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

Expect Different.

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

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:__________________________
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  ☐ Lifestyle management
  ☐ Genomic (Gene) testing  ☐ Food allergy testing
  ☐ Neurotransmitter testing  ☐ Stress management
  ☐ Spinal and Joint Health  ☐ Physical Conditioning
  ☐ Weight Loss  ☐ hormone testing
  ☐ Genomic (Gene) testing  ☐ Pain management
  ☐ Food allergy testing  ☐ 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?  ☐ At work?
  ☐ Between 3 days and 8 weeks ago?  ☐ At home?
  ☐ Between 8 weeks and 4 months ago?  ☐ Somewhere else?
  ☐ More than 4 months ago?
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? _____________________________________________________
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.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = no pain</td>
<td>1-2 = some pain</td>
<td>3-5 = affecting work</td>
<td>6-7 = can’t work</td>
<td>8-9 = bad enough to go to the hospital</td>
<td>10 = worst pain I’ve ever felt in my life</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 = no symptoms</td>
<td>1-2 = mild, annoying</td>
<td>3-5 = affecting extra activities</td>
<td>6-7 = affecting work</td>
<td>8-9 = can barely function</td>
<td>10 = can’t function</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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
“Sf” 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:____________________________________________________________________
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:____________________________________________________________________
Health Screening

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

☐ Chest pain  ☐ Jaw pain  ☐ Pain in your left arm
☐ Shortness of breath  ☐ Light-headedness  ☐ Pale skin
☐ Blackouts  ☐ Swelling in your left arm  ☐ Excessive sweating w/o exertion
☐ Nausea  ☐ Difficulty talking  ☐ Dizziness or vertigo
☐ Vomiting  ☐ Difficulty swallowing  ☐ Disequilibrium or feeling unsteady
☐ Double vision  ☐ Severe headache  ☐ Abnormal eye movements
☐ Numbness  ☐ Abnormal sweating  ☐ 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: ______________
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  | Convulsion, epilepsy, or other seizures |
| C | P  | Neck pain/stiffness | C | P  | Losing time, memory, or blacking out |
| C | P  | Upper back pain/stiffness | C | P  | Paralysis |
| C | P  | Mid-back pain/stiffness | C | P  | Stroke, or mini-stroke/TIA |
| C | P  | Low back pain/stiffness | C | P  | Trouble sleeping |
| C | P  | Hip or pelvis pain | C | P  | Trouble with focus |
| C | P  | Auto accident | C | P  | Fainting spells |
| C | P  | Machine/industrial/farm accident | C | P  | Tire easily |
| C | P  | Pain in the foot, elbow, knee, ankle, or toes | C | P  | Blurred or double vision |
| C | P  | Pain in the shoulder, elbow, wrist, hand, or fingers | C | P  | Recent lack of coordination |
| C | P  | Jaw pain or click | C | P  | Head and/or arms feel heavy and/or tired |
| C | P  | Chronic headaches | C | P  | Concussion |
| C | P  | Sprain, strain, or sports injury | C | P  | Other Head injury |
| C | P  | Trouble with prolonged sitting, standing, or lying down | C | P  | Spontaneous jerking or movement |
| C | P  | Trouble with walking, bending, twisting, or lifting | C | P  | Persistent headache |
| C | P  | Osteoporosis | C | P  | Lost muscle tone |
| C | P  | Dislocated joints | C | P  | Muscle cramping |
| C | P  | Fractured bones | C | P  | Tremors or shaking (while resting or while moving?____________) |
| C | P  | Torn ligament or muscle | C | P  | Muscle twitching or weakness |
| C | P  | Bone infection (osteomyelitis) | C | P  | ADD/ADHD/behavior problems – as (circle one or both) child or adult |
| C | P  | Herniated/bulging disc | C | P  | Dyslexia |
| C | P  | Scoliosis or spinal curve | C | P  | Autism Spectrum (including Asperger’s) |
| C | P  | Osteoarthritis or DJD | C | P  | |
| C | P  | Rheumatoid arthritis | C | P  | |
| C | P  | Gout | C | P  | |
| C | P  | Ankylosing spondylitis | C | P  | |
| C | P  | Migraine headaches | C | P  | |
| C | P  | Cluster headaches | C | P  | |
| C | P  | Tension/stress headaches | C | P  | |
| C | P  | Blood pressure headache | C | P  | |
| C | P  | Allergy/Sinus headaches | C | P  | |
| C | P  | TMJ headache | C | P  | |
| C | P  | Other headache | C | P  | |
| C | P  | Balance problems | C | P  | |
| C | P  | Mental or emotional disorder | C | P  | |
| C | P  | Ear infections or earaches | C | P  | |
| C | P  | Tinnitus or Ringing in the ears | C | P  | |
| C | P  | Hearing loss | C | P  | |
| C | P  | Sinus problems | C | P  | |
| C | P  | Irregular heartbeats | C | P  | |
| C | P  | Heart murmur | C | P  | |
| C | P  | Leg pain with physical activity | C | P  | |
| C | P  | Dizziness/lightheaded with exercise | C | P  | |
| C | P  | High blood pressure | C | P  | |
| C | P  | Atherosclerosis or arteriosclerosis | C | P  | |
| C | P  | Heart attack | C | P  | |

