Dr. Kenneth N. Haas, DC
Haas Wellness Centers
3315 Springbank Lane, Suite 102
Charlotte, North Carolina 28226
704-837-2420

PERSONAL DATA & ADMISSION (PLEASE PRINT LEGIBLY)

Patient Information

First Name: _____ M.I.: ___ Last Name: _____
Address: _____ City: _____ St.: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Birth date: _____ Age: _____ Sex: Male Female Marital Status: S M D W
Social Security #: _____ Number of Children: _____
Email: _____
Occupation: _____ Employer: _____
Work Address: _____ City: _____ St.: ___ Zip: ____
Referral Source: _____

Spouse Information

First Name: _____ M.I.: ____ Last Name: _____
Occupation: _____ Employer: _____
Work Address: _____ City: _____ St.: ____ Zip: ____
Social Security #: _____ Birthdate: _____ Work Phone: _____

Payment is expected at time of service. We accept cash, check, Mastercard, Visa, American Express and Discover. If you would like us to file with your insurance, please provide a copy of your current insurance card(s).
Haas Wellness Center will contact you via email with exclusive offers from Haas Wellness Center, in addition to information regarding your care. If you do not wish to receive promotional offers please initial here to opt out_____. We do not spam or sell your email information to a third party.

Statement of Account

I, _____ , clearly understand and agree that all services rendered on my behalf are charged directly to myself and that I am personally responsible for payment, when said charges are incurred.

I further understand and agree that health and/or accident insurance policies are an arrangement between the insurance companies and myself (and/or my dependents). This office will prepare the necessary reports and forms (which may at any point in the future become subject to a nominal fee) to assist myself in seeking collection or reimbursement from the insurance companies for services rendered. Any amount authorized to be paid directly to this office will be credited to my account (and/or my dependents should a balance be due) upon receipt.
If I should suspend or terminate my care and treatment in this office, any fee(s) for professional services rendered will become due and payable immediately. Any unpaid balance due this office may at any point, become subject to a finance charge of 1.5% interest per month (18% annually). Should it become necessary to initiate any collection proceedings, I will then become responsible for any legal and/or other fees involved in said collection of fees due (current and/or past due).
Patient Signature: _____ Dated: _____

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

I authorize Whole Person Health dba Haas Wellness Centers to release the following health information to:

_____
Specify name and title of person to receive health information

_____
Address, City, State, Zip Code

Information to be disclosed (mark all that apply):

_ Medical Records
_ Diagnostic Records
_ Treatment Records
_ Other: _____

The purpose of this release is for (check one or more):

_Continuity of care
_At the request of the patient/patient representative
_Billing and payment of bill
_Other (state reason)_____

YOUR RIGHTS

This authorization to release health information is voluntary. Your refusal to sign will not affect your ability to obtain treatment or payment or your eligibility for benefits.

This authorization may be revoked at any time. The revocation must be in writing, signed by you or your patient representative, and delivered to: Haas Wellness Center, 3315 Springbank Lane, Suite 102, Charlotte, NC 28226. The revocation will take effect when Haas Wellness Center receives it. Your notice will not apply to actions taken by the requesting person/entity prior to the date they receive your written request to revoke authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this Authorization expires_____**(**insert applicable date or event). If no date is indicated, the Authorization will expire 12 months after the date of signing this form.

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

_____
Print Name

_____
Signature (Patient, Parent, Guardian)

_____
Date Time

_____
Relationship to Patient (Parent, Guardian, Patient Representative)

_____
Witness (only if patient unable to sign)or Interpreter

Dr. Kenneth N. Haas, DC
Haas Wellness Centers
3315 Springbank Lane, Suite 102
Charlotte, North Carolina 28226
704-837-2420

OFFICE POLICY STATEMENT & INSURANCE COVERAGE

Our office will be happy to work with you and/or your dependents in processing and filing insurance claims, as they relate to the services, products, treatment and care rendered in our office only. This service is offered only after your eligibility (and/or your dependent's eligibility) has been verified with either the insurance company or another reliable source (employee benefits office, personnel director, etc.). The presentation of an insurance card is not a verification that coverage is in effect, nor does it guarantee coverage for all aspects of chiropractic care & treatment in this office.

However, it must be understood that the contract for insurance coverage exists ONLY between the insurance company and the insured (and/or their dependents). At no point does our office make any representation regarding any affiliation with your insurance company or any guarantees in regards to the exact amount of coverage offered. Therefore, it is important to understand that ALL services rendered to you (and/or your dependents) are charged directly to your (and/or your dependent's) account(s) AND that you are personally liable and ultimately responsible for payment of the entire bill(s).

Our office will perform the necessary requirements in order to process all insurance claims in a timely and efficient manner. Please understand that our office makes NO guarantee (implied, written, verbal or otherwise) that your insurance company will honor or pay any of the claims submitted on your (and/or your dependent's) behalf. We will make every reasonable effort, at the onset of treatment, to receive some form of verification of your (and/or your dependent's) eligibility, the services covered and the approximate percentage or dollar amount of benefits allowed. Presently, this service and courtesy is currently performed without any additional costs to you and/or your insurance carrier.

If you (and/or your dependents) should discontinue care without the authorization of the doctor, any balance due on your (and/or your dependents) account(s) will become due and payable immediately. Should any insurance checks be received in our office after the discontinuation of care, they will be forwarded to you, IF AND ONLY IF, the balance of your (and/or your dependent's) account(s) is zero. Otherwise, the proceeds of any insurance check received in this office will be applied to your (and/or your dependent's) account(s) to reduce your (and/or your dependent's) indebtedness.

Any unpaid balance due this office may at any point, becomes subject to a finance charge of 1.5% interest per month (18% annually). Should it become necessary to initiate any collection proceedings, you will then become responsible for any legal and/or other fees involved in said collection of fees due (current and/or past due).

Should your insurance company require any documentation in regards to the determination and payment of any possible benefits due for services provided in this office, you hereby authorize the release of such medical and/or other pertinent information (obtained and kept on file in this office only) which is deemed necessary to process said claim(s).

