An Even Vida Clinic

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PATIENT REGISTRATION AND HISTORY

Please complete this Patient Registration and History Form, as well as any other requested documents.

Patient Background

Your Name: _____ Date of Birth: _____ Age: ____ M/F
(First / Middle / Last)
Home Address: _____ City/State: _____ Zip _____
Home Phone: _(_____)_____ Work Phone: _(_____)_____ Cell Phone: _(_____)_____
Email: _____ Best Way To Contact You? _____
Who can we thank for referring you or how did you hear about us? _____
Occupation: _____ Employer: _____ How Long: _____
Work Status (circle one) Full-Time Part-Time Retired Unemployed Self-Employed Other:_____
Marital Status (circle one) Single Married Divorced Widowed Other: _____ # of Children: _____ Ages: _____

Why Are You Seeking Treatment, current condition, or focus of care?

Please briefly describe: _____
Date Primary Reason or Symptoms Began: _____ Is this a result of an accident or injury? _____

Please indicate your exposure to the following therapies:

Chiropractic Care:	Y	N	Massage Therapy:	Y	N
Acupuncture:	Y	N	Applied Kinesiology	Y	N
Nutrition/Supplementation:	Y	N	Osteopath Manip.	Y	N
Medicinal Herbs:	Y	N	Other: _____		
Homeopathy:	Y	N	If yes, date of most recent visit:___ _____		

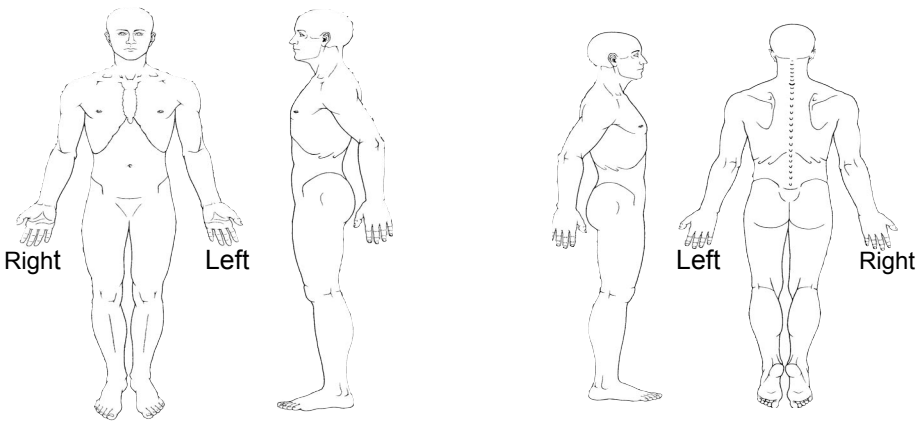
What are your health goals?

___ Remove/Reduce Pain
___ Gain more energy and stamina
___ Fix the cause of the problem
___ Restore health and reduce illness
___ Achieve optimal wholeness

What do you believe is going on or would help? _____
_____

Indicate any of the following areas if applicable on the chart below with following letter/symbol

Surgical Scars (S)
Numbness (N)
Dull Ache (D)
Sharp/Stabbing (+)
Knot (K)
Burning (B)
Pins/Needles (P)
Pain (PN)
Other: _____ (O)
_____
Severity Today:
1 2 3 4 5 6 7 8 9 10
At Best:
1 2 3 4 5 6 7 8 9 10
At Worst:
1 2 3 4 5 6 7 8 9 10



Patient Background Continued

Are you currently under any other care? Y/N If so, please explain/describe: _____
_____
Since onset of primary reason for being here, it has gotten: Worse Same Better
Does it change (get better or worse) in: Morning Midday Afternoon Night No Pattern
Does anything help or improve your status? Describe: _____
Do you have any Emotional Stressors that you believe may be related to or affecting your status? Describe: _____
_____
Have you been diagnosed with/by a diagnosing professional? Y/N If so please list: _____
_____

Family Diseases (List which family member)

_____Alcoholism/Drug Abuse
_____Anemia
_____Cancer:_____
_____Cold Sores
_____Deep Vein Thrombosis
_____Detached Retina
_____Diabetes
_____Diverticulitis/IBS
_____Eczema
_____Emphysema
_____Epilepsy
_____Goiter
_____Gout
_____Heart Disease
_____Hepatitis
_____HIV/AIDS
_____Miscarriage
_____Mumps
_____Pleurisy
_____Pneumonia
_____Polio
_____Rheumatic Fever
_____Seizures/Fainting
_____Stroke
_____Tumors
_____Ulcers
_____Vaccination Reaction
_____Other: _____
_____

Medications, OTC, Supplements	Reason For Taking	How Long or Date Started

Patient Review of Systems

Below answer the questions or circle the number that applies to you. **Leave blank** if it does not apply to you.

