Spectrum Applied Kinesiology

Patient Information & History

Date: _____

Patient Information

Name: _____

(First) (Initial) (Last)

Address:_____

_____

Birthday: _____ Age: ____ ☐ Male ☐ Female

Social Security # _____/_____/_____

Occupation: _____

Employer: _____

Parents Name(if a minor): _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐Seperated

Spouse's Name: _____

# of Children: _____

Accident Information

Is your condition due to an accident ☐ Y ☐ N

Date of accident: _____

Type of accident ☐ Auto ☐ Work ☐ Other

To whom have you reported the accident?

☐ Insurance ☐ Worker's Comp ☐ Employer

Attorney Name: _____

Attorney Phone: _____

Contact Information

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Best way to reach you ☐ Home ☐ Cell ☐ Work

Patient Conditon

What is your major symptom/problem? _____

When did your symptoms begin? _____

Have you had this problem before? _____

Is this problem: ☐ constant ☐ comes and goes

How does it feel: ☐ Burning ☐ Sharp ☐ Shooting ☐ Dull
☐ Tingling ☐ Throbbing ☐ Swelling ☐ Other_____

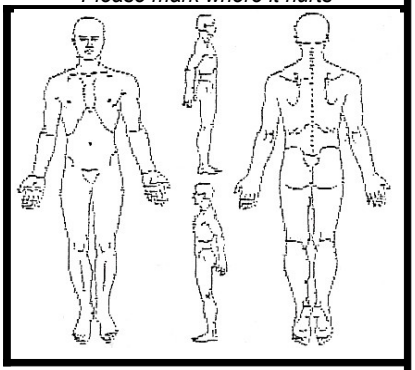
Circle below the severity of your pain on a scale of 0 to 10

(no pain) **0 1 2 3 4 5 6 7 8 9 10** (severe pain)

What makes your condition better? _____

What makes your condition worse? _____

Please mark where it hurts



Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities/movements that are painful to perform:

☐ Sitting ☐ Stading ☐ Walking ☐ Bending ☐ Lying down ☐ Driving ☐ Reading ☐ Getting up

What treatment have you had for this condition in the past? (surgery, medication, chiropractic, etc.)

_____

Have you had X-rays, MRI or other tests for this condition? What test? When? _____

_____

Health History

Check any of the following conditions you have had:

☐ AIDS/HIV
☐ Allergies
☐ Anxiety/Depression
☐ Arm/shoulder pain
☐ Arthritis
☐ Asthma
☐ Bladder problems
☐ Cancer type_____
☐ Chronic fatigue
☐ Deafness
☐ Diabetes
☐ Digestion problems
☐ Earache
☐ Ear ringing
☐ Epilepsy
☐ Headaches
☐ Headaches -Migraine
☐ Heart Disease
☐ Hemorrhoids
☐ Herniated disk
☐ High blood pressure
☐ Insomnia
☐ Irregular cycle
☐ Kidney problems
☐ Leg pain
☐ Low back pain
☐ Neck pain
☐ Osteoporosis
☐ Poor circulation
☐ Prostate problems
☐ Rheumatoid Arthritis
☐ Sciatica
☐ Shingles
☐ Sinus Infection
☐ Stroke
☐ Thryoid problems
☐ TMJ
☐ Venereal disease
☐ Vertigo/Dizziness

Females: Are you pregnant ☐ Yes ☐ No

Explain any check marks: _____

_____

Check any of the following conditions that a family member has had:

☐ Cancer
☐ Rheumatoid Arthritis
☐ Diabetes
☐ Heart Problems
☐ Lung Problems
☐ High Blood Pressure
☐ Epilepsy
☐ Chronic Back Problems
☐ Chronic Headaches
☐ Lupus
☐ Other_____

Stressors

☐ Smoking Packs/ Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/ Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Exercise

☐ None
☐ Moderate
☐ Daily
☐ Heavy

Have you had any:	**Description**	**Date**
Automobile accidents		
Surgeries		
Broken bones		
Falls/Head injuries		

Please list any medications you are taking (including birth control and vitamins)

_____

I certify that the above information is complete and accurate to the best of my knowledge. I agree to notify this doctor immediately whenever I have changes in my health condition.

Patients Signature: _____ Date: _____

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list the 5 major health concerns in your order of importance:

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

PART II **Please circle the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard, dry, or small stool	**0**	**1**	**2**	**3**
Coated tongue or "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Use laxatives frequently	**0**	**1**	**2**	**3**

Category II				
Excessive belching, burping, or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**

Category III				
Stomach pain, burning, or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Use antacids	**0**	**1**	**2**	**3**
Feel hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	**0**	**1**	**2**	**3**

Category IV				
Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category V				
Greasy or high-fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and/or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates from clay-colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed?		**Yes**	**No**	

Category VI				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get light-headed if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, or have tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory/forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**

Category VII				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category VIII				
Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow-starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only.

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal?	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle, greater than 32 days	Yes	No		
Shortened menses, less than every 24 days	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcoholic beverages do you consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you work out? _____

List the three worst foods you eat during the average week: _____, _____, _____

List the three healthiest foods you eat during the average week: _____, _____, _____

Do you smoke?_____ If yes, how many times a day: _____

Rate your stress levels on a scale of 1-10 during the average week: _____

Please list any medications you currently take and for what conditions:

_____

Please list any natural supplements you currently take and for what conditions:

_____

Spectrum Applied Kinesiology
Office Policy and Financial Agreement

All services rendered by our office will be charged directly to you on the day of your appointment, and you are personally responsible for payment. We accept Visa, Mastercard, checks, auto debit (when on file) and cash.