Patient Signature: _____ Dated: _____

HAAS
WELLNESS CENTER
Dr Kenneth N. Haas
Chiropractic Physician
3315 Spring Bank Lane Suite 102
Charlotte, North Carolina 28226
704-837-2420 888-602-5883
Fax 704-246-5193
www.HaasWellnesscenters.com

NOTICE for Medicare & Insurance

MEDICARE NECESSITY FOR TREATMENT

Medicare does not cover Maintenance Therapy for your spinal joint problems.
The official Medicare guidelines that define your benefits are reprinted below. Your help is needed to bill Medicare properly.

Medicare Carriers Manuel, Part 3, Chapter 2 - Section 2251.3 - Necessity for Treatment

The patient must have a significant health problem in the form of a neuromusculosketal condition necessitating treatment, and the manipulative services rendered must have a direct therapeutic relationship to the patient's condition and provide reasonable expectation of recovery or improvement or function. The patient must have a subluxation of the spine as demonstrated by x-ray or physical exam.

Most spinal joint problems fall into the following categories:

- Acute subluxation - A patient's condition is considered acute when the patient is being treated for a new injury, identified by x-ray or physical exam as specified above. The result of Chiropractic manipulation is expected to be an improvement in, or arrest of progression of the patient's condition.
- Chronic subluxation - A patient's condition is considered chronic when it is not expected to significantly improve or be resolved with further treatment (as is the case with an acute condition), but where the continued therapy can be expected to result in some functional improvement. Once the clinical status has remained stable for a given condition, **without expectation of additional** objective clinical improvements, further manipulative treatment is considered maintenance therapy and is not covered.
- Maintenance Therapy - Maintenance therapy includes services that seek to prevent disease, promote health and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition. When further clinical improvement cannot reasonably be expected from continuous ongoing care, and the chiropractic treatment becomes supportive rather than corrective in nature, the treatment is then considered maintenance therapy,

In summary, when you have an **Acute** condition (e.g. injury or re-injury), or a **Chronic** condition that needs rehabilitation, it is covered by Medicare. However, Medicare does not cover **Maintenance Therapy and Spinal Decompression** for
keeping you well after you are stabilized. The decision making process in our office for placing you in one of these three categories above is based on:

1) Outcomes assessment scores,

2)Patient history and physical examination, and

3) "Global Impression of Change" by the patient.

If you have questions or disagree with your clinical category, please discuss it with us.

Thank you.

Patient Name:_____ Identification Number:_____

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for the items and services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the items and services below.

Items and Services	Reason Medicare May Not Pay	Estimated Cost
□ Manual Manipulation of the Spine Spinal Decompression	Medicare NEVER pays for maintenance care	$30.67
□ Examination (EIM) □ Re-exam □ Laser, Percussion , MFR □ Footbath □ Durable Medical Equipment □ Vitamins and Analgesic Creams	These are NON-COVERED items and services under Medicare when ordered and or delivered by a chiropractic physician.	$150 - $250 $80 - $120 $20 - $35 $50 - $60 $ varies $5 - $120

WHAT YOU NEED TO DO NOW:

- **Read this notice, so you can make an informed decision about your care.**
- **Ask us any questions that you may have after you finish reading.**
- **Choose an option below about whether to receive the items and services listed above.**

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

OPTIONS: **Check only one box. We cannot choose a box for you.**

□ **OPTION 1. I** want the **items and services listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.**

□ **OPTION 2. I want the items and services listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for/payment. I cannot appeal if Medicare is not billed.**

□ **OPTION 3. I don't want the items and services listed above. I understand with this choice I am not responsible for payment and I cannot appeal to see if Medicare would pay.**

Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing **call 1-800-MEDICARE** (1-800-633-4227 TIY: 1-877-486-2048).

Sign below means that you have received and understand this notice. You also receive a copy.

Signature:	**Date:**

FonnCMS-R-131 *(03/08)* Form Approved OMB No. 0938-0566

Informed Consent

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, nutrition, including various modes of physical therapy, CranioSacral therapy, massage therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment. All documents are signed via an Electronic Signature and I agree.

Patient Signature_____ Date_____

Witness Signature_____ Date_____

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704-837-2420

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I understand and have been provided with a Notice of Privacy Practices for Protected Health Information Practices that provides a more complete description of information uses and discloses. I understand that I have the following rights and privileges:

The right to review the notice prior to signing this consent.
The right to object to the use of my health information for directory purposes, and
The right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment, or health care operations

_____ _____
Patient Signature Date

_____ _____
Witness Date

Dr. Kenneth N. Haas, DC
Haas Wellness Centers
3315 Springbank Lane, Suite 102
Charlotte, North Carolina 28226
704-837-2420

HIPAA Notice of Privacy Practices

Effective Date: _*9/23/13*__

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact _Dr. Kenneth N. Haas, DC.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding health information about you
- Follow the terms of our notice that is currently in effect

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION:

The following describes the ways we may use and disclose health information that identifies you ("Health Information"). Except for the purposes described below, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

For Treatment. We may use and disclose Health Information for your treatment and to provide you with treatment-related health care services. For example, we may disclose Health Information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

For Payment. We may use and disclose Health Information so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may give your health plan information about you so that they will pay for your treatment.

For Health Care Operations. We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may use and disclose information to make sure the obstetrical or gynecological care you receive is of the highest quality. We also may share information with other entities that have a relationship with you (for example, your health plan) for their health care operation activities.

Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services. We may use and disclose Health Information to contact you to remind you that you have an appointment with us. We also may use and disclose Health Information to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share Health Information with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research. Under certain circumstances, we may use and disclose Health Information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. Before we use or disclose Health Information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any Health Information.

SPECIAL SITUATIONS:

As Required by Law. We will disclose Health Information when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Disclosures, however, will be made only to someone who may be able to help prevent the threat.

Business Associates. We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation. If you are an organ donor, we may use or release Health Information to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose Health Information for public health activities. These activities generally include disclosures to prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Data Breach Notification Purposes. We may use or disclose your Protected Health Information to provide legally required notices of unauthorized access to or disclosure of your health information.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release Health Information if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release Health Information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release Health Information to funeral directors as necessary for their duties.

