

Chiropractic First, Family Wellness Center
Confidential Nutrition Member Information

Name: _____ Home Phone: _____ Work/Cell: _____ Date: _____

Address: _____ City/State/ZIP: _____

Email: _____ Social Security Number: _____

D.O.B.: _____ Age: _____ Who may we thank for referring you? _____

Occupation: _____ Employer: _____

Sex: M / F Height: _____ Weight: _____ Single/ Married/ Divorced/ Widowed Spouse's Name: _____

Describe health of spouse: _____ Number of Children, if any: _____

Name of Child	Age	Sex	Any physical conditions or concerns?
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____
_____	_____	M/F	_____

Is this appointment for the whole family? Family: _____ Self: _____

Your hobbies/interests/activities: _____

Primary reason for consulting our office: _____

Do you exercise? NO YES: How often? _____ What type? _____

Rate your diet: Healthy Average Poor Coffee: Never/Rare/Moderate/Daily

Alcohol: Never/Rare/Moderate/Daily Smoker? No Yes ___# packs/day since year: ___ Past smoker? No Yes

What is the present reason for consulting our office?

Symptom Relief Maintaining Your Current Level of Health Optimum Wellness

Other doctors you are currently seeing: _____

Current medications: _____

Over the counter drugs taken in the past 3 months: _____

Current Vitamins/Supplements _____

List any major illnesses (with approx. dates): _____

List all surgeries: _____

Past accidents or injuries: _____

Any family history of serious illness: Cancer / Diabetes / Heart Problems / Other: _____

Any family pets or other animals you or family members are in close contact with: _____

Health is the most valuable asset in the world – YOU and YOUR FAMILY’S. Healing includes taking responsibility for that health. Aspects of this responsibility are attending the classes, following your care plan, and meeting your financial obligations. The insurance industry pays for the treatment of symptoms and disease. We do not treat symptoms and disease. Therefore we operate on a fee for service basis. However, you may submit your claims for your own personal reimbursement. Nutrition consults and supplements are not a covered service by Medicare.

I clearly understand that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I further understand and am informed that, as in all health care, there are some slight risks to treatment and do not expect the doctor to be able to anticipate or explain all risks and combinations; and wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interest. I have read this consent and intend this consent form to cover the entire course of my care and any care in the future.

Signature: _____

Witness: _____

Print: _____

Date: _____

Chiropractic First, Family Wellness Center

**Permission and Authorization Form Regarding the Use of
Nutrition Response Testing**

Please Read Before Signing:

I specifically authorize the natural health practitioners at Chiropractic First, Inc. to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, and **not for the treatment, or “cure” of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body’s physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for “diagnosing” or “treating” of any disease including conditions of cancer, AIDS, infections or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body’s natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone: (____) _____ - _____

Signed: _____

If minor, signature of parent or guardian required

Witness: _____

SYSTEMS SURVEY FORM



Patient _____ Doctor _____ Date _____

Birth Date ____ / ____ / ____ Approx Weight _____ Vegetarian: Yes ** No **

INSTRUCTIONS: Fill in only the circles which apply to you. Leave blank if you don't have the problem.

- Fill in the circle marked 1 for MILD symptoms (occurs rarely).
- Fill in the circle marked 2 for MODERATE symptoms (occurs several times a month).
- Fill in the circle marked 3 for SEVERE symptoms (occurs almost constantly).
- **Leave circles BLANK if they don't apply to you!**

GROUP 1

- | | | |
|--------------------------------|---|--------------------------------|
| 1 ○○○○ Acid foods upset | 8 ○○○○ Gag easily | 15 ○○○○ Appetite reduced |
| 2 ○○○○ Get chilled often | 9 ○○○○ Unable to relax; startles easily | 16 ○○○○ Cold sweats often |
| 3 ○○○○ "Lump" in throat | 10 ○○○○ Extremities cold, clammy | 17 ○○○○ Fever easily raised |
| 4 ○○○○ Dry mouth-eyes-nose | 11 ○○○○ Strong light irritates | 18 ○○○○ Neuralgia-like pains |
| 5 ○○○○ Pulse speeds after meal | 12 ○○○○ Urine amount reduced | 19 ○○○○ Staring, blinks little |
| 6 ○○○○ Keyed up - fail to calm | 13 ○○○○ Heart pounds after retiring | 20 ○○○○ Sour stomach often |
| 7 ○○○○ Cut heals slowly | 14 ○○○○ "Nervous" stomach | |

