Confidential Patient Health Record Date: ___/___/_____

Circle One: Divorced Married Single Separated Widowed

Birth Date: ___/___/_____ Age: ______ Gender: Male/ Female

First: ______________________ Middle: ______ Last: ________________________

Address: ____________________ City: _______________ State: ____ Zip: ________

Home Phone: ______________________ Cell Phone: __________________________

Social Security#:____-____-______ Email Address: ____________________________

Spouses Name: _______________ Children (Ages):______________________________

How did you hear about us?

____

Employer

Business Name: ____________________Occupation/Job Title: ___________________

Business Phone: ___________________ Business Fax: __________________________

Primary Care Physician: ____________________ Phone: ________________________

Emergency Contact: _______________________ Phone: ________________________

Who is Responsible for Your Bill?

☐ Self ☐ Insurance ☐ Medicare ☐ Other (be specific)

____

Insurance: ___________________ Insured person's name: _____________________

Ins. Person's Soc. Sec. #:______________ Ins. Person's Date of Birth: ____________

Subscriber ID: ________________________ Group #:__________________________

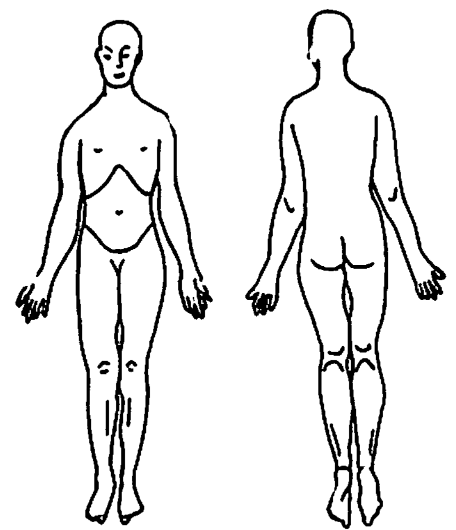
Contact Persons Name: ____________________ Phone Number: _________________

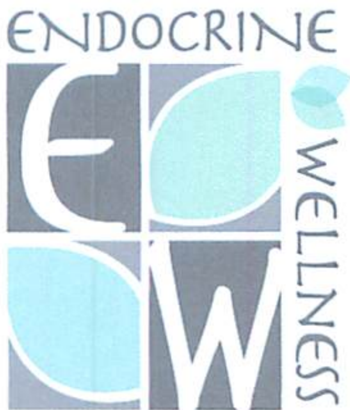
Are you experiencing any pain or adverse sensations?

On the diagram to the right, use the letters below to indicate the type and location of any sensations you are feeling right now:

A= Ache **B**= Burning **N**= Numbness

S= Stabbing **P** =Pins and Needles **O**=Other





Male Health History Questionnaire

(To be completed by patient)

Name: ______________________ Date: ______________

Date of Birth: ______________ Age: ________

Weight: __________ Height: __________

Chief Complaint(s):

____

____

____

Prescription Drug Usage – Please check if you use any of the following & then list exact names of any medications you are currently using:

- □ Antacids, Zantac, Pepcid AC, Rolaids, etc.
- □ Chemotherapy
- □ Laxatives
- □ Ulcer medications
- □ Antibiotic/Antifungal
- □ Anti-diabetic/Insulin
- □ Relaxants/Sleeping pills
- □ Thyroid
- □ Radiation
- □ Antidepressants
- □ Aspirin/Acetaminophen
- □ Cortisone/Anti-Inflammatory
- □ Heart medications
- □ High blood pressure medicine
- □ Statins/Cholesterol lowering medications

□ Hormones – If so, what? ______________________ When? ______________ Dosage? __________

Please list names of any medications you are currently taking:

____

____

____

____

____

Are you allergic to any drugs that you know of? (if so please list names):

____

____

____

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Revised 09/20/2012

Supplement/Vitamin Usage – Please list any supplements/vitamins you are currently taking:

____

____

____

____

____

Surgeries, Accidents, Trauma's – Please list any surgeries, accidents, or trauma's you have had. Please be sure to include dates as well.