National Security and Intelligence Activities. We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose Health Information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND OPT

Individuals Involved in Your Care or Payment for Your Care. Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care., If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

Disaster Relief. We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your Protected Health Information will be made only with your written authorization:

1. Uses and disclosures of Protected Health Information for marketing purposes; and

2. Disclosures that constitute a sale of your Protected Health Information

Other uses and disclosures of Protected Health Information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may

revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose Protected Health Information under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

YOUR RIGHTS:

You have the following rights regarding Health Information we have about you:

Right to Inspect and Copy. You have a right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy this Health Information, you must make your request, in writing, to Dr. Kenneth N. Haas, DC. We have up to 30 days to make your Protected Health Information available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state of federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your Protected Health Information is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your Protected Health Information in the form or format you request, if it is readily producible in such form or format. If the Protected Health Information is not readily producible in the form or format you request your record will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic medical record.

Right to Get Notice of a Breach. You have the right to be notified upon a breach of any of your unsecured Protected Health Information.

Right to Amend. If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our office. To request an amendment, you must make your request, in writing, to Dr. Kenneth N. Haas, DC.

Right to an Accounting of Disclosures. You have the right to request a list of certain disclosures we made of Health Information for purposes other than treatment, payment and health care operations or for which you provided written authorization. To request an accounting of disclosures, you must make your request, in writing, to Dr. Kenneth N. Haas, DC.

Right to Request Restrictions. You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to Dr. Kenneth N. Haas, DC. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your Protected Health Information to a health plan for payment or health care operation purposes and such information you wish to restrict pertains solely to a health care item or service for which you have paid us “out-of-pocket” in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.

Out-of-Pocket-Payments. If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your Protected Health

Information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to Dr. Kenneth N. Haas, DC. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Dr. Kenneth N. Haas, DC

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CHANGES TO THIS NOTICE:

We reserve the right to change this notice and make the new notice apply to Health Information we already have as well as any information we receive in the future. We will post a copy of our current notice at our office. The notice will contain the effective date on the first page, in the top right-hand corner.

COMPLAINTS:

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact Dr. Kenneth N. Haas, DC. All complaints must be made in writing. **You will not be penalized for filing a complaint**.

Please complete all forms in as much detail as possible. **(BLACK INK ONLY) We do not charge for an initial 15 minute consultation. Any services performed after the consultation will be charged at the regular fee schedule.**

Please arrive 20 minutes before scheduled appointment. Bring all medications and supplements you are currently taking.

Manipulation is the only service covered by Medicare. Although we are a Medicare provider we do not accept assignment for Medicare patients.

We require 24 hour notice for missed appointments. If you miss an appointment without notice we reserve the right to charge for the complete visit.

I am requesting: (Please check one)

- ❑ The most minimal amount of care to "patch up the symptoms" of my problem.
- ❑ I am looking to resolve my symptoms and then go on to "fix the cause" of my problems.
- ❑ I want to take care of my problem and then go on to "achieve optimal health and wellness."

Please list the goals you would like to achieve in working with our office, and reason for this goal.

1. _____ Reason: _____
2. _____ Reason: _____
3. _____ Reason: _____
4. _____ Reason: _____
5. _____ Reason: _____
6. _____ Reason: _____
7. _____ Reason: _____
8. _____ Reason: _____
9. _____ Reason: _____
10. _____ Reason: _____

Name (Printed) _____ Signature _____ Date_____

Dr. Kenneth N. Haas, DC
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COMPREHENSIVE CASE HISTORY

Patient Name: _____ **Date:**_____

_____

Are you pregnant? _____Yes _____No

This form is a comprehensive case history which can help us to better understand your chief complaint for which you are consulting our office. The more detailed your answers and descriptions, the better we can evaluate your case and determine the appropriate course of treatment. This information, when combined with the other forms we have requested you complete, gives our office a better understanding of your entire health picture. All information our office collects regarding your medical history is held in the strictest confidence and will only be used in this office. Thank you for your cooperation. **Please answer all questions. If the question does not apply to you, put NA.**

GENERAL PAIN DISABILITY INDEX

How Long Have You Had This Pain? _____ Years _____ Months _____ Weeks _____ Days

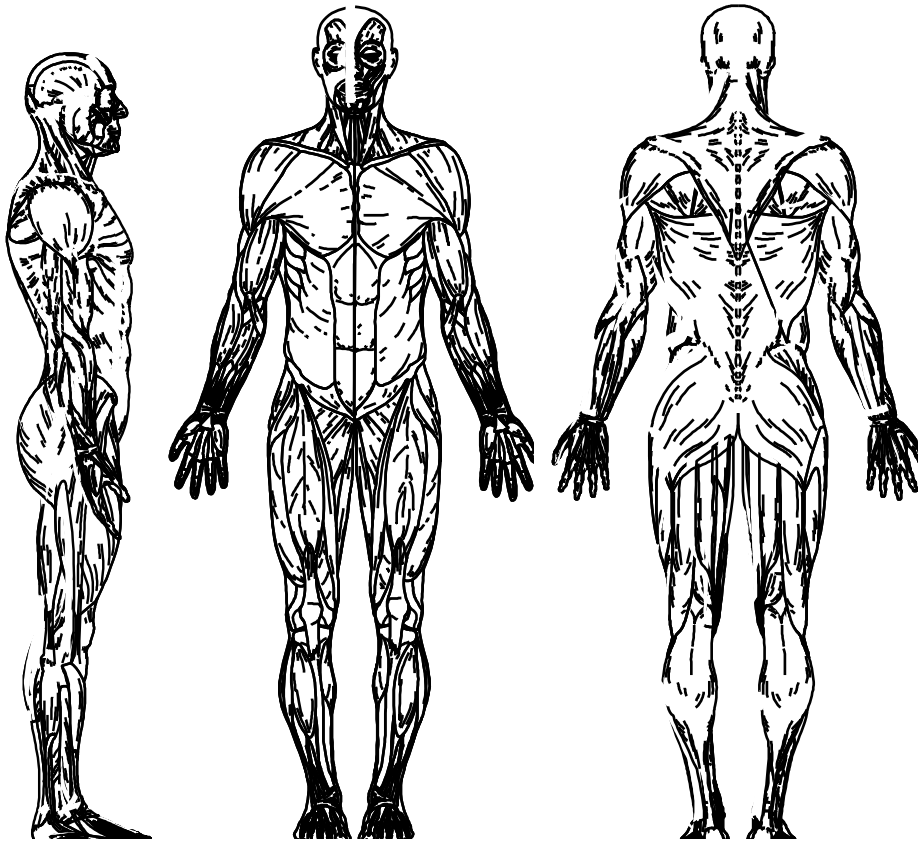
Is This Your First Episode of This Pain? _____ Yes _____ No

Please use the indicated key (letters listed below) to note the type and location of your pain sensations that you are presently experiencing on the illustrations shown below. If not listed, please draw any other symptom that you have.