For patients with Medical Insurance:
As we provide service via direct payment, our office does not take medical insurance. In lieu of this we can provide you with a bill that you can submit yourself.

For Patients Eligible for Medicare:
Spectrum Applied Kinesiology and Chiropractic is a non-participating Medicare provider. All services rendered by this office will be charged directly to you on the day of your appointment, and you are personally responsible for payment. We bill Medicare every 30 days and you will receive any reimbusements due to you. Medicare limits care and payment to spinal manipulation to treat acute, painful musculoskeletal conditions. Medicare defines any other type of treament as maintenance therapy and will not pay for it. Medicare defines maintenance therapy as follows: 'A care plan that seeks to prevent disease, promote health, and prolong and enhance the quality of life, or maintain or prevent deterioration of a chronic condition." Due to Medicares limited coverage, your supplemental insurance may not pay for services Medicare denies.

For Personal Injury or Auto Accident Patients
If you are involved in an auto accident or "slip and fall", all services rendered by our office will be charged directly to you on the day of your appointment, and you are personally repsonsible for payment. If you have medical payments as part of your auto insurance policy, we will bill to them first. If you retain an attorney, he/she must sign a lien with our office. In the event you are no longer represented by your current attorney and do not retain another, or your auto insurance stops payment, your account is due and payable in full the first day you are not represented. You must supply a credit card number on file for us to collect said funds, and we will auto debit no later then 10 days after not being represented by an attorney or your med-pay expiration date.

Interest, Return Check Fees and Missed Appointments
As provided by state law, we reserve the right to

- Charge interest in the amount of 18% on late balances due beyond 30 days
- Collect any legal or collection fees.
- Pass along our bank fee for any returned checks
- Charge $45.00 for scheduled appointments missed and not cancelled 24 hours beforehand.
- Turn delinquent accounts over to collection agencies and report such deliquencies to the credit bureau.

By signing this financial policy, I authorize the release of medical or other information necessary to process my claim. I also request payment of government/insurance benefits to myself if due a reimbursement or payment of those medical benefits directly to Spectrum Applied Kinesiology & Chiropractic if I owe any money.
By my signature below, I acknowledge that I have read this entire form and thoroughly understand it.

_____

Signature Date

Spectrum Applied Kinesiology

Informed Consent
(Examination/Evaluation of All Patients)

By signing this form, you are consenting to an examination by Dr. _____. Dr. _____ employs standard chiropractic examination methods, including the following:

- Observation: General assessment/appraisal in all positions.

- Inspection: Viewing/looking at your body parts. Visualization included general body viewing in standard position, front, back and side. All symptomatic (painful) body parts may be viewed.

- Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.

- Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity of tissues, integrity and orthopedic/neurological testing; these are standard tests to access your neuro-musculo-skeletal systems.

NOTE: *You do not have to submit to any examination procedure. I ask you to comply to the best of your ability and report changes in your pain. All procedures are accomplished to your tolerance.*

I, _____ understand the above agreement and agree to submit to the best procedure and accept the risks and consequences of their application.

Signed: _____ Date: _____

Spectrum Applied Kinesiology

Notice of Privacy Practices

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

Spectrum Applied Kinesiology is required by law, to maintain the privacy and confidentiality of your protected health informaiton and provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of your health care information

Treatment

We may disclose your health care informaiton to other healthcare professioals within our practice for the purpose of treatment, payment and healthcare operations. (Example)

> *"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Spectrum Applied Kinesiology." "It is our policy to provide a substitute health care provider, authorized by Spectrum Applied Kinesiology to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness or other emergency sisuation."*

Payment

We may disclose your health information to your insurance provider for the purpose of payment or health operations. (Example)

> "*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Spectrum Applied Kinesiology for health services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to you to submit with the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition and codes which describe the health care services received."*

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify or assist in notifying a family member or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing and controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judical proceeding.

Law Enforcement

We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or mising person, complying with a court order or subpoena or other law enforcement purposes.

Deceased Persons

We may disclose your health informaiton to coroners or medical examiners.

Organ Donation

We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

Public Satety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing

We may contact you for marketing purposes or fundraising purposes, as described below:

> *"As a courtesy to our patients, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. We may also contact you for an event sponsored by us. If you are not at home, we will leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during the recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."*

Change of Ownership

In the event that Spectrum Applied Kinesiology is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Spectrum Applied Kinesiology is not required to agree to the restriction that you requested.
- You have the right to have your health information received and communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.

- You have a right to request that Spectrum Applied Kinesiology amend your protected health information. Please be advised, however, that Spectrum Applied Kinesiology is not required to agree to amend your protected health information. If your request to amend your health information had been denied, you will be provided with an explanation of your denial reason(s) and information about how you can disagree with the denial.
- You have the right to receive an accounting of disclosures of your protected health information made by Spectrum Applied Kinesiology.
- You have the right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices

Spectrum Applied Kinesiology reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all the information that it maintains. Until such amendment is made, Spectrum Applied Kinesiology is required by law to comply with this Notice.

Spectrum Applied Kinesiolgoy is requred by law to maintain the privacy of your health information and provide you with notie of its legal duties and privacy practives with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact our office by calling 916-482-4150.

Complaints

Complaints about your Privacy rights, or how Spectrum Applied Kinesiology has handled your health information should be directed to Jennifer Patrick by calling this office at 916-482-4150.

If you are not satisfied with the manner in which our office handles your complaint, you may submit a formal complaint to:
DHHS, Office of Civil Rights
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ___/___/____

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Spectrum Applied Kinesiology with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____
Patient' Printed Name

_____
Patient's Signature Date

_____
Authorized Facility Signature Date