

Confidential Patient Information

Please Complete All Data To The Best Of Your Ability

General Information

Name _____ Date _____ Home Phone _____

Address _____ City _____ Zip _____ S.S.# _____

Age _____ Birth Date _____ Marital Status M S W D How many children? _____

Occupation _____ Employer _____ Office Phone _____

Work Address _____ Email Address _____

Name of Spouse _____ Occupation _____ Employer _____

Spouse's Work Address _____

How did you hear about us? Referred By: _____ Internet Ad Health Fair Gym

Current health complaints/ reasons for consulting our office (in order of importance):

1. _____ Date First Appeared _____

2. _____ Date First Appeared _____

3. _____ Date First Appeared _____

Have you had the same or similar problem (s) before? ___Yes ___ No When: _____

Do you have a family member with the same problems? _____ If so, who? _____

Other doctors you have seen for this problem (s) _____

Surgeries you have had for this condition? _____

Primary Physician

My primary physician: _____ City: _____

I authorize AlignLife to communicate to my primary physician about my care and the results I receive at this office.

Signature: _____ Date: _____

FINANCIAL ARRANGEMENT

Our office has conservative fees and comfortable payment arrangements. We want to make sure that our patients are able to receive the needed care in an affordable manner. All services must be paid at the time of service. If alternate payment arrangements are needed, this must be discussed before services are rendered. However, we will discuss all fees before any services are provided.

I have read and understand the statements above.

Name: _____ Signature: _____ Date: _____

PARENT/LEGAL GUARDIAN (Complete if patient is under 18 years of age)

If the patient is a minor, and you are the parent or the legal guardian of the patient, signing below will allow our office to evaluate your child.

Name: _____ Signature: _____ Date: _____



Health Appraisal

Name: _____ Age: _____ Gender: **M** **F** Hgt: ___' ___" Wght: _____

Please answer the following questions by circling either yes or no and provide explanations when requested.

1. PERSONAL AND FAMILY HISOTRY		
Condition	FAMILY	PERSONAL
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type 1	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes Type 2	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/> Type:	<input type="checkbox"/> Type:
Anemia	<input type="checkbox"/>	<input type="checkbox"/> Last Lab Test:
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/> What Foods:
2. LIFESTYLE		
Y / N	a. Do you smoke? If yes, how many packs a day? _____	
Y / N	b. Do you drink alcohol? If yes, how many drinks a week? _____	
Y / N	c. Do you drink caffeinated beverages? If yes, what kind and how many daily? _____	
	d. How many 8oz glasses of water do you drink per day: ____ What kind? Tap Filtered Distilled RO	
	e. How many times do you eat fast food each week? _____	
	f. How many servings of fruits & vegetables are you eating daily? 0 1 2 3 4 5 6 7 8 9 10 1 medium fruit = 1 serving 1 cup raw vegetables = 1 serving	
Y / N	g. Do you think you need to take vitamin supplementation?	
Y / N	h. Are you currently taking a multivitamin? If yes, please name: _____	
Y / N	i. Are you presently or have you ever been on blood thinning medication?	
	j. On a scale of 1 to 10, what level of stress do you experience daily? 1 2 3 4 5 6 7 8 9 10	
3. WEIGHT LOSS		
Y / N	a. Are you at your ideal weight? If no, what is your desired weight? _____	
	b. What programs have you tried to lose weight in the past? _____	
	c. What has been the biggest struggle in losing weight? _____	
4. EXERCISE		
Y / N	a. Do you engage in any cardiovascular exercise (e.g., aerobics, walking, etc.)? If so, which activities? _____	
	b. How many days per week? _____ For how long? _____ hours _____ minutes	
Y / N	c. Do you reach your target heart rate?	
Unsure	MALE: 220-AGE = MAX (Target 60-70%) FEMALE: 226-AGE = (Target 60-70%)	
Y / N	d. Do you do any form of resistance exercises (lift weights) on a consistent basis?	
Y / N	e. Do you ever experience pain after exercising? If so, where? _____	

5. SUPPLEMENTATION

List all supplements you are currently taking.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. MEDICATIONS

List all prescriptions you are currently taking.

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

-----For Women Only-----

- 1. Y / N Are you pregnant or planning a pregnancy?
- 2. Y / N Are you taking birth control?
- 3. Y / N Have you had a hysterectomy?
- 4. Y / N Are you taking estrogen replacement therapy?

On a scale of 1 to 10, what is your commitment to making a lifestyle improvement? 1 2 3 4 5 6 7 8 9 10

Subjective Health Assessment

Name: _____

Date: _____

Please rate the following symptoms that you have experienced during the past 30 days.