A (Aches) B (Burning) C (Cold) G (Grabbing) H (Hot) I (Itching)

N (Numb) P (Pounding) PR (Pressure) SH (Shooting) SQ (Squeezing) St (Stinging)

Right Left



Condition/Complaint History

1. □ Acute condition □ Chronic condition
2. When did your symptoms and/or condition begin or were first noticeable? (Please list an exact date if possible) _____
3. □ Symptom onset was immediate □ Symptom onset was gradual
4. Do you recall any specific precipitating/contributing factors which might have preceded the onset of your present symptoms and/or condition (automobile accident, slip & fall, emotional trauma, chemical exposure, food poisoning, insect bite, etc.)? _____
5. Have you at any time in the past experienced any of the same and/or similar symptoms as you are presenting with today? □ No □ Yes If yes, please indicate when and how long your previous symptoms lasted? _____
6. Have you previously consulted with other physicians or other health professionals regarding this problem?
   □ Medical Doctor □ Chiropractic Physician □ Dentist □ Acupuncturist
   □ Massage Therapist □ Nutritionist □ Osteopath □ Psychologist
   □ Other (please list) _____
7. If you answered yes to #6, please list the provider seen, his/her suggested diagnosis/condition given, the treatment recommendations (prescription drugs, exercise, nutrition, adjustments, physical therapy, etc.), whether or not you followed the recommendations and your overall response to the care (for each health practitioner). _____
8. Please describe (in detail) the exact location or region of your body where your symptoms are most prevalent. _____
9. Please describe (in detail) any radiating, referred or other associated symptoms (location & region) you are experiencing along with your chief complaint. _____
10. □ Symptoms are constant □ Symptoms are intermittent (list frequency & duration)

11. □ Symptoms are severe □ Symptoms are moderate □ Symptoms are mild □ Symptoms have varying intensity

12. Please describe your symptom sensations in detail (hot, cold, numb, burning, fatigued, aching, gnawing, throbbing, etc.) _____

_____

_____

13. □ Condition improving □ Conditions getting worse □ Condition staying the same

14. Please list those items (posture, physical activity, nutrition, drugs, rest, foods, etc.) that seem to improve your symptomatic picture. _____

_____

15. Please list those items (posture, physical activity, nutrition, drugs, rest, foods, etc.) that seem to make your symptomatic picture worse. _____

_____

16. Since the onset of your symptoms, have you noticed any change in ANY body functions (diarrhea, constipation, increased heart rate, vision, sexual, respiration, mental clarity, energy levels, etc.). _____

_____

_____

17. Please list any other symptoms, problems or conditions that you are currently experiencing.

_____

_____

Medical History

1. Have you ever been involved in an automobile accident? □ Yes □ No If yes, please describe the accident and when it occurred. _____

_____

_____

2. Have you ever been involved in an "on-the-job" injury? □ Yes □ No If yes, please describe the accident and when it occurred. _____

_____

3. Have you ever sustained any other injuries/accidents? □ Yes □ No If yes, please describe the accident and when it occurred. _____

_____

4. Please list all "childhood" diseases you have had. _____

_____

5. Please list all immunizations you have received. _____

_____

6. Please list any significant medical history information relating to your father. _____

_____

7. Please list any significant medical history information relating to your mother. _____

_____

8. Please list any significant medical history information relating to your grandfather. _____

_____

9. Please list any significant medical history information relating to your grandmother_____

_____

10. Please list any significant medical history information relating to your siblings. _____

_____

Lifestyle History

1. Do you eat breakfast? □ Yes □ No
2. Do you eat lunch? □ Yes □ No
3. Do you eat dinner? □ Yes □ No
4. Do you eat prior to bed? □ Yes □ No
5. Do you drink coffee? □ Yes □ No If yes, how much each day? _____
6. Do you drink tea? □ Yes □ No If yes, how much each day? _____
7. Do you smoke? □ Yes □ No If yes, how much each day? _____
8. Do you drink sodas? □ Yes □ No If yes, how much each day? _____
9. How much water do you drink on a daily basis? _____
10. Do you drink alcohol? □ Yes □ No If yes, how much each day? _____
11. Are you a vegetarian? □ Yes □ No
12. What is your Blood Type?(circle) **A** **B** **AB** **O**
13. Do you believe you are allergic to any foods? □Yes □No If yes, please list the offending foods. _____
14. Do you experience any sleep dysfunctions? □ Yes □ No If yes, please describe your difficulties. _____
15. Is your job stressful? □ Yes □ No If yes, please rate on a scale of 1-10. _____
16. Is your personal life stressful? □ Yes □ No If yes, please rate on a scale of 1-10. _____
17. Have you □gained or □lost any weight in the last year? □ Yes □ No If yes, please indicate how much and over what period of time. _____

Patient Signature: _____ Dated: _____

GENERAL PAIN DISABILITY INDEX

The rating scales listed below are designed to measure the degree to which several aspects of your life are presently disrupted by chronic or fairly acute pain. In other words, we would like to know exactly how much of your pain/symptoms are preventing you from doing what you would normally do in your daily life. Please respond to each category by indicating the ***overall*** impact of the pain/symptoms in your life, not just when the pain/symptoms are at the absolute worst.

