sleep is reduced by less than one-quarter.
3. Because of pain my normal nights sleep is reduced by less than one-half.
4. Because of pain my normal nights sleep is reduced by less than three-quarters.
5. Pain prevents me from sleeping at all.

Section 8 – Social Life
0. My social life is normal and gives me no pain.
1. My social life is normal but it increases the degree of pain.
2. Pain has no significant effect on my social life apart from limiting my more energetic interests, e.g., dancing, etc.
3. Pain has restricted my social life and I do not go out very often.
4. Pain has restricted my social life to my home.
5. I have hardly any social life because of the pain.

Section 9 – Traveling
0. I get no pain when traveling.
1. I get some pain when traveling but none of my usual forms of travel make it any worse.
2. I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
3. I get extra pain while traveling which compels to seek alternative forms of travel.
4. Pain restricts me to short necessary journeys under ½ hour.
5. Pain restricts all forms of travel.

Section 10 – Changing Degree of Pain
0. My pain is rapidly getting better.
1. My pain fluctuates but is definitely getting better.
2. My pain seems to be getting better but improvement is slow.
3. My pain is neither getting better or worse.
4. My pain is gradually worsening.
5. My pain is rapidly worsening.

TOTAL _____

San Antonio Family Alternative Medicine

Suprasegmental Patient Questionnaire

Please rank each item on a scale of 0-4
0 = never
1 = rarely
2 = occasionally
3 = frequently
4 = very frequently

DLC

Feelings of sadness		Decreased interest in others	
Moodiness		Feelings of hopelessness about the future	
Negativity or pessimism		Feelings of helplessness or powerlessness	
Low energy		Feeling dissatisfied or bored	
Irritability		Excessive guilt	
Suicidal thoughts or feelings		Crying easily	
Low self-esteem		Lowered interest in things considered fun	
Sleep changes		Appetite changes	
Forgetfulness		Decreased interest in sex	
Poor concentration		Negative sensitivity to smells and odors	

Total:	Total:

BG

Panic attacks		Feelings of nervousness or anxiety	
Poor handwriting		Headaches / sore muscles	
Shyness or timidity		Hand tremors	
Tics		Heart pounding, rapid heart rate, chest pain	
Conflict avoidance		Troubled breathing or feelings of being smothered	
Low motivation		Feeling dizzy, faint, or unsteady on feet	
Excessive motivation		Avoidance of public places from fear of anxiety	
Quick startle reaction		Periods of nausea and stomach upset	
Persistent phobias		Tendency to predict the worst	
Easily embarrassed		Fear of being judged or scrutinized	
Sweating easily		Excessive worrying about what others think	
Hot or cold flashes / hot or cold hands		Tendency to freeze in anxiety-provoking situations	

Total:	Total:

PFC

Trouble listening		Trouble sustaining attention in routine situations	
Easily distracted		Inability to pay close attention to detail or avoid mistakes	
Poor planning skills		Lack of clear goals or forward thinking	
Boredom		Difficulty expressing feelings	
Lethargy		Difficulty following through or finishing things	
Lack of motivation		Difficulty expressing empathy for others	
Excessive daydreaming		Feelings of spaciness or being in a fog	
Conflict seeking		Trouble learning from experience, makes repetitive mistakes	
Difficulty awaiting turn		Difficulty remaining seated when expected	
Restlessness		Interruption of or intrusion on others	
Impulsivity		Blurting out answers before questions are completed	
Talking too much or too little			

Total:	Total:

CS

Needless worrying		Tendency to say no without first thinking about the question	
Dislike of change		Others say you worry too much	
Hold grudges		Being upset unless things are done a certain way	
Compulsive behaviors		Upset when things do not go your way	
Repetitive negativity		Upset when things get out of place	
Trouble shifting behavior from task to task		Being argumentative or oppositional	
Tendency to hold onto own opinions and not listen to others		Trouble shifting attention from subject to subject	
Tendency to get locked into a course of action, whether or not it is good		Difficulty seeing options in situations	
Tendency to predict negative outcomes			