GROUP 2

- | | | |
|--|--|--|
| 21 ○○○○ Joint stiffness on arising | 29 ○○○○ Digestion rapid | 37 ○○○○ "Slow starter" |
| 22 ○○○○ Muscle-leg-toe cramps at night | 30 ○○○○ Vomiting frequent | 38 ○○○○ Get "chilled" infrequently |
| 23 ○○○○ "Butterfly" stomach, cramps | 31 ○○○○ Hoarseness frequent | 39 ○○○○ Perspire easily |
| 24 ○○○○ Eyes or nose watery | 32 ○○○○ Breathing irregular | 40 ○○○○ Circulation poor, sensitive to cold |
| 25 ○○○○ Eyes blink often | 33 ○○○○ Pulse slow; feels "irregular" | 41 ○○○○ Subject to colds, asthma, bronchitis |
| 26 ○○○○ Eyelids swollen, puffy | 34 ○○○○ Gagging reflex slow | |
| 27 ○○○○ Indigestion soon after meals | 35 ○○○○ Difficulty swallowing | |
| 28 ○○○○ Always seems hungry; feels "lightheaded" often | 36 ○○○○ Constipation, diarrhea alternating | |

GROUP 3

- | | | |
|--|--|---|
| 42 ○○○○ Eat when nervous | 49 ○○○○ Heart palpitates if meals missed or delayed | 53 ○○○○ Crave candy or coffee in afternoons |
| 43 ○○○○ Excessive appetite | 50 ○○○○ Afternoon headaches | 54 ○○○○ Moods of depression - "blues" or melancholy |
| 44 ○○○○ Hungry between meals | 51 ○○○○ Overeating sweets upsets | 55 ○○○○ Abnormal craving for sweets or snacks |
| 45 ○○○○ Irritable before meals | 52 ○○○○ Awaken after few hours sleep - hard to get back to sleep | |
| 46 ○○○○ Get "shaky" if hungry | | |
| 47 ○○○○ Fatigue, eating relieves | | |
| 48 ○○○○ "Lightheaded" if meals delayed | | |

GROUP 4

- | | | |
|---|--|--|
| 56 ○○○○ Hands and feet go to sleep easily, numbness | 63 ○○○○ Get "drowsy" often | 68 ○○○○ Bruise easily, "black and blue" spots |
| 57 ○○○○ Sigh frequently, "air hunger" | 64 ○○○○ Swollen ankles, worse at night | 69 ○○○○ Tendency to anemia |
| 58 ○○○○ Aware of "breathing heavily" | 65 ○○○○ Muscle cramps, worse during exercise; get "charley horses" | 70 ○○○○ "Nose bleeds" frequent |
| 59 ○○○○ High altitude discomfort | 66 ○○○○ Shortness of breath on exertion | 71 ○○○○ Noises in head, or "ringing in ears" |
| 60 ○○○○ Opens windows in closed rooms | 67 ○○○○ Dull pain in chest or radiating into left arm, worse on exertion | 72 ○○○○ Tension under the breastbone, or feeling of "tightness", worse on exertion |
| 61 ○○○○ Susceptible to colds and fevers | | |
| 62 ○○○○ Afternoon "yawner" | | |