For each of the six categories of daily living listed below, **PLEASE CIRCLE THE NUMBER WHICH BEST DESCRIBES YOUR PRESENT LEVEL OF ACTIVITY**. A score of "0" (zero) means no disability or impairment with those activities at all and a score of "10" (ten) signifies that all of the activities in which you would normally be involved have been disrupted or are prevented due to the pain/symptoms you are experiencing.

1. **Family/Home Responsibilities** This category refers to activities related to the home or family. It includes daily chores and duties performed around the house (yard work, laundry, etc.) and errands/favors for other family members (driving children to school, etc.).

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

2. **Recreation** This category includes hobbies, sports and other similar leisure time activities.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

3. **Social Activity** This category refers to activities which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out and other social functions.

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

4. **Occupation** This category refers to activities that are a part of or directly related to your job. This includes non-paying jobs as well (stay-at-home parent, volunteer work, etc.).

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

5. **Self-Care** This category includes activities which involve personal maintenance and independent daily living (taking a shower/bath, driving a car, getting dressed, etc.).

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

6. **Life-Support** This category refers to basic life-supporting behaviors (eating, sleeping, breathing, etc.).

0 1 2 3 4 5 6 7 8 9 10
Completely Able to Function — **Totally Unable To Function**

TOTAL SCORE _____ **Signature** _____

Dr. Kenneth N. Haas, DC
Haas Wellness Centers
3315 Springbank Lane, Suite 102
Charlotte, North Carolina 28226
704-837-2420

HISTORY OF INJURIES

Patient Name: _____ **Date:** _____

Please mark the on the diagrams (shown below) all regions of your body which have ever been severely injured, traumatized or physically effected. Use the following abbreviation keys to note what occurred in each region and then list the date of each onset. Thank you for your cooperation.

CC (Concussions) **LA (Lacerations)**

_____ _____

_____

CT (Contusions/Bruises) **SU (Surgeries)**

_____ _____

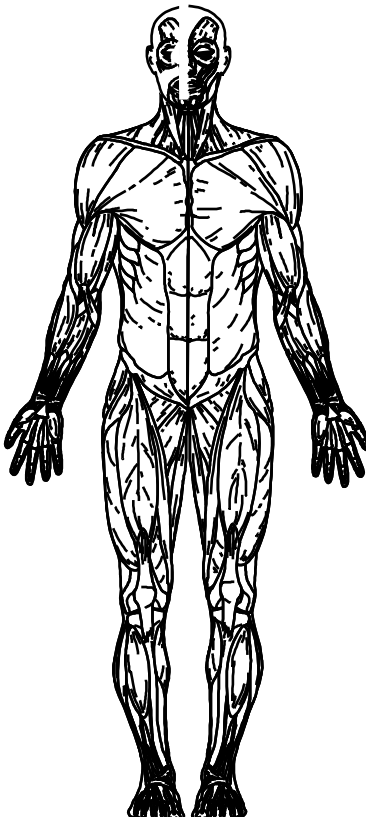
FL (Falls &/or Other Injuries) **SP (Sprain/Ligament Damage)**