Total:	Total:

TL

Mild paranoia		History of family violence or explosiveness	
Memory problems		History of head injury or trauma	
Periods of forgetfulness		Short fuse or periods of extreme irritability	
Spaciness or confusion		Periods of rage without provocation	
Periods of déjà vu		Reading comprehension problems	

TL continued

Periods of panic		Irritability that tends to build and then explode	

Frequent misinterpretation of comments as negative when they aren't		Dark thoughts of suicide or homocide	
Auditory or visual hallucinations		Preoccupation with moral or religious ideas	
Headaches or abdominal pain of an uncertain/unknown cause			

Total:	Total:

Please rank each item on a scale of 0-2
2 = you're good at this or interested in this
1 = you're OK at this but occasionally have problems, or you have neutral interest in this
0 = you're poor at this, have problems with this, or are not interested in this

RB

Recognizing faces		Recognizing out-of-focus objects	
Good memory for location		Recognition of emotional tone of voice	
Good memory for direction		Respond well to new situations	
Understand nonverbal communication		Understand the main ideas of words/phrases	
Good abstract thought		Recognition of rotated objects	
Understand humor and metaphors		Appropriate social behavior and responses	
Ability to fight off compulsion		Ability to focus	
Ability to do math		Music skills	
Good self image		Ability to rhyme	
Ability to think clearly		Ability to tune out irrelevant stimuli	
Ability to have good imagination		Ability to decode the emotions of others	
Ability to read books		Ability to understand symbolism	
Ability to predict what others will do		Ability to control repetitive thought	
Ability to control hyperactivity		Ability to understand false perceptions	
Ability to control what you say		Ability to have good motor control	
Ability to sleep		Ability to have emotional tone in voice	
Ability to build/maintain relationships		Ability to have smooth, fluid movement	
Ability to deal with feelings		Ability to cry or be spontaneous	
Ability to express fantasies		Ability to avoid alcohol and drugs	
Ability to control anxiety/fear		Do you get motion sickness?	Y / N
Do you have an autoimmune illness?	Y / N	Do you have an irregular heart beat?	Y / N

Total (of the numbered questions):	Total (of the numbered questions):

LB

Ability to comprehend reading		Ability to understand when someone's talking to you	
Ability to remember facts and figures		Ability to identify objects	
Ability to speak clearly		High level of intelligence	
Ability to find words		Ability to focus on smaller details	
Ability to care for self (grooming)		Ability to enjoy music	
Ability to draw pictures		Ability to have a positive, happy attitude	

Ability to understand math/science		Ability to control shyness	
Do you have dyslexia?	Y / N	Ability to follow directions	
Are you athletic?	Y / N	Are you prone to chronic infections?	Y / N
Do you have any cysts or tumors?	Y / N	Do you have good language skills?	Y / N
Do you drink alcohol excessively?	Y / N	Do you drink coffee or other stimulants?	Y / N
Do you take any illegal/party drugs?	Y / N	Do you exercise regularly?	Y / N
Do you have a good diet?	Y / N	Are you under significant stress right now?	Y / N

Total (of the numbered questions):	Total (of the numbered questions):

I, _____, have answered the above questions as accurately as possible,
(print patient's name)
nderstanding that the information on these questionnaires is private and confidential.

Patient signature:_____ Date:_____

Doctor's signature: _____ Date:_____

Interpreter's signature:_____ Date:_____

HOLMES-RAHE STRESS TEST

For each event that has happened to you in the past 12 months, please mark the number of times it has happened to you in the first blank, and in the second blank, please multiply the Value by the number of times a year to get the Total for each event. Then, add up the right column and total at the bottom. It may be best to use a calculator!

