Chiropractic First, Family Wellness Center

Confidential Nutrition Member Information

Date: _____

Name: _____Best contact number: _____ Other number: _____

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

GROUP 2

	1	2	3	
21	○	○	○	Joint stiffness on arising
22	○	○	○	Muscle-leg-toe cramps at night
23	○	○	○	"Butterfly" stomach, cramps
24	○	○	○	Eyes or nose watery
25	○	○	○	Eyes blink often
26	○	○	○	Eyelids swollen, puffy
27	○	○	○	Indigestion soon after meals
28	○	○	○	Always seems hungry; feels "lightheaded" often
29	○	○	○	Digestion rapid
30	○	○	○	Vomiting frequent
31	○	○	○	Hoarseness frequent
32	○	○	○	Breathing irregular
33	○	○	○	Pulse slow; feels "irregular"
34	○	○	○	Gagging reflex slow
35	○	○	○	Difficulty swallowing
36	○	○	○	Constipation, diarrhea alternating
37	○	○	○	"Slow starter"
38	○	○	○	Get "chilled" infrequently
39	○	○	○	Perspire easily
40	○	○	○	Circulation poor, sensitive to cold
41	○	○	○	Subject to colds, asthma, bronchitis

GROUP 3

	1	2	3	
42	○	○	○	Eat when nervous
43	○	○	○	Excessive appetite
44	○	○	○	Hungry between meals
45	○	○	○	Irritable before meals
46	○	○	○	Get "shaky" if hungry
47	○	○	○	Fatigue, eating relieves
48	○	○	○	"Lightheaded" if meals delayed
49	○	○	○	Heart palpitates if meals missed or delayed
50	○	○	○	Afternoon headaches
51	○	○	○	Overeating sweets upsets
52	○	○	○	Awaken after few hours sleep - hard to get back to sleep
53	○	○	○	Crave candy or coffee in afternoons
54	○	○	○	Moods of depression - "blues" or melancholy
55	○	○	○	Abnormal craving for sweets or snacks

GROUP 4

	1	2	3	
56	○	○	○	Hands and feet go to sleep easily, numbness
57	○	○	○	Sigh frequently, "air hunger"
58	○	○	○	Aware of "breathing heavily"
59	○	○	○	High altitude discomfort
60	○	○	○	Opens windows in closed rooms
61	○	○	○	Susceptible to colds and fevers
62	○	○	○	Afternoon "yawner"
63	○	○	○	Get "drowsy" often
64	○	○	○	Swollen ankles, worse at night
65	○	○	○	Muscle cramps, worse during exercise; get "charley horses"
66	○	○	○	Shortness of breath on exertion
67	○	○	○	Dull pain in chest or radiating into left arm, worse on exertion
68	○	○	○	Bruise easily, "black and blue" spots
69	○	○	○	Tendency to anemia
70	○	○	○	"Nose bleeds" frequent
71	○	○	○	Noises in head, or "ringing in ears"
72	○	○	○	Tension under the breastbone, or feeling of "tightness", worse on exertion

SYSTEMS SURVEY FORM - PAGE 2

GROUP 5

1 2 3

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

GROUP 6

1 2 3

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

GROUP 7

(A)

1 2 3

107 ○○○ Insomnia
108 ○○○ Nervousness
109 ○○○ Can't gain weight
110 ○○○ Intolerance to heat
111 ○○○ Highly emotional
112 ○○○ Flush easily
113 ○○○ Night sweats
114 ○○○ Thin, moist skin
115 ○○○ Inward trembling
116 ○○○ Heart palpitates
117 ○○○ Increased appetite without weight gain
118 ○○○ Pulse fast at rest
119 ○○○ Eyelids and face twitch
120 ○○○ Irritable and restless
121 ○○○ Can't work under pressure

(B)

1 2 3

122 ○○○ Increase in weight
123 ○○○ Decrease in appetite
124 ○○○ Fatigue easily
125 ○○○ Ringing in ears
126 ○○○ Sleepy during day
127 ○○○ Sensitive to cold
128 ○○○ Dry or scaly skin
129 ○○○ Constipation
130 ○○○ Mental sluggishness
131 ○○○ Hair coarse, falls out
132 ○○○ Headaches upon arising, wear off during day
133 ○○○ Slow pulse, below 65
134 ○○○ Frequency of urination
135 ○○○ Impaired hearing
136 ○○○ Reduced initiative