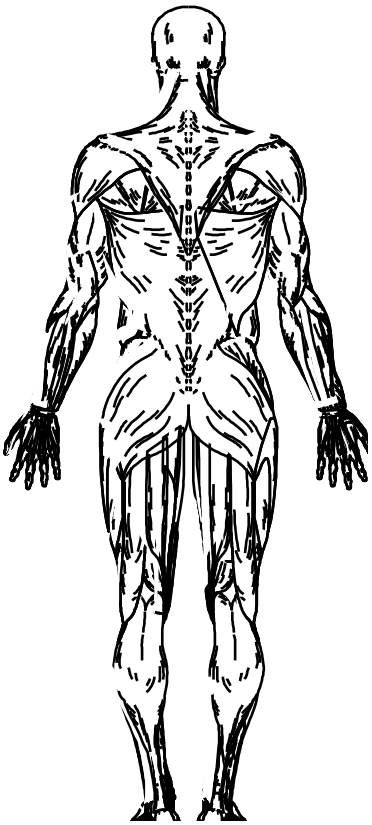
_____ _____

FR (Fractures) **ST (Strains/Muscle & Tendon Damage)**

_____ _____

SCARS **OTHER**





PATIENT SYMPTOM SURVEY

DATE_____

PATIENT'S NAME_____ ***DOB*** ____/____/_____

WEIGHT_____ ***HEIGHT***_____ ***BLOOD PRESSURE***_____ ***PULSE***_____ ***O_2***_____

This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time…

Primary Complaints

090 ☐ General Good Health
091 ☐ Desires Nutritional & Metabolic Analysis
001 ☐ Skin Disorder 692.9
002 ☐ Acne 706.1
003 ☐ Psoriasis 696.1
004 ☐ Urticaria (Hives) 708.9
005 ☐ ADD/ADHD 314.00/314.01
006 ☐ Allergies, Unspecified 477.9
007 ☐ Allergic Rhinitis from food 477.1
008 ☐ Sinusitis 461.9
009 ☐ Alzheimer's 331.0
010 ☐ Poor Concentration/Memory 310.1
011 ☐ Parkinson's Disease 332.0
012 ☐ Anemia 285.9
013 ☐ Arthritic Disorder 716.90
014 ☐ Osteoporosis 733.00
015 ☐ Asthma 493.90
016 ☐ Emphysema 492.8
017 ☐ Cancer
018 ☐ Breast 174.9female 175.9male
019 ☐ Prostate 185
020 ☐ Lung 162.9
021 ☐ Colon and Rectal 153.9
022 ☐ Skin 173.9
023 ☐ Leukemia w/o remission 208.90 Leukemia w/ remission 208.91
024 ☐ Lymphoma, malignant 202.8
025 ☐ Brain Tumor, malignant 191.9
027 ☐ Anxiety Disorder 300.00
028 ☐ Autism 299.00
033 ☐ Edema 782.3
034 ☐ Eczema 692.9
035 ☐ Chronic Fatigue 780.71
036 ☐ Circulatory Disorder 459.9
037 ☐ Heart Disease 429.9
038 ☐ High Cholesterol 272.0
039 ☐ High Blood Pressure 401.9
040 ☐ Low Blood Pressure 458.9
041 ☐ Tachycardia (High Heart Rate) 785.00
042 ☐ Numbness 782.0
043 ☐ Constipation 564.0
044 ☐ Indigestion 536.8
045 ☐ Ulcerative Colitis 556.9
046 ☐ Depression 311
047 ☐ Diabetes Mellitus 250.0
030 ☐ Diabetes Type I 250.01
031 ☐ Diabetes Type II 250.02
029 ☐ Hyperglycemia [high blood sugar] 790.29
048 ☐ Hypoglycemia [low blood sugar] 251.2
049 ☐ Dizziness/Balance Problem 780.4
050 ☐ Ear Infection 381.4
051 ☐ Epstein Barr 075
052 ☐ Eye Problems 379.91
053 ☐ Cataracts 366.9
054 ☐ Glaucoma 365.9
055 ☐ Macular Degeneration 362.50
056 ☐ Fever 780.6
057 ☐ Fibromyalgia 729.1
058 ☐ Gallbladder Disorder 575.9
059 ☐ Gout 274.9
060 ☐ Headaches 784.0
061 ☐ Hearing Loss 389.9
062 ☐ Infertility, male 606.9
064 ☐ Liver Disease 571.9
065 ☐ Hepatitis 573.3
066 ☐ Hepatitis B 070.30
067 ☐ Hepatitis C 070.51
068 ☐ Kidney Disorder 593.9 or Bladder Disorder 596.9
063 ☐ Prostate Disorder 602.9
069 ☐ Hyperthyroidism 242.90
070 ☐ Hypothyroidism 244.9
071 ☐ Systemic Lupus 710.0
072 ☐ Infertility, female 628.9
073 ☐ Interstitial Cystitis 595.1
074 ☐ Irregular Menstrual Cycle 626.4
075 ☐ Menopausal Symptoms 627.2
076 ☐ Hot Flashes 627.2
077 ☐ Mental Disorder 300.9
078 ☐ Insomnia 780.52
079 ☐ Mouth/Throat/Tongue
080 ☐ Canker Sores 528.2
081 ☐ Overweight 278.02
082 ☐ Underweight 783.22
083 ☐ Sexual Disorder 302.89
084 ☐ Spinal Problems 724.9
085 ☐ Obesity 278.00
086 ☐ GERD 530.81
087 ☐ HIV 042
088 ☐ Crohn's Disease 555.9
089 ☐ Irritable Bowel Syndrome 564.1
092 ☐ Normal Pregnancy v22.2
**only applicable if *currently* pregnant
093 ☐ Shingles 053.9
140 ☐ Migraines 346.90
141 ☐ Rheumatoid Arthritis 714.0
142 ☐ Non-Systemic Lupus 695.4
143 ☐ Multiple Sclerosis 340
144 ☐ ALS (Lou Gerigs) 335.20
145 ☐ Polymyalgia Rheumatica 725
146 ☐ Scleroderma 710.1
171 ☐ Goiter 240.9
178 ☐ Raynaud's Syndrome 443.8
179 ☐ Hemochromatosis 275.0
180 ☐ Thalassemia 282.49
181 ☐ Brain aneurysm 431

If necessary, please state your most significant concern…

General Health

100 ☐ Fingernail base is pink
101 ☐ Fingernail base is purple
102 ☐ Fingernails have ridges or white spots
103 ☐ Fingernails are soft
104 ☐ Fingernails are splitting
105 ☐ Fingernails peel
106 ☐ Pale fingernail beds
107 ☐ Blacks out easily
108 ☐ Balance problems
109 ☐ Difficulty walking
110 ☐ Has tattoos
111 ☐ Brittle hair
112 ☐ Dry hair
113 ☐ Thin hair
114 ☐ Hair loss
115 ☐ Drinks alcoholic beverages daily
116 ☐ Drinks less than 8 glasses of water per day
117 ☐ Currently on Chemotherapy
118 ☐ Currently on radiation treatment
119 ☐ Had chemotherapy in the past
120 ☐ Has had radiation treatments in the past
121 ☐ Gained over 20 lbs in the last 12 months
122 ☐ Somewhat Overweight
123 ☐ Somewhat Underweight
124 ☐ Unexplained loss of >20lbs in last 4 months
125 ☐ Energy level is worse than it was 5 years ago
127 ☐ Sleeps less than 6 hours per night
128 ☐ Unable to recall dreams the next day
129 ☐ Sensitive to chemicals, paint, fumes, cologne
130 ☐ Had blood transfusion in the past
131 ☐ Had transplant in the past
138 ☐ Takes anti-rejection drugs
132 ☐ Had a major accident or injury
137 ☐ Sleep Apnea
139 ☐ Toxic chemical exposure
175 ☐ Has been out of the country recently
176 ☐ Had childhood vaccines
177 ☐ Had a vaccine in the last 12 months
147 ☐ Had a flu shot last year
182 ☐ Had a pneumonia vaccine last year
183 ☐ Had a Hepatitis B vaccine in the last 2 years.

Has a family history of:

184 ☐ Cancer
185 ☐ Heart Disease
186 ☐ Diabetes
187 ☐ Alcoholism
188 ☐ Depression
189 ☐ Obesity

Lifestyle & Environment

Do you use? ☐ Well Water ☐ City Water Filtered? ☐ Yes ☐ No Filter Type? _____

What kind of pipes are in your home? ☐ Steel ☐ CPVC ☐ Copper ☐ Pex ☐ Other _____

What year was your home built? _____ Any renovations in the past year? _____

Do you use chlorine bleach or other heavy duty cleaners in your home/work? ☐ Yes ☐ No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry? ☐ Yes ☐ No

Explain: _____

Have you ever worked around industrial solvents, chemicals or pesticides? ☐ Yes ☐ No