RANK	EVENT:	VALUE	YOUR SCORE #/Yr	Total:
1.	Death of spouse	100	x _____	= _____
2.	Divorce	73	x _____	= _____
3.	Marital separation	65	x _____	= _____
4.	Jail term	63	x _____	= _____
5.	Death of close family member	63	x _____	= _____
6.	Personal injury or illness	53	x _____	= _____
7.	Marriage	50	x _____	= _____
8.	Fired from work	47	x _____	= _____
9.	Marital reconciliation	45	x _____	= _____
10.	Retirement	45	x _____	= _____
11.	Change in family member's health	44	x _____	= _____
12.	Pregnancy	40	x _____	= _____
13.	Sex difficulties	39	x _____	= _____
14.	Addition to family	39	x _____	= _____
15.	Business readjustment	39	x _____	= _____
16.	Change in financial status	38	x _____	= _____
17.	Death of close friend	37	x _____	= _____
18.	Change in number of marital arguments	35	x _____	= _____
19.	Mortgage or loan over $10,000	31	x _____	= _____
20.	Foreclosure of mortgage or loan	30	x _____	= _____
21.	Change in work responsibilities	29	x _____	= _____
22.	Son or daughter leaving home	29	x _____	= _____
23.	Trouble with in-laws	29	x _____	= _____
24.	Outstanding personal achievement	28	x _____	= _____
25.	Spouse begins or starts work	26	x _____	= _____
26.	Starting or finishing school	26	x _____	= _____
27.	Change in living conditions	25	x _____	= _____
28.	Revision of personal habits	24	x _____	= _____
29.	Trouble with boss	23	x _____	= _____
30.	Change in work hours, conditions	20	x _____	= _____
31.	Change in residence	20	x _____	= _____
32.	Change in schools	20	x _____	= _____
33.	Change recreational habits	19	x _____	= _____
34.	Change in church activities	19	x _____	= _____
35.	Change in social activities	18	x _____	= _____
36.	Mortgage or loan under $10,000	18	x _____	= _____
37.	Change in sleeping habits	16	x _____	= _____
38.	Change in number of family gatherings	15	x _____	= _____
39.	Change in eating habits	14	x _____	= _____
40.	Vacation	13	x _____	= _____
41.	Christmas season	12	x _____	= _____
42.	Minor violation of the law	11	x _____	= _____

TOTAL: _____

San Antonio Family Alternative Medicine – "Expect Different"

1931 N.W. Military Hwy, Suite 204, Castle Hills, TX 78213 (210) 340-2150

Consent to Examination and Diagnostic Procedures Patient Initials:_____

I do hereby authorize the Doctors of Chiropractic at San Antonio Family Alternative Medicine and/or their associates, or assistants to perform upon me (or the patient below, for whom I'm legally responsible) examination and diagnostic procedures arising from any current, past, or unforeseen condition(s), which San Antonio Family Alternative Medicine may consider necessary or advisable in the course of my health care. I understand and agree that the Doctors of Chiropractic and their associates or assistants, have the right to refuse to accept me as a patient at any time before treatment begins. The consultation (taking of a history) and conducting of a physical examination are not considered treatment, but are part of the information-gathering process so that the doctor can determine whether to accept me as a patient.

Informed Consent to Chiropractic Adjustments and Care Patient Initials:_____

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of therapy and diagnostic tests on me (or the patient below, for whom I am legally responsible) by the Doctors of Chiropractic at San Antonio Family Alternative Medicine and/or their assistants or associates who now, or in the future treat me while affiliated at said office. I have had an opportunity to discuss with the Doctor of Chiropractic adjustments and other procedures. I understand as that results are not guaranteed in conventional medicine, results are also not guaranteed in the practice of complementary and alternative medicine, including chiropractic. I've been informed and understand that as in the practice of conventional medicine, there are some risks associated with adjustment treatments, including but not limited to fractures, dislocations, and sprain/strains of soft tissue; and there are also risks associated with nutritional and herbal counseling, including but not limited to drug interactions or unforeseen allergies, sensitivities, or unforeseen complications in cases of inborn genetic errors. I do not expect the doctors to anticipate and explain all risks and complications and I wish to rely on the doctors to exercise their best judgment during the course of the procedure that the doctor feels at the time, based on all factors known at that time, is in my best interest.