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

"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:_______
difficulty or painful breathing
chronic/frequent cough
snoring
other lung problems
ulcers
abdominal pain
ceeliac disease
irritable bowel syndrome
ulcerative colitis or crohn’s disease
excessive thirst
diabetes
(circle) over or under active thyroid
night sweats
(circle) adrenal or thyroid problem
acne
eczema
dermatitis
psoriasis
change in hair pattern
shingles
warts
bruise easily
pits, dents, weakness in fingernails
change in fingernail appearance
nervousness
depression
mania
phobias
risk taking behavior
mood changes
panic attacks
post-traumatic stress
irritability
anger easily
excessive or chronic stress
prostate problems
erectile dysfunction
premature ejaculation
pms or menstrual problems
breast or vaginal discharge
breast lumps or soreness
kidney problems or disease
difficult, or frequent urination
feelings of urgency to urinate
frequent or infrequent urination
bleeding disorder
anemia
slow to clot
excessive clotting
varicose veins
bruise easily
blood vessel/vascular disease
seasonal allergies
food allergies
autoimmune disease
immunodeficiency
frequent cold or flu
alcoholism
cancer (location? stage? treatment?)
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 me 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

<table>
<thead>
<tr>
<th>DLC</th>
<th>BG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feelings of sadness</td>
<td>Panic attacks</td>
</tr>
<tr>
<td>Decreased interest in others</td>
<td>Feelings of nervousness or anxiety</td>
</tr>
<tr>
<td>Moodiness</td>
<td>Poor handwriting</td>
</tr>
<tr>
<td>Feelings of hopelessness about the future</td>
<td>Headaches / sore muscles</td>
</tr>
<tr>
<td>Negativity or pessimism</td>
<td>Shyness or timidity</td>
</tr>
<tr>
<td>Feelings of helplessness or powerlessness</td>
<td>Hand tremors</td>
</tr>
<tr>
<td>Low energy</td>
<td>Tics</td>
</tr>
<tr>
<td>Feeling dissatisfied or bored</td>
<td>Heart pounding, rapid heart rate, chest pain</td>
</tr>
<tr>
<td>Irritability</td>
<td>Conflict avoidance</td>
</tr>
<tr>
<td>Excessive guilt</td>
<td>Low motivation</td>
</tr>
<tr>
<td>Suicidal thoughts or feelings</td>
<td>Excessive motivation</td>
</tr>
<tr>
<td>Crying easily</td>
<td>Avoidance of public places from fear of anxiety</td>
</tr>
<tr>
<td>Low self-esteem</td>
<td>Quick startle reaction</td>
</tr>
<tr>
<td>Lowered interest in things considered fun</td>
<td>Periods of nausea and stomach upset</td>
</tr>
<tr>
<td>Sleep changes</td>
<td>Persistent phobias</td>
</tr>
<tr>
<td>Appetite changes</td>
<td>Easily embarrassed</td>
</tr>
<tr>
<td>Forgetfulness</td>
<td>Fear of being judged or scrutinized</td>
</tr>
<tr>
<td>Decreased interest in sex</td>
<td>Sweating easily</td>
</tr>
<tr>
<td>Poor concentration</td>
<td>Excessive worrying about what others think</td>
</tr>
<tr>
<td>Negative sensitivity to smells and odors</td>
<td>Hot or cold flashes / hot or cold hands</td>
</tr>
<tr>
<td>Trouble listening</td>
<td>Trouble sustaining attention in routine situations</td>
</tr>
<tr>
<td>-------------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Easily distracted</td>
<td>Inability to pay close attention to detail or avoid mistakes</td>
</tr>
<tr>
<td>Poor planning skills</td>
<td>Lack of clear goals or forward thinking</td>
</tr>
<tr>
<td>Boredom</td>
<td>Difficulty expressing feelings</td>
</tr>
<tr>
<td>Lethargy</td>
<td>Difficulty following through or finishing things</td>
</tr>
<tr>