0 = Never 1 = Occasional and Mild 2 = Occasional and Severe 3 = Often and Mild 4 = Often and Severe

<u>Head</u>		<u>Heart, Lungs</u>	
0 1 2 3 4	Headache	0 1 2 3 4	Irregular Heart Beat
0 1 2 3 4	Faintness	0 1 2 3 4	Rapid, Pounding Heart Beat
0 1 2 3 4	Dizziness	0 1 2 3 4	Chest Pain
0 1 2 3 4	Sleeplessness	0 1 2 3 4	Chest Congestion
	___ Total	0 1 2 3 4	Asthma
<u>Eyes, Ears, Nose, Throat</u>		0 1 2 3 4	Bronchitis
0 1 2 3 4	Stuffy Nose	0 1 2 3 4	Shortness of Breath
0 1 2 3 4	Sinus Trouble		___ Total
0 1 2 3 4	Hay Fever	<u>Skin</u>	
0 1 2 3 4	Sneezing	0 1 2 3 4	Acne
0 1 2 3 4	Nasal Congestion	0 1 2 3 4	Dry, Scaly Skin
0 1 2 3 4	Swollen Eyes	0 1 2 3 4	Hair Loss
0 1 2 3 4	Reddened Eyes	0 1 2 3 4	Excessive Sweating
0 1 2 3 4	Watery, Itchy Eyes	0 1 2 3 4	Oily Skin
0 1 2 3 4	Dark Circles Under Eyes	0 1 2 3 4	Hot Flashes
0 1 2 3 4	Blurred Vision		___ Total
0 1 2 3 4	Earache, Ear Infection	<u>Digestion</u>	
0 1 2 3 4	Ringing in the Ears	0 1 2 3 4	Nausea, Vomiting
0 1 2 3 4	Coughing	0 1 2 3 4	Diarrhea
0 1 2 3 4	Sore Throat	0 1 2 3 4	Constipation
0 1 2 3 4	Hoarseness, Loss of Voice	0 1 2 3 4	Heartburn
0 1 2 3 4	Canker Sore	0 1 2 3 4	Stomach Pain
0 1 2 3 4	Discolored Lips or Gums	0 1 2 3 4	Bloating
	___ Total	0 1 2 3 4	Belching, Gas
<u>Memory, Emotions</u>			___ Total
0 1 2 3 4	Mood Swings	<u>Joints</u>	
0 1 2 3 4	Anxiety, Nervousness	0 1 2 3 4	Stiffness/Lack of Motion
0 1 2 3 4	Anger, Irritability	0 1 2 3 4	Arthritis
0 1 2 3 4	Aggressiveness	0 1 2 3 4	Pain in the Muscles
0 1 2 3 4	Depression	0 1 2 3 4	Pain in the Joints
0 1 2 3 4	Poor Memory		___ Total
0 1 2 3 4	Confusion	<u>Energy Levels</u>	
0 1 2 3 4	Lack of Concentration	0 1 2 3 4	Weakness
0 1 2 3 4	Difficulty in Making Decisions	0 1 2 3 4	Fatigue
0 1 2 3 4	Stuttering	0 1 2 3 4	Hyperactivity
0 1 2 3 4	Slurred Speech	0 1 2 3 4	Restlessness
0 1 2 3 4	Learning Disabilities		___ Total
	___ Total	<u>Weight</u>	
		0 1 2 3 4	Binge Eating/Drinking
		0 1 2 3 4	Craving Certain Foods
		0 1 2 3 4	Excessive Weight
		0 1 2 3 4	Water Retention
		0 1 2 3 4	Overweight
			___ Total
			Grand Total _____

Terms of Acceptance for Nutritional Care

We solely provide any suggested nutritional advice or dietary advice, and the adjunctive schedule of nutrition to upgrade the quality of foods and nutrients in your diet and to support the healthy function of your body.

We use diagnostic testing to find dysfunction in the organ systems of the body. We will not use any of the diagnostic testing to diagnose and/or treat disease, but only to enhance the function of the human body. Regardless of what the disease is called, we do not offer to treat it.

A vitamin, mineral, trace element, amino acid or herb is not a drug. Although any of these substances may have an effect on any disease process or symptom, this does not mean that anyone can be misrepresent or classify them as drugs.

I understand the objectives pertaining to my nutritional care in this office. My questions have been answered to my satisfaction. Therefore, I accept nutritional care on this basis.

(Signature)

(Date)

PATIENT PRIVACY CONSENT FORM

FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT ANALYSIS, TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, _____ hereby state that by signing this consent, I acknowledge and agree as follows:

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

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

___ 3. I understand that, and consent to, the following appointment reminders that will be used by the practice:

- Postcards mailed to the addresses I have provided.
- Telephoning me at the numbers I have provided and leaving messages for me on my answering machine or with the individual answering the phone.

___ 4. The practice may use and/or disclose my PHI (which includes information about my health or condition, analysis, and the treatment provided to me) in order for the practice to make analyses about my condition(s), treat me, obtain payment for that treatment, and as necessary for the practice to conduct its specific health care operations.

___ 5. I understand that I have the right to request that the practice restrict how my PHI is used and/or disclosed except to obtain payment for treatment provided. However, the practice is not required to agree to any restrictions that I have requested, and I have the right to refuse treatment.

___ 6. I understand that this consent is valid as long as I am a patient in this office. I further understand that I have the right to revoke this consent, in writing at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the practice has already taken action in reliance on this consent. If I revoke this consent at any time, the practice has the right to refuse to treat me.

___ 7. I give Align Life permission to treat me in a room that is not fully enclosed. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with the doctor at any time in private, I understand the doctor will provide a private room for consultations.

___ 8. The doctor recommends that my spouse be present at my report of findings visit; therefore I hereby give permission for my protected health information to be disclosed at that time and at any time my spouse contacts the office to check on my status.

___ 9. This office posts a notice for Patient of the Week. If I receive that designation I authorize Align Life to post my name in the office.

I have read and understand the above statements. I understand that I have the right to refuse to sign this authorization. If I choose to decline signing this consent form, this practice will not treat me.

Date: _____

Patient's Name (Printed) _____

Patient Name (Signed) _____

Patient DOB: _____