____

____

____

____

____

Lifestyle

Dietary Habits: Describe the foods you normally eat:

BREAKFAST: ____

____

LUNCH: ____

____

DINNER: ____

____

SNACKS: ____

____

Do you consume the following?			**If so, how much?**
1. Soda or carbonated beverages?	YES	NO	______________
2. White flour products?	YES	NO	______________
3. Fried foods?	YES	NO	______________
4. Coffee?	YES	NO	______________
5. Fast foods regularly?	YES	NO	______________
6. Sweets and/or refined carbohydrates?	YES	NO	______________
7. Alcoholic beverages?	YES	NO	______________
8. Any tobacco products?	YES	NO	______________

Are you a vegetarian? YES NO

Are you currently involved in an exercise program? YES NO How often? ______________

How would you rate your stress level? (1=Low, 10=Extreme) 1 2 3 4 5 6 7 8 9 10

How do you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

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Male Anatomy

Have you had a vasectomy? YES NO When? ______________________

Experienced any symptoms related to the vasectomy? YES NO
If so, please explain: ______________________
____

Reverse vasectomy? YES NO When? ______________________

Do you have any history of prostate problems? YES NO
If so, please explain: ______________________
____

When was your last prostate exam? ______________________

What were your most recent PSA results? ____________ Date ____________

Does your bladder always feel full?	YES	NO	SOMETIMES
Do you experience inconsistent pressure or pain during urination?	YES	NO	SOMETIMES
Does ejaculation cause pain?	YES	NO	SOMETIMES
Do you experience low sex drive?	YES	NO	SOMETIMES
Do you have premature ejaculation?	YES	NO	SOMETIMES

Sleep

How well do you sleep?
- ☐ Well
- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Insomnia

What is the average number of hours you most often sleep each night? ____________

Do you wake up with night sweats? YES NO

When you wake in the morning do you still feel tired? YES NO
If yes, how often? ______________________

Do you keep your room completely dark at night? YES NO

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Signs & Symptoms *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

Section 1:

Do you experience bloating?	1	2	3
Fullness for extended time after meals?	1	2	3
Fatigue or low energy after eating?	1	2	3
Do you experience indigestion?	1	2	3
Uncomfortable/adverse reactions to food?	1	2	3
Weight gain?	1	2	3
Trouble losing weight?	1	2	3
Weight loss?	1	2	3
Water retention?	1	2	3
Belching/Gas? (circle)	1	2	3
Stomach burning/Nausea? (circle)	1	2	3

Section 2:

Do you suffer with constipation?	1	2	3
Light colored stool?	1	2	3
Loose stools?	1	2	3
Diarrhea?	1	2	3
Persistent gas?	1	2	3
Digestive problems?	1	2	3

Section 3:

Low blood sugar / Hypoglycemia?	1	2	3
Sweet cravings?	1	2	3
Carbohydrate cravings?	1	2	3
Caffeine/Stimulant cravings? (circle)	1	2	3
Constant hunger?	1	2	3

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Signs & Symptoms, Cont'd *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily). If you do not know the answer to a question or if it does not pertain to you simply leave it blank.*

Section 4:

Low mood/depression? (circle)	1	2	3
Mood swings?	1	2	3
Irritability?	1	2	3
Anxiety?	1	2	3
Anger/aggression?	1	2	3
Nervousness?	1	2	3
Overly reactive?	1	2	3
Short fuse?	1	2	3

Section 5:

Discouragement/pessimism? (circle)	1	2	3
Decreased interest in activities/relationships? (circle)	1	2	3
Decreased initiative/motivation/drive? (circle)	1	2	3
Decreased productivity at work?	1	2	3

Section 6:

Concentration problems?	1	2	3
Poor memory?	1	2	3
Foggy thinking?	1	2	3
Increased fatigue?	1	2	3
Lowered self-esteem/self image? (circle)	1	2	3
Care for others before yourself?	1	2	3
Sadness/crying? (circle)	1	2	3

Section 7:

Decrease in strength/stamina? (circle)	1	2	3
Decrease in athletic performance?	1	2	3
Decreased lean muscle mass?	1	2	3
Muscle soreness/weakness? (circle)	1	2	3
Body/joint aches? (circle)	1	2	3
Increased fat on hips/breasts/thighs? (circle)	1	2	3
Poor stamina?	1	2	3
Persistent leg cramps?	1	2	3

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Signs & Symptoms, Cont'd *(INSTRUCTIONS: Circle the number that best describes the intensity of your current symptoms. 1 = Mild (happens approximately once per month), 2 = Moderate (happens weekly), 3 = Severe (happens almost daily).* ***If you do not know the answer to a question or if it does not pertain to you simply leave it blank.***