(C)

1 2 3

137 ○○○ Failing memory
138 ○○○ Low blood pressure
139 ○○○ Increased sex drive
140 ○○○ Headaches, "splitting or rending" type
141 ○○○ Decreased sugar tolerance

(D)

1 2 3

142 ○○○ Abnormal thirst
143 ○○○ Bloating of abdomen
144 ○○○ Weight gain around hips or waist
145 ○○○ Sex drive reduced or lacking
146 ○○○ Tendency to ulcers, colitis
147 ○○○ Increased sugar tolerance
148 ○○○ Women: menstrual disorders
149 ○○○ Young girls: lack of menstrual function

(E)

1 2 3

150 ○○○ Dizziness
151 ○○○ Headaches
152 ○○○ Hot flashes
153 ○○○ Increased blood pressure
154 ○○○ Hair growth on face or body (female)
155 ○○○ Sugar in urine (not diabetes)
156 ○○○ Masculine tendencies (female)

(F)

1 2 3

157 ○○○ Weakness, dizziness
158 ○○○ Chronic fatigue
159 ○○○ Low blood pressure
160 ○○○ Nails weak, ridged
161 ○○○ Tendency to hives
162 ○○○ Arthritic tendencies
163 ○○○ Perspiration increase
164 ○○○ Bowel disorders
165 ○○○ Poor circulation
166 ○○○ Swollen ankles
167 ○○○ Crave salt
168 ○○○ Brown spots or bronzing of skin
169 ○○○ Allergies - tendency to asthma
170 ○○○ Weakness after colds, influenza
171 ○○○ Exhaustion - muscular and nervous
172 ○○○ Respiratory disorders

SYSTEMS SURVEY FORM - PAGE 3

GROUP 8

	1	2	3			1	2	3			1	2	3	
173	○	○	○	Apprehension	183	○	○	○	Noise sensitivity	193	○	○	○	Insomnia
174	○	○	○	Irritability	184	○	○	○	Acoustic hallucinations	194	○	○	○	Anxiety
175	○	○	○	Morbid fears	185	○	○	○	Tendency to cry without reason	195	○	○	○	Anorexia
176	○	○	○	Never seems to get well	186	○	○	○	Hair is coarse and/or thinning	196	○	○	○	Inability to concentrate; confusion
177	○	○	○	Forgetfulness	187	○	○	○	Weakness					
178	○	○	○	Indigestion	188	○	○	○	Fatigue	197	○	○	○	Frequent stuffy nose; sinus infections
179	○	○	○	Poor appetite	189	○	○	○	Skin sensitive to touch					
180	○	○	○	Craving for sweets	190	○	○	○	Tendency toward hives	198	○	○	○	Allergy to some foods
181	○	○	○	Muscular soreness	191	○	○	○	Nervousness	199	○	○	○	Loose joints
182	○	○	○	Depression; feelings of dread	192	○	○	○	Headache					

FEMALE ONLY

	1	2	3			1	2	3	
200	○	○	○	Very easily fatigued	206	○	○	○	Menstruate too frequently
201	○	○	○	Premenstrual tension	207	○	○	○	Vaginal discharge
202	○	○	○	Painful menses	208			○	Hysterectomy / ovaries removed
203	○	○	○	Depressed feelings before menstruation	209	○	○	○	Menopausal hot flashes
204	○	○	○	Menstruation excessive and prolonged	210	○	○	○	Menses scanty or missed
					211	○	○	○	Acne, worse at menses
205	○	○	○	Painful breasts	212	○	○	○	Depression of long standing

MALE ONLY

	1	2	3	
213	○	○	○	Prostate trouble
214	○	○	○	Urination difficult or dribbling
215	○	○	○	Night urination frequent
216	○	○	○	Depression
217	○	○	○	Pain on inside of legs or heels
218	○	○	○	Feeling of incomplete bowel evacuation
219	○	○	○	Lack of energy
220	○	○	○	Migrating aches and pains
221	○	○	○	Tire too easily
222	○	○	○	Avoids activity
223	○	○	○	Leg nervousness at night
224	○	○	○	Diminished sex drive

IMPORTANT

Please list the five main complaints you have in the order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES

Any two days during the month

FEMALES HAVING MENSTRUAL CYCLES

The 2nd and 3rd day of flow OR any 5 days in a row

MALES

Any 2 days during the month

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____
Date	_____	Temperature	_____

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 _____

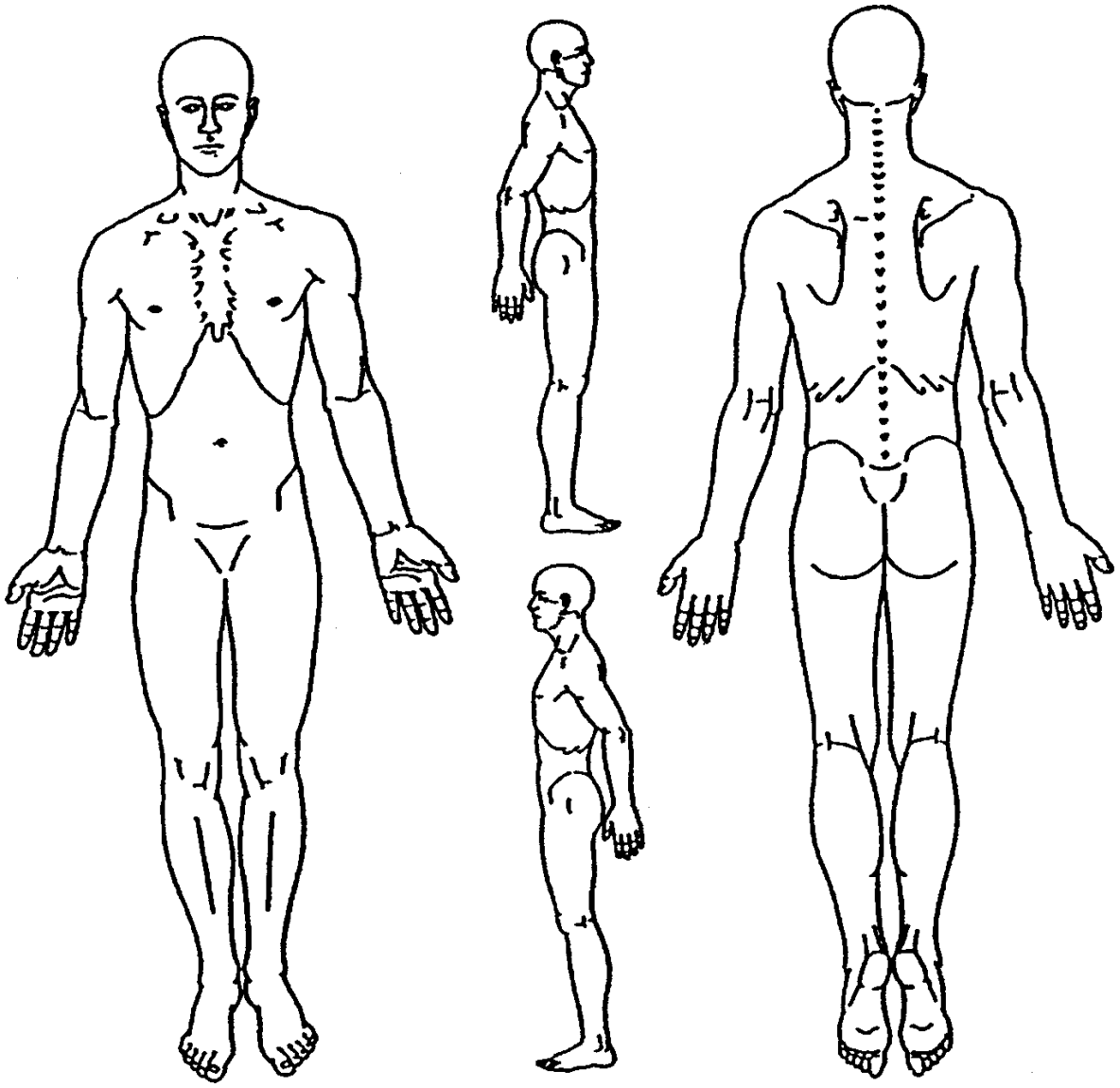
Blood Clotting Time _____ Hemoglobin _____ Blood Type _____ Weight _____

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