Explain: _____

380 ☐ Drinks beverages from a can
370 ☐ Drinks alcohol
371 ☐ Drinks caffeinated coffee
372 ☐ Drinks caffeinated pop/soda
373 ☐ Drinks caffeinated tea
374 ☐ Drinks decaffeinated coffee
375 ☐ Drinks decaffeinated pop/soda
376 ☐ Drinks decaffeinated tea
377 ☐ Drinks >3 cups of coffee daily
378 ☐ Drinks >3 cups of tea per day
388 ☐ Drinks diet pop/soda
379 ☐ Drinks >1 pop/sodas per day

I had 4 alcoholic drinks in one day:

172 ☐ never
173 ☐ more than 3 months ago
174 ☐ less than 3 months ago

381 ☐ Has >5 alcoholic drinks/week
391 ☐ Craves sugar / starches
382 ☐ Currently smokes
383 ☐ Quit smoking in last 5 years
384 ☐ Smoked for >5 years
385 ☐ Smokes >1 pack per day
126 ☐ Rarely exercises
133 ☐ Regularly exercises
386 ☐ Takes Vitamins
134 ☐ Vegetarian
135 ☐ Eats no red meat
136 ☐ Eats no meat, no dairy
387 ☐ Frequent use of artificial sweeteners
389 ☐ Anorexia
390 ☐ Bulimic

Surgeries

700 ☐ Tonsillectomy and/or Adenoids
701 ☐ Appendix
702 ☐ Gallbladder
703 ☐ Thyroid
704 ☐ Hysterectomy, complete
705 ☐ Hysterectomy, partial
706 ☐ Tubal ligation
707 ☐ Breast implants
708 ☐ Cancer
709 ☐ Coronary by-pass
710 ☐ Spinal surgery
711 ☐ Extremity surgery
712 ☐ Hip replacement
713 ☐ Knee replacement
714 ☐ Splenectomy
715 ☐ Radiated thyroid
716 ☐ Cataract surgery
717 ☐ Hemorroidectomy
718 ☐ Bariatric/Weight loss

Type: _____

Gastrointestinal

265 ☐ 4-5 bowel movements per week
266 ☐ 3 or less bowel movements per week
267 ☐ 6 or more bowel movements per week
268 ☐ Black tarry stools
269 ☐ Pale or yellow colored stool
270 ☐ Blood stools
271 ☐ Constipation
272 ☐ Hemorrhoids
273 ☐ Loose bowel movements
274 ☐ Frequent diarrhea
275 ☐ Frequent nausea
276 ☐ Frequent vomiting
277 ☐ Abdominal gas
278 ☐ Belching and burping after eating
279 ☐ Bloated after eating
280 ☐ Severe abdominal pains
281 ☐ Stomach ulcers
282 ☐ Uses digestive aids
283 ☐ Uses laxatives
284 ☐ Immediate indigestion upon eating
285 ☐ Indigestion in 2 hours or more after meals
286 ☐ Indigestion within 1 hour after meals
287 ☐ Difficulty swallowing
288 ☐ Eating relieves fatigue
289 ☐ Eats when nervous
290 ☐ Excessive hunger
291 ☐ Poor appetite
292 ☐ Experiences fainting spells when hungry
293 ☐ Feels shaky when hungry
294 ☐ Frequently drowsy after eating a meal
295 ☐ Gall bladder disease
296 ☐ Has had intestinal worms
297 ☐ Reflux/Hiatal hernia
298 ☐ Liver disease
299 ☐ Irritable Bowel Syndrome
300 ☐ Diverticulitis
301 ☐ Diverticulosis

Respiratory

485 ☐ Catches severe colds
486 ☐ Chronic chest condition
487 ☐ Chronic cough
488 ☐ Constant runny nose
489 ☐ COPD
490 ☐ Difficulty breathing
491 ☐ Frequent colds
492 ☐ Frequent nose bleeds
493 ☐ Frequent sinus infections
494 ☐ Frequent stuffy nose
495 ☐ Hay fever
496 ☐ Nasal polyps
497 ☐ Night sweats
498 ☐ Post nasal drip
499 ☐ Sneezing spells
500 ☐ Spits up blood
501 ☐ Spits up phlegm
502 ☐ Wheezes

Mouth and Throat

400 ☐ Bad breath
401 ☐ Bitter taste in the mouth in the morning
402 ☐ Dry mouth
403 ☐ Excessive saliva
404 ☐ Sores or cracks in the corners of the mouth
405 ☐ Glands often swell
406 ☐ Frequent canker sores
407 ☐ Frequent fever blisters
408 ☐ Frequent sore throats
409 ☐ Frequently has a sore tongue
410 ☐ Sore gums
411 ☐ Swollen gums
412 ☐ Swollen tongue
413 ☐ Tongue burns
414 ☐ Tongue has grooves or fissures
415 ☐ Tongue is coated
416 ☐ Gums bleed when brushing teeth
417 ☐ Toothaches
418 ☐ Amalgam dental fillings
420 ☐ Other dental fillings (gold, composite, etc)
419 ☐ Has had root canal(s)

Endocrine

245 ☐ Coarse hair
246 ☐ Coarse skin
247 ☐ Diabetic
248 ☐ Excessive thirst
249 ☐ Frequently feels cold
250 ☐ Frequently feels hot
251 ☐ Gets lightheaded when standing quickly
252 ☐ Heals slowly
253 ☐ Unusually jumpy or nervous
254 ☐ Unusually tired most of the time

Cardiovascular

190 ☐ Cold feet
191 ☐ Cold hands
192 ☐ Experiences shortness of breath while sitting still
193 ☐ Heart skips beats
194 ☐ Tendency of High blood pressure
195 ☐ Leg cramps during bedtime
196 ☐ Leg cramps during daytime
197 ☐ Low blood pressure at times
198 ☐ Pain in leg/hips when walking
199 ☐ Frequent swollen ankles
200 ☐ Pains in the heart or chest
201 ☐ Spells of rapid heart rate

202 ☐ Troubled with blood clots
203 ☐ Unusually slow pulse rate
204 ☐ Varicose veins
205 ☐ Heart palpitations