HIPAA Privacy Policy Patient Initials:_____

With my signature below, I give consent for San Antonio Family Alternative Medicine to use and/or disclose information about me (or someone else for whom I have the legal authority to sign) that is protected under federal privacy law for the sole purpose of treatment, payment, and health care operations. I have reviewed the Privacy Policy of this Practice before signing this consent. The Privacy Policy may be amended from time to time, and I may always obtain a copy of the current policy without charge, simply by asking for one.

- I have the right to request restriction (in writing) on how my information is used and/or disclosed in order to execute treatment, payment, or healthcare operations. While San Antonio Family Alternative Medicine isn't required to agree to restrictions, San Antonio Family Alternative Medicine is bound to honor and abide by any such restrictions to which it has agreed.
- I have the right to revoke this consent (in writing). Revocations will be honored from the time written and delivered to the San Antonio Family Alternative Medicine office, but revocation can't affect any action already taken in reliance upon the consent given.
- I realize that my personal information that is protected by federal privacy law may be used and/or disclosed with my consent, and that the information may be subject to re-disclosure by the recipient. The re-disclosure by said recipient may not be protected by federal privacy law.

The Practice may communicate confidential information to me, including any invoices for services, at the following address/phone number/fax number/email address: (If space is left blank, the contact information on the front page of the intake form will be used.)

_____

The Practice may communicate confidential information about me to the following individuals (please write name/relation).

Name:_____ Relation:_____

Name:_____ Relation:_____

Name:_____ Relation:_____

I have read, or have had read to me, the above consents. I also have had the opportunity to ask questions about their content, and by signing below, I agree to the above-named procedures. I intend this consent form to cover the entire course of my treatment for my present condition and for any future condition(s) for which I request treatment. I further permit copies of this authorization to be used in place of the original.

_____	_____	_____
Print Patient's Name	Patient's Signature	Date
_____	_____	_____
Print Guardian's Name (for minor patient)	Guardian's Signature	Date

Revised: 12-29-2010

San Antonio Family Alternative Medicine

Having fun helping people

Cancellation and Reschedule Policy

- We understand that Life Happens and sometimes you can't make your scheduled appointment. We would appreciate a call beforehand, so that we can plan accordingly. If you don't appear for appointment and you have not called us (via phone at 340-2150, as we don't accept cancellations by email or text message), you'll need to honor a $30 no-show fee before or at the time of your next appointment.

- If you're running late for your appointment, please call us. If you're more than 15 minutes late for a regular appointment, or 30 minutes late for the first appointment, we'll need to reschedule so that we can give you the time and attention you deserve.

Print Patient's name	Patient's Signature	Date
Print Guardian's name (if patient is a minor)	Guardian's Signature	Date

San Antonio Family Alternative Medicine – "Expect Different"
1931 N.W. Military Hwy, Suite 204, Castle Hills, TX 78213

Chiropractic Financial Agreement

- **Our Usual and Customary rates** are: Evaluation/Exam $70 per 15 min; Adjustments average $70, with a 15% discount with costs paid in full at the time of service. Extremity (arm and leg) adjustments are $45 each, which is included in the adjustment price when paid in full at time of service. Soft tissue therapy is $55 per region worked, and is included in the adjustment price with costs paid in full at the time of service.

    - I will pay $ 75-165 for Initial Evaluation/Physical Assessment **at the time** of my appointment.
    - I understand that a basic medical exam (i.e. annual physical) isn't a substitute for a thorough biomechanical and medical evaluation performed by a chiropractic physician.
    - I will pay $ 55 for Advanced Chiropractic visits **at the time** of my appointment.
    - The Doctor will provide periodic checkups to evaluate my progress and I will pay $ 55-80 for the Re-Evaluation/Follow-up Exam **at the time** of my appointment.

- I understand that Medicare does **not** cover services in the manner that they are provided in this office. I will **not** attempt to submit my receipts to, or seek reimbursement from, Medicare. If I am eligible to enroll in Medicare or receive Medicare benefits, I will sign an addition ABN form at least every 2 years.
- I understand that payments made **after** the time of service are subject to the full Usual and Customary rates as described above (average full cost for a chiropractic visit totals about $ 285, depending on the individual services provided). This policy is dictated to us by the contracts we hold with health insurance companies, and it must be applied consistently to all patients in the practice, regardless of insurance coverage.