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

- | | | |
|---|--|--|
| <p>1 2 3
73 ○○○ Dizziness</p> <p>74 ○○○ Dry skin</p> <p>75 ○○○ Burning feet</p> <p>76 ○○○ Blurred vision</p> <p>77 ○○○ Itching skin and feet</p> <p>78 ○○○ Excessive falling hair</p> <p>79 ○○○ Frequent skin rashes</p> <p>80 ○○○ Bitter, metallic taste in mouth in mornings</p> <p>81 ○○○ Bowel movements painful or difficult</p> <p>82 ○○○ Worrier, feels insecure</p> | <p>1 2 3
83 ○○○ Feeling queasy; headache over eyes</p> <p>84 ○○○ Greasy foods upset</p> <p>85 ○○○ Stools light colored</p> <p>86 ○○○ Skin peels on foot soles</p> <p>87 ○○○ Pain between shoulder blades</p> <p>88 ○○○ Use laxatives</p> <p>89 ○○○ Stools alternate from soft to watery</p> <p>90 ○○○ History of gallbladder attacks or gallstones</p> | <p>1 2 3
91 ○○○ Sneezing attacks</p> <p>92 ○○○ Dreaming, nightmare type bad dreams</p> <p>93 ○○○ Bad breath (halitosis)</p> <p>94 ○○○ Milk products cause distress</p> <p>95 ○○○ Sensitive to hot weather</p> <p>96 ○○○ Burning or itching anus</p> <p>97 ○○○ Crave sweets</p> |
|---|--|--|

GROUP 6

- | | | |
|--|---|--|
| <p>1 2 3
98 ○○○ Loss of taste for meat</p> <p>99 ○○○ Lower bowel gas several hours after eating</p> <p>100 ○○○ Burning stomach sensations, eating relieves</p> | <p>1 2 3
101 ○○○ Coated tongue</p> <p>102 ○○○ Pass large amounts of foul-smelling gas</p> <p>103 ○○○ Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.</p> | <p>1 2 3
104 ○○○ Mucous colitis or "irritable bowel"</p> <p>105 ○○○ Gas shortly after eating</p> <p>106 ○○○ Stomach "bloating" after</p> |
|--|---|--|

GROUP 7

- | | | |
|---|--|--|
| <p>(A)</p> <p>1 2 3
107 ○○○ Insomnia</p> <p>108 ○○○ Nervousness</p> <p>109 ○○○ Can't gain weight</p> <p>110 ○○○ Intolerance to heat</p> <p>111 ○○○ Highly emotional</p> <p>112 ○○○ Flush easily</p> <p>113 ○○○ Night sweats</p> <p>114 ○○○ Thin, moist skin</p> <p>115 ○○○ Inward trembling</p> <p>116 ○○○ Heart palpitates</p> <p>117 ○○○ Increased appetite without weight gain</p> <p>118 ○○○ Pulse fast at rest</p> <p>119 ○○○ Eyelids and face twitch</p> <p>120 ○○○ Irritable and restless</p> <p>121 ○○○ Can't work under pressure</p> | <p>(C)</p> <p>1 2 3