1 -Mild (occurs once or twice a month)
2 -Moderate (occurs several times a month)
3 -Severe (you are aware of it almost constantly)

Do you get tired at a particular time? _____
What kind of food do you prefer? Sweet/Salty/Sour
Spicy/Bitter/Tangy
How much water do you consume? _____
How many hours of sleep do you regularly get?_____
What time do you usually go to bed? _____
What time do you wake up? _____

Do you exercise and how often? _____
What type of activity do you do? _____
Has there been any significant change that has occurred in the last 3 years (marriage, divorce, birth, death, move, job change, etc)?_____
_____

1 2 3 Acid foods upset (1)
1 2 3 Get chilled, often (2)
1 2 3 “Lump” in throat (3)
1 2 3 Dry mouth-eyes-nose (4)
1 2 3 Pulse speeds after meal (5)
1 2 3 Keyed up-fail to calm (6)
1 2 3 Gag easily (8)
1 2 3 Unable to relax; startles easily (9)
1 2 3 Extremities cold, clammy (10)
1 2 3 Strong light irritates
1 2 3 Urine amount reduced (12)
1 2 3 Heart pounds after retiring/resting (13)
1 2 3 “Nervous” stomach (14)
1 2 3 Appetite reduced (15)
1 2 3 Cold sweats often (16)
1 2 3 Fever easily raised (17)
1 2 3 Nerve or shooting like pain (18)
1 2 3 Staring, blinks little (19)
1 2 3 Sour stomach frequent (20)
Y N Do you fall asleep when you read
_____ How many hours can you read

1 2 3 Joint Stiffness after arising (21)
1 2 3 Muscle-leg-toe cramps at night (22)
1 2 3 “Butterfly” stomach, cramps (23)
1 2 3 Eyes or nose watery (24)
1 2 3 Eyes blink often (25)
1 2 3 Eyelids swollen, puffy (26)
1 2 3 Indigestion soon after meals (27)
1 2 3 Always seems hungry; “lightheaded” often (28)
1 2 3 Digestion rapid (29)
1 2 3 Vomiting frequently (30)
1 2 3 Hoarseness frequently (31)
1 2 3 Breathing irregularities (32)
1 2 3 Pulse slow; feels “irregular” (33)
1 2 3 Gagging reflex slow or none (34)
1 2 3 Difficulty swallowing (35)
1 2 3 Constipation, diarrhea alternating (36)
1 2 3 “Slow starter” getting up, focused, etc (37)
1 2 3 Difficulty cooling down (38)
1 2 3 Circulation poor, sensitive to cold (39)
1 2 3 Perspire easily (40)
1 2 3 Subject to colds, asthma, bronchitis (41)

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1 2 3 Dark circles/bags under the eyes
1 2 3 Smelly feet
1 2 3 Cracks on the heels of feet

1 2 3 Hair on head thinning all over
1 2 3 Slobber, drool or spit when talking

1 2 3 Eat when nervous (42)
1 2 3 Excessive appetite (43)
1 2 3 Hungry between meals (44)
1 2 3 Irritable before meals (45)
1 2 3 Get “shaky” if hungry (46)
1 2 3 Fatigue, eating relieves (47)
1 2 3 “Lightheaded” if meals delayed (48)
1 2 3 Heart thumps if meals missed/delayed (49)
1 2 3 Afternoon headaches (50)
1 2 3 Overeating sweets upsets system/body (51)
1 2 3 Awaken after few hours sleep-hard to get back to sleep (52)
1 2 3 Crave candy or coffee in afternoon (53)
1 2 3 Moods of depression-”blues” or melancholy (54)
1 2 3 Preference for sweets and sugary foods (55)
1 2 3 Headache if you don’t eat regularly
1 2 3 Skin tags develop
1 2 3 Frequent urination
1 2 3 Excessive thirst
1 2 3 Burning urination, acetone breath
1 2 3 Thickened, discolored toenails
1 2 3 Bladder/vagina infections/fungus problems
1 2 3 Thick saliva, mucousy