Skin

520 ☐ Bruises easily
521 ☐ Excessive perspiration
522 ☐ Frequent goose bumps
523 ☐ Has acne
524 ☐ Has Psoriasis
525 ☐ Hives
526 ☐ Itchy skin
527 ☐ Problems with Eczema
528 ☐ Has moles which are changing in size and/or color
530 ☐ Skin is rough, especially on the back of the arms
529 ☐ Skin eruptions
531 ☐ Skin is tender
532 ☐ Sores that heal slowly
533 ☐ Troubled with boils
534 ☐ Dry skin

Ears

220 ☐ Discharge from ears
221 ☐ Hard of hearing
222 ☐ Punctured ear drum
223 ☐ Recurrent ear infection
224 ☐ Ringing or noises in the ears
225 ☐ Tinnitus

Eyes

320 ☐ Bloodshot eyes
321 ☐ Blurred vision
322 ☐ Cross eyes
323 ☐ Eye pain
324 ☐ Eyes feel gritty
325 ☐ Eyes watery
326 ☐ Mild Glaucoma
327 ☐ Far sighted
328 ☐ Developing cataracts
329 ☐ Mild Macular degeneration
330 ☐ Itchy eyes
331 ☐ Near sighted
332 ☐ Dry Eyes

Feet

350 ☐ Corns
351 ☐ Frequent foot cramps
352 ☐ Heel spurs
353 ☐ Painful feet
354 ☐ Plantar warts
355 ☐ Swelling in the feet and/or ankles
356 ☐ Plantar fasciitis
357 ☐ Fungal Infection

Neuromuscular

440 ☐ Bites nails
441 ☐ Frequent muscle soreness
442 ☐ Muscle spasms
443 ☐ Muscle weakness
444 ☐ Tremors
445 ☐ Frequent headaches
446 ☐ Often dizzy
447 ☐ Frequently feels faint
448 ☐ Has Epilepsy
449 ☐ Has motion sickness
450 ☐ Has Osteoarthritis
451 ☐ Has Rheumatism
452 ☐ Rheumatoid Arthritis
453 ☐ Joint stiffness in the morning
454 ☐ Swollen joints
455 ☐ Leg pain at rest
456 ☐ Spinal curvature
457 ☐ Low back pain
458 ☐ Neck pain
459 ☐ Pain between the shoulders
460 ☐ Shoulder/arm pain
461 ☐ Numbness/tingling in the body
462 ☐ Sleep walks
463 ☐ Stutters or stammers
464 ☐ Nerve pain

Behavior Patterns

150 ☐ Afraid to eat anywhere except home
151 ☐ Always needs someone to advise
152 ☐ Cries often
153 ☐ Difficulty concentrating
154 ☐ Difficulty falling asleep
155 ☐ Difficulty staying asleep
156 ☐ Easily angered
157 ☐ Feelings are easily hurt
158 ☐ Frequently becomes scared for no reason
159 ☐ Frequently miserable or blue
160 ☐ Has to be on guard even with friends
161 ☐ Often annoyed by people
162 ☐ Recurrent bad dreams
163 ☐ Sometimes wishes to be dead or away from it all
164 ☐ Upset by criticism
165 ☐ Poor memory
166 ☐ Scared to be alone
167 ☐ Strange people or places cause fear
168 ☐ Under considerable emotional stress
169 ☐ Unhappy when other are happy
170 ☐ Brain fog

Urinary

555 ☐ Urinates more than 2 times per night

556 ☐ Bed wetting
557 ☐ Blood in the urine
558 ☐ Difficulty starting urination
559 ☐ Painful urination
560 ☐ Frequent urination
561 ☐ Troubled by urgent urination
562 ☐ Incontinence when sneezing or laughing
563 ☐ Loses bladder control
564 ☐ Frequent bladder infections
565 ☐ Frequent kidney infections
566 ☐ Kidney stones

Men Only

585 ☐ Difficulty completing intercourse
586 ☐ Difficulty getting or keeping an erection
587 ☐ Discharge from the urethra
588 ☐ Had a vasectomy
589 ☐ Had difficulty fathering children
590 ☐ Lumps in the testicles
591 ☐ Painful genitals
592 ☐ Prostate troubles
593 ☐ Sores on external genitalia
594 ☐ Herpes
595 ☐ Sexual diseases

Women Only

610 ☐ Heavy hair growth on face or body
611 ☐ Cycles are every 27-29 days
612 ☐ Abnormal cycle >29 days and/or <26 days
613 ☐ PMS
614 ☐ Menstrual cramps
615 ☐ Painful periods
616 ☐ Acne worse at menstruation
617 ☐ Excessive menstrual flow
618 ☐ Retains fluid during periods
619 ☐ Pre-menstrual depression
620 ☐ Currently taking birth control medication
621 ☐ Has taken birth control medication more than 1 year
622 ☐ Has taken birth control medication within the last year
623 ☐ Has had miscarriage
624 ☐ Hot flashes
625 ☐ Takes hormone replacement medication
627 ☐ Diminished sexual desire
628 ☐ Painful intercourse
629 ☐ Poor or infrequent orgasm
630 ☐ Lumps in the breasts
631 ☐ Tender breasts
633 ☐ Vaginal discharge
634 ☐ Bloody spotting discharge
635 ☐ Yeast infections
636 ☐ Sores on external genitalia
637 ☐ Herpes
638 ☐ Sexual diseases
639 ☐ Endometriosis
640 ☐ Breast reduction
641 ☐ Breast augmentation
642 ☐ Abortion
643 ☐ D&C
644 ☐ Tubal pregnancy
645 ☐ Uterine fibroids
646 ☐ Ovarian fibroids
647 ☐ Breast fibroids
648 ☐ Currently Breastfeeding

Medications

Please list all drugs you are currently taking on a daily basis.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

DRUG	***PRESCRIBED FOR:***	***HOW LONG***

Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc

- ☐ Dairy
- ☐ Eggs
- ☐ Garlic
- ☐ Gluten
- ☐ Mold
- ☐ Peanut
- ☐ Ragweed
- ☐ Shellfish
- ☐ Soy
- ☐ Sulfa drugs
- ☐ Tree nuts
- ☐ Wheat

☐ Other _____

Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

VITAMIN	***BRAND***	***DOSAGE***