137 ○○○ Failing memory</p> <p>138 ○○○ Low blood pressure</p> <p>139 ○○○ Increased sex drive</p> <p>140 ○○○ Headaches, "splitting or rending" type</p> <p>141 ○○○ Decreased sugar tolerance</p> | <p>(E)</p> <p>1 2 3
150 ○○○ Dizziness</p> <p>151 ○○○ Headaches</p> <p>152 ○○○ Hot flashes</p> <p>153 ○○○ Increased blood pressure</p> <p>154 ○○○ Hair growth on face or body (female)</p> <p>155 ○○○ Sugar in urine (not diabetes)</p> <p>156 ○○○ Masculine tendencies (female)</p> |
| <p>(B)</p> <p>1 2 3
122 ○○○ Increase in weight</p> <p>123 ○○○ Decrease in appetite</p> <p>124 ○○○ Fatigue easily</p> <p>125 ○○○ Ringing in ears</p> <p>126 ○○○ Sleepy during day</p> <p>127 ○○○ Sensitive to cold</p> <p>128 ○○○ Dry or scaly skin</p> <p>129 ○○○ Constipation</p> <p>130 ○○○ Mental sluggishness</p> <p>131 ○○○ Hair coarse, falls out</p> <p>132 ○○○ Headaches upon arising, wear off during day</p> <p>133 ○○○ Slow pulse, below 65</p> <p>134 ○○○ Frequency of urination</p> <p>135 ○○○ Impaired hearing</p> <p>136 ○○○ Reduced initiative</p> | <p>(D)</p> <p>1 2 3
142 ○○○ Abnormal thirst</p> <p>143 ○○○ Bloating of abdomen</p> <p>144 ○○○ Weight gain around hips or waist</p> <p>145 ○○○ Sex drive reduced or lacking</p> <p>146 ○○○ Tendency to ulcers, colitis</p> <p>147 ○○○ Increased sugar tolerance</p> <p>148 ○○○ Women: menstrual disorders</p> <p>149 ○○○ Young girls: lack of menstrual function</p> | <p>(F)</p> <p>1 2 3
157 ○○○ Weakness, dizziness</p> <p>158 ○○○ Chronic fatigue</p> <p>159 ○○○ Low blood pressure</p> <p>160 ○○○ Nails weak, ridged</p> <p>161 ○○○ Tendency to hives</p> <p>162 ○○○ Arthritic tendencies</p> <p>163 ○○○ Perspiration increase</p> <p>164 ○○○ Bowel disorders</p> <p>165 ○○○ Poor circulation</p> <p>166 ○○○ Swollen ankles</p> <p>167 ○○○ Crave salt</p> <p>168 ○○○ Brown spots or bronzing of skin</p> <p>169 ○○○ Allergies - tendency to asthma</p> <p>170 ○○○ Weakness after colds, influenza</p> <p>171 ○○○ Exhaustion - muscular and nervous</p> <p>172 ○○○ Respiratory disorders</p> |