We understand *firsthand* that circumstances may make it difficult to pay for medical care, including alternative and complementary medicine. **Please let us know so that we can make individual arrangements.**

Patient's Name_____

Patient's Signature_____ Date _____/____/____

Revised: 01-19-2011

San Antonio Family Alternative Medicine Office Protocols

Please keep this for your reference.

Welcome!

We've got a few housekeeping items we like to get out of the way, so everyone is on the same page, and so that everyone can have an enjoyable, relaxing, and healthy experience at our office. In fact, this isn't just *our* office; it belongs to all of us! We're fairly lenient about most of these, only "cracking down" if anything becomes a pattern.

We ask that you be on time for every appointment. We understand that life happens; time gets away from us, or sometimes we can encounter unexpected traffic jams. If you know you're going to be late, we do appreciate a call so that we don't worry and wonder what happened.

If you can't make your appointment, don't worry! We realize circumstances come up that we can't always avoid. If you know you can't make your appointment, please **do call us** to at least let us know so that we can offer the time to another patient who might really appreciate being able to take your spot.

We ask that our patients and employees/contractors refrain from wearing perfume, cologne, or other heavy scents to the office. We're *not* so lenient about this. We do see many chemically sensitive patients with allergies and overactive immune systems (in fact, this is true of one of the doctors who must spend all day here). Those wearing strong scents may be asked to return later without colognes or perfumes.

We do require that everyone pay for all services rendered at the time of service, unless insurance coverage has been verified. We accept cash, Personal Check (our machine requires your driver's license number), Visa, Mastercard, and Discover. (We apologize that we are not set up to accept Business/Corporate checks or American Express cards.)

All of the rates quoted in the Financial Agreement are actually Time Of Service (TOS) discounted rates. If you do forget to bring your wallet or checkbook, we can let it slide the first time only, and for 1 day; after that, however, regular higher insurance rates will apply (we're actually bound to do this by law, as we're required to treat cash and insurance patients the same, the ONLY exception being for payment on the same day you receive services). We legally have to be strict on this one, and unfortunately, we're not allowed to be lenient at all.

If you are sick with a regular cold, flu, or any non-contagious disease but can otherwise make it to the office, please do come in for chiropractic adjustments! (Please reschedule any massage therapy for another day, however, as it may make you feel much worse before you feel better.) Please do stay home if you have a contagious disease such as bronchitis, pneumonia, or any other condition that can be transmitted (other than regular cold or flu). Please do seek antibiotic treatment, and please DO return when you are no longer contagious! We'll help you get better faster.

After your initial visit with either (or both) doctor(s), in order to go forward with chiropractic or functional medicine, it's standard healthcare practice that you have a physical assessment/exam to establish a baseline to which we can compare future progress. If you see both doctors, you only need to have one initial physical, as long as it's been less than 3-6 months and there haven't been any changes to your health/stress level. This is a legal requirement and unfortunately, an exam from another provider can't be used as a substitute.

Even though we are currently HIPAA-exempt, we do insist upon HIPAA compliance, and your information will not be shared with any other patients (or even your friends or family members) without your written permission. The only people we share health information with are other relevant practitioners in the clinic or with our colleagues in order to obtain further expert advice on how best to serve you.

In the interest of protecting this privacy, we do ask that to discuss anything healthcare-related (including information, advice, or recommendations) that you 1) make an appointment so we can set aside time just for you, OR that you 2) attend one of our free Tuesday night health classes to ask questions once we open up the floor to miscellaneous questions. We don't give any official information, advice, or recommendations over the phone, email, in the front lobby, or anywhere else outside of our personal offices (other than health classes, time permitting). We appreciate your patience and understanding!

We know you can choose anyone to help you get healthy ~ thank you for choosing us!