Section 8:

Elevated cholesterol?	1	2	3
Elevated blood pressure?	1	2	3
Headaches/Migraines? (circle)	1	2	3
Muscle pain/Joint aches/Backache? (circle)	1	2	3

Section 9:

Head hair loss/body hair loss? (circle)	1	2	3
Dry skin?	1	2	3

Section 10:

Lowered libido?	1	2	3
Erectile dysfunction (ED)?	1	2	3
Pain w/ ejaculation?	1	2	3
Frequent need to urinate?	1	2	3
Urination is delayed/strained/incomplete? (circle)	1	2	3
Pain with urination?	1	2	3
Blood in the urine?	1	2	3
Bone loss/osteoporosis?	1	2	3

Patient Acknowledgement

For use and/or disclosure of Protected Health Information (PHI)
To carry out Treatment, Payment, and Healthcare Operations

I _________________________, hereby states that by signing this consent, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The practice explained to me that the Privacy Notice would be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent, and has encouraged me to read the Privacy Notice
carefully prior to my signing this consent.

2. The practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.

3. The Practice's "Notice of Privacy Practices" is available upon request. I may also request a copy from this office at anytime via US mail.

4. This Notice of Privacy Practices also describes my rights and the duties of this office with respect to my protected health information.

I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

______________________________	______________________
Printed name of Patient	Date
______________________________	______________________
Signature of Patient, Parent, or legal guardian	Witness

Payment Policy

___ **CASH:** Payment in full is expected at the time the service is done.

___ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize direct payment of benefits to this office for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance.

___ **ALL INSURANCE AND MEDICARE:** I hereby authorize this office to release any medical or incidental information that may be necessary for medical care or processing applications for financial benefits. If I receive payment from my insurance carrier during the period which the clinic has accepted assignment of benefits, I will bring the check into this office within 3 days of receipt and endorse it over to the office. Failure to do this may result in collection action. If I discontinue care for any reason other than discharge by the doctor, I will be responsible for any unpaid balance regardless of any claims submitted to my insurance company, at the time I discontinue care. This office does not promise that any insurance company will pay. In the event that the insurance company disputes or rejects the claim, it will be my responsibility to pay all the charges and pursue reimbursement from the insurance company on my own.

___ **CANCELLATION POLICY:** 24 hour notice must be given to cancel an appointment. In case of a short notice or no notice cancellation, a $25.00 cancellation fee will be charged.

___ **PAST DUE ACCOUNT POLICY:** After 60 days of non-payment, a $25.00 late fee will be added to my account to be compounded monthly. If necessary, my account will be turned over to a collections agency. As a last resort, the office will take legal action and all reasonable attorney and court fees incurred to collect fees due to this office will be added to my account and I will be responsible.

****I have read and understand the above and hereby agree to abide by the provisions as specified. Thank you for your cooperation and understanding.**

Patient Name:______________________________

______________________________ ______________

Signature of Patient, Parent, or Legal Guardian Date

Information Release Form

Name: ______________________________________ Date: _______________

Contact Preferences

By signing below I give permission to Whole Health Chiropractic to leave messages regarding my appointments, nutrition, or other health information via the following methods unless otherwise specified (strike through any methods you wish to not receive).

- Voice Message on Home Number / Cell Number / Business Number
- Text Message to provided number
- Email Message to provided email address
- Demand Force – email/text appointment reminders, newsletters, birthday wishes, etc.
    - Contact settings can be changed by following the instructions in an email or text.

Sign: ____ Date: _________________

Digital Contact Release

I understand that Whole Health Chiropractic seeks to be available for questions and further clarification that may be required through email, texting, Facebook messages, or other digital outlets. I also understand that many of these forms may not be compliant with HIPAA (health information portability and accountability act) privacy standards for medical information. By signing I agree to allow Whole Health Chiropractic staff and doctors to discuss my health information with me via these non-secure forms. Nothing will be intentionally made public.

Sign: ____ Date: _________________

*By refusing signature, you are declining contact through these forms and all health information questions must be addressed by appointment or phone call.