SYSTEMS SURVEY FORM - PAGE 4

Please list any medications you are taking:

No Medications

Please list any vitamins, herbs, or supplements you are taking:

No Vitamins

Please list any allergies you have:

No Allergies

Please list any surgeries you have had in the past 12 months:

No Recent Surgeries

Please list any other surgeries or medical procedures you have had:

No Other Surgeries

TO BE COMPLETED BY DOCTOR

Blood Pressure: Recumbent _____ Standing _____

Pulse: Recumbent _____ Standing _____

Hema-Combistix Urine Readings: pH _____ Albumin % _____ Glucose % _____

Occult Blood _____ pH of Saliva _____ pH of Stool Specimen _____

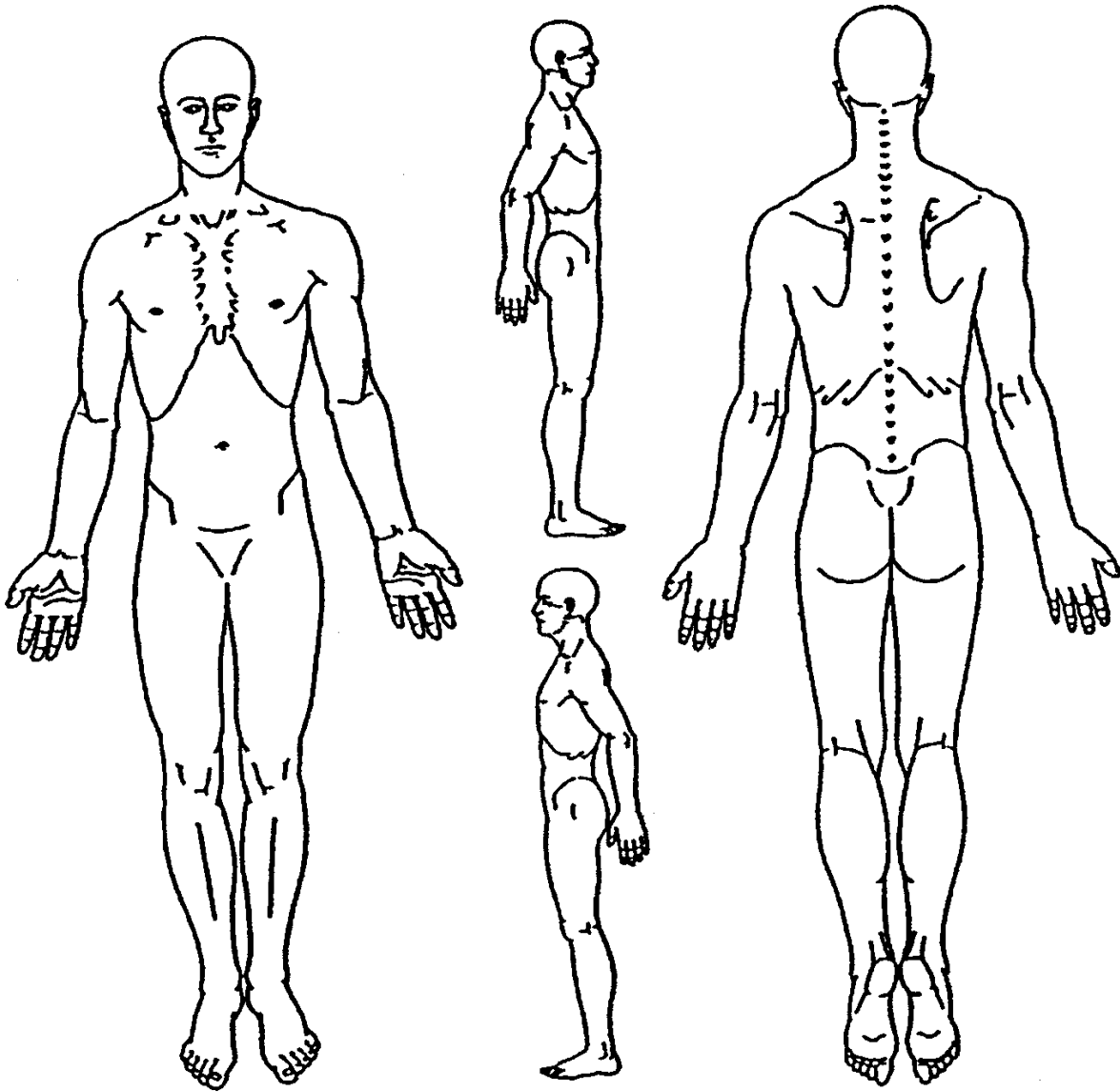
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

SYSTEMS SURVEY FORM - PAGE 5

Use the letters listed below to indicate the type and location of your pain and sensations:

KEY

- A = ACHE
- B = BURNING
- S = STABBING
- N = NUMBNESS
- P = PINS & NEEDLES
- O = OTHER



PLEASE INDICATE THE LEVEL OF PAIN YOU ARE EXPERIENCING

NO PAIN

SEVERE PAIN

0 1 2 3 4 5 6 7 8 9 10

Patient Signature _____ Date _____

Chiropractic First

NOTICE OF PRIVACY FOR: PATIENT'S PROTECTED HEALTH INFORMATION

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Worker's Compensation Claim to verify that treatment has been rendered.
- To determine patient's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained.
- Emergency situations.
- Abuse, neglect, or domestic violence.
- Appointment reminders to household members or answering machines.
- Mailings for appointment reminders, birthday cards, bills and other correspondence.
- Sign-In logs may be disclosed to verify office visits.

Any other uses or disclosures will only be made with your specific written prior authorization.

Please note the Doctors of Chiropractic First utilize an open area for the delivery of care and it is understood that if a patient/client needs to speak on a matter of personal privacy it is solely the responsibility of the patient to request a private area for the discussion to take place.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Dr. Andrew Williamson
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected by health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

Name of Patient (print)

Signature of Patient/Legal Representative

Date