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

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1 2 3 Dizziness (73)
1 2 3 Dry skin (74)
1 2 3 Burning feet (75)
1 2 3 Blurred vision (76)
1 2 3 Itching skin and feet (77)
1 2 3 Excessive falling hair (78)
1 2 3 Frequent skin rashes (79)
1 2 3 Bitter, metallic taste in mouth in mornings (80)
1 2 3 Headache with bad taste in mouth
1 2 3 Bowel movements painful or difficult (81)
1 2 3 Worrier, feels insecure (82)
1 2 3 Feeling queasy; headache over eyes (83)
1 2 3 Greasy foods upset (84)
1 2 3 Stools light-colored (85)
1 2 3 Skin peels on foot soles (86)
1 2 3 Pain between shoulder blades (87)
1 2 3 Use laxatives (88)
1 2 3 Stools alternate from soft to watery (89)
1 2 3 History of gallbladder attacks or gallstones (90)
1 2 3 Sneezing attacks (91)
1 2 3 Dreaming, nightmare type bad dreams (92)
1 2 3 Bad breath (halitosis) (93)
1 2 3 Milk products cause distress (94)
1 2 3 Sensitive to hot weather (95)
1 2 3 Burning or itching anus (96)
1 2 3 Crave sweets (97)
1 2 3 Varicose veins or hemorrhoids
1 2 3 Wakes up between 1 to 3 AM
1 2 3 Pain behind or inside the knee
Y N Do you wake up tired after a full nights rest

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

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1 2 3 Dizziness (150)
1 2 3 Headaches (151)
1 2 3 Hot flashes (152)
1 2 3 Increased blood pressure (153)
1 2 3 Female: Hair growth on face or body (154)
1 2 3 Sugar in urine (not diabetes) (155)
1 2 3 Female: Masculine tendencies (156)
1 2 3 Male: feminine tendencies
1 2 3 Insensitivity to light (always have sunglasses)
1 2 3 Over-sexually aroused
1 2 3 Exercise or stress makes tired/fatigue

1 2 3 Weakness, dizziness (157)
1 2 3 Chronic fatigue (158)
1 2 3 Low Blood Pressure (159)
1 2 3 Nails weak, ridges appear (160)
1 2 3 Tendency to hives (161)
1 2 3 Arthritic tendencies (162)

1 2 3 Increase in weight (122)
1 2 3 Fatigues easily (124)
1 2 3 Ringing in the ears (125)
1 2 3 Sleepy during the day (126)
1 2 3 Have cold hands and/or feet
1 2 3 Sensitivity to cold (127)
1 2 3 Wants or prefers warm weather
1 2 3 Impaired hearing (135)
1 2 3 Poor circulation
1 2 3 Dry, chapped, flaky or scaly skin (128)
1 2 3 Cracks that bleed in hands or feet
1 2 3 Frequent use of lotions to soothe skin
1 2 3 Wounds or cuts heal slowly (7)
1 2 3 Bruise easily or visibly
1 2 3 Reduced initiative (136)
1 2 3 Nails are brittle or easily crack
1 2 3 Hair grows slowly
1 2 3 Infrequent need for haircuts or shaving
1 2 3 Hair coarse body/head or falls out (131)
1 2 3 Headaches upon arising, wear off or decrease during the day (132)
1 2 3 Mental sluggishness (130)
1 2 3 Change in hair loss amount
1 2 3 Increase cholesterol or fat in blood
1 2 3 Weight change, loss or gain

1 2 3 Frequency of urination (134)
1 2 3 Feels or looks puffy or swollen
1 2 3 Decreased energy levels
1 2 3 Decreased appetite (123)
1 2 3 Weight gain that is difficult to lose
1 2 3 Constipation (129)
1 2 3 Slow pulse rate, below 65 (133)
1 2 3 Irregular menstrual periods
1 2 3 Miscarriages
1 2 3 Insomnia (107)
1 2 3 Nervousness (108)
1 2 3 Can't gain weight (109)
1 2 3 Intolerance to heat (110)
1 2 3 Prefers cool or cold weather
1 2 3 Highly emotional (111)
1 2 3 Flush or turns red easily (112)
1 2 3 Night sweats (113)
1 2 3 Thin, moist/oily skin (114)
1 2 3 Inward trembling or shaky (115)
1 2 3 Increased appetite without weight gain (117)
1 2 3 Pulse fast at rest (118)
1 2 3 Eyelids and face twitch (119)
1 2 3 Irritable and restless (120)
1 2 3 Can't work under pressure (121)
1 2 3 Poor balance
1 2 3 Increase heart rate or aware of heart (116)
1 2 3 Shortness of breath