Testimonial Release

Whole Health Chiropractic enjoys using testimonials to aid in patient awareness and education. I understand that by becoming a patient, my story may be told in written or oral form including online media. I understand that I have the right to determine the level of information revealed that connects me to the testimony personally including my name, initials, location, etc.

I am aware that I can request the removal of my identifying information at any time.

By signing below I give Whole Health Chiropractic the authority to use my:

(Please select all that apply)

- My initials
- My name
- Nothing (pseudonym)
- Picture (if provided)

Sign: ____ Date: _________________

Informed Consent to Chiropractic and Associated Care

SERVICES

–Chiropractic & Manual Therapy: Chiropractic treatment will involve the doctor using their hands or an instrument to move your joints in order to impact the nervous system, which regulates the entire body. This may or may not result in a harmless "pop" sound, depending on the various techniques used. Manual therapies, such as myofascial reconfiguration and trigger point release, will involve the use of hands or tools to break up adhesions and impact the nervous system. *Risks:* The risks of Chiropractic and manual therapies include mild skin irritation, soreness or bruising. Extremely rare risks can include fracture, strain, sprain, stroke, or possible injury to intervertebral discs, nerves, the spinal cord or arteries in the neck. These risks are diminished by performing a thorough history, risk assessment, and examination.

–Acupuncture & Meridian Therapy: Acupuncture involves the use of needles to stimulate points on the body known to produce certain effects. Meridian therapy is the study of the energy systems in the body as it pertains to Traditional Chinese and other Eastern medicine practices, which includes acupressure, auriculotherapy, and some use of traditional herbal principles. *Risks:* The risks of Acupuncture therapy include bruising, numbness or tingling near needle sites for a few days, dizziness or fainting. Rare risks include organ puncture or infection. These risks are diminished by using sterile, disposable needles and practicing in a clean and safe environment.

–Functional Nutrition & Supplementation: Nutritional evaluation may include history, signs and symptoms analysis, laboratory testing (serum, skin, hair, urine, stool, saliva, etc), muscle testing, and bio-resonance testing. Recommendations may include lifestyle modification, dietary changes, and supplement suggestions. *Risks*: The risks of dietary and certain supplemental care may result in diarrhea, constipation, nausea, gas, headache, rashes or allergic response, toxicities, and deficiencies. These are diminished by taking ownership of the foods eaten and supplements taken, following general recommendations, and informing my medical and other doctors of any nutritional supplements or dietary changes. A full history, including medications, family and social history, is taken.

–Bio-resonance Testing: Bio-resonance testing is a form of bio-feedback that allows deeper analysis of the human body. It is not licensed by the FDA to diagnose or treat any condition and is not employed by most practitioners in this way. All decisions are ultimately made based on clinical and laboratory information regarding therapies or nutritional recommendations.

Alternatives: Alternatives to Chiropractic and these associated methods include medical care (including medications and/or surgical procedures), massage therapy, physical therapy, over-the-counter medication, and other self-care.

Risks of Non-Treatment: Delay of treatment may allow for progression of the current condition or reduction in healing with greater likelihood of formation of chronic pain or lifestyle limitations.

CONSENT TO TREATMENT

I hereby desire and request care via the methods above from Whole Health Chiropractic for myself or the patient, named below, for whom I am legally responsible. I have been informed of the risks, benefits and alternatives to Chiropractic, manual therapy, acupuncture, nutritional and herbal modification, and biofeedback testing. I am aware it is my sole responsibility to inform my physician to the best of my knowledge any health history or risk information so that my care plan may be adjusted accordingly. I also accept responsibility for seeking appropriate care for any conditions that arise before or after beginning care, including but not limited to pregnancy, diabetes, and any communicable diseases.

I understand that my doctor at Whole Health Chiropractic cannot make any promises or guarantees regarding a cure or improvement of my condition. I understand they will share their professional opinion regarding potential results from Chiropractic care and will discuss treatment options with me, but it is my responsibility to remain informed and in charge of the direction of my care.

I have been given the opportunity to ask pertinent questions regarding the above information. I understand that I am responsible for payment at time of service. My signature signifies that I have read this document and understand its purpose. I release Whole Health Chiropractic and its employed or affiliated practitioners from any liability.

Patient Name (print): ____________________ Legal Guardian (required to sign if patient under 18): ____________________

Sign: ____________________ Date: __________ Witness: ____________________ Date: __________