<td>Lack of motivation</td>
<td>Difficulty expressing empathy for others</td>
</tr>
<tr>
<td>Excessive daydreaming</td>
<td>Feelings of spaciness or being in a fog</td>
</tr>
<tr>
<td>Conflict seeking</td>
<td>Trouble learning from experience, makes repetitive mistakes</td>
</tr>
<tr>
<td>Difficulty awaiting turn</td>
<td>Difficulty remaining seated when expected</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Interruption of or intrusion on others</td>
</tr>
<tr>
<td>Impulsivity</td>
<td>Blurtling out answers before questions are completed</td>
</tr>
<tr>
<td>Talking too much or too little</td>
<td></td>
</tr>
</tbody>
</table>

**Total:**

**CS**

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

**Total:**

**TL**

<table>
<thead>
<tr>
<th>Mild paranoia</th>
<th>History of family violence or explosiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Memory problems</td>
<td>History of head injury or trauma</td>
</tr>
<tr>
<td>Periods of forgetfulness</td>
<td>Short fuse or periods of extreme irritability</td>
</tr>
<tr>
<td>Spaciness or confusion</td>
<td>Periods of rage without provocation</td>
</tr>
<tr>
<td>Periods of déjà vu</td>
<td>Reading comprehension problems</td>
</tr>
</tbody>
</table>

**TL continued**

| Periods of panic | Irritability that tends to build and then explode |

6/24/2010
<table>
<thead>
<tr>
<th>Frequent misinterpretation of comments as negative when they aren't</th>
<th>Dark thoughts of suicide or homicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Auditory or visual hallucinations</td>
<td>Preoccupation with moral or religious ideas</td>
</tr>
<tr>
<td>Headaches or abdominal pain of an uncertain/unknown cause</td>
<td></td>
</tr>
</tbody>
</table>

**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**

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

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

**LB**

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

6/24/2010
<table>
<thead>
<tr>
<th>Question</th>
<th>Y / N</th>
<th>Question</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have dyslexia?</td>
<td>Y / N</td>
<td>Ability to control shyness</td>
<td>Y / N</td>
</tr>
<tr>
<td>Are you athletic?</td>
<td>Y / N</td>
<td>Are you prone to chronic infections?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Do you have any cysts or tumors?</td>
<td>Y / N</td>
<td>Do you have good language skills?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Do you drink alcohol excessively?</td>
<td>Y / N</td>
<td>Do you drink coffee or other stimulants?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Do you take any illegal/party drugs?</td>
<td>Y / N</td>
<td>Do you exercise regularly?</td>
<td>Y / N</td>
</tr>
<tr>
<td>Do you have a good diet?</td>
<td>Y / N</td>
<td>Are you under significant stress right now?</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

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

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

I, ____________________________________________, have answered the above questions as accurately as possible, understanding 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!

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

TOTAL:
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
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  Guardian’s Signature  Date

(if patient is a minor)
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 ___/___/___
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!

Revised: 09-16-2010