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1 2 3 Failing memory (137)
1 2 3 Low blood pressure (138)
1 2 3 Increased sex drive (139)
1 2 3 Headaches "splitting or rending" type (140)
1 2 3 Random Headaches without a pattern
1 2 3 Decreased sugar intolerance (141)
1 2 3 Abnormal thirst (142)
1 2 3 Bloating of abdomen (143)

1 2 3 Weight gain around hips or waist (144)
1 2 3 Sex drive reduced or lacking (145)
1 2 3 Tendency to ulcers, colitis (146)
1 2 3 Increased sugar tolerance (147)
1 2 3 Women: menstrual disorders (148)
1 2 3 Young girls: lack of menstrual function (149)

1 2 3 Symptoms worse at night or when its dark out

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1 2 3 Apprehension (173)
1 2 3 Irritability (174)
1 2 3 Morbid fears (175)
1 2 3 Never seems to get well (176)
1 2 3 Forgetfulness (177)
1 2 3 Indigestion (178)
1 2 3 Poor appetite (179)
1 2 3 Cravings for sweets (180)
1 2 3 Muscular soreness (181)
1 2 3 Depression; feeling of dread (182)
1 2 3 Noise sensitivity (183)
1 2 3 Acoustic hallucinations (184)
1 2 3 Tendency to cry without reason (185)
1 2 3 Hair is coarse and/or thinning (186)

1 2 3 Weakness (187)
1 2 3 Fatigue (188)
1 2 3 Skin sensitive to touch (189)
1 2 3 Tendency towards hives (189)
1 2 3 Nervousness (191)
1 2 3 Headache (192)
1 2 3 Insomnia (193)
1 2 3 Anxiety (194)
1 2 3 Anorexia (195)
1 2 3 Inability to concentrate (196)
1 2 3 Frequent stuffy nose; sinus infections (197)
1 2 3 Allergy to some foods (198)
1 2 3 Loose joints (199)

Females Only

1 2 3 Very easily fatigued (200)
1 2 3 Premenstrual tension (201)
1 2 3 Painful menses (202)
1 2 3 Depressed feelings (203)
1 2 3 Menstruation excessive and prolonged (204)
1 2 3 Painful breasts (205)
1 2 3 Menstruate too frequently (206)

1 2 3 Vaginal discharge (207)
1 2 3 Hysterectomy/ovaries removed (208)
1 2 3 Menopausal hot flashes (209)
1 2 3 Menses scanty or missed (210)
1 2 3 Acne, worse at menses (211)
1 2 3 Depression of long standing (212)
1 2 3 Headache worse/starts with menses

Males Only

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

HIPAA & CONSENT

We would like you to know how our office will be using your information and the rights that you have as a patient here regarding your records. Before we begin with your healthcare needs we must require you to read and sign this consent form stating that you understand and agree how your records will be used.

1. The patient understands and agrees to allow An Even Vída Clinic to use their patient information for the purpose of treatment, payment, and health care operations.

2. The patient has the right to examine and obtain a copy of his/her own health records at any time. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their patient information. Our office will not release any of your records without your written permission

3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.

4. The patient may provide a written request to revoke consent at any time during care. This would not effect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the consent has been presented.

5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known to An Even Vida Clinic to assure that your records are not readily available to those who do not need them.

6. If the patient refuses to sign this consent for the purpose of treatment, payment, and health care operations the physician has the right to refuse care.

I agree to the above HIPPA/Consent Initial_____

PATIENT BILLING INFORMATION & CONSENT FOR PROFESSIONAL SERVICES

I understand that all payments are due to An Even Vída Clinic at the time services are rendered. All bills are due and payable in full at date of service.

All fees are based upon individual services rendered, and may vary from visit to visit depending upon the doctors specific recommendations. *An initial visit usually consists of a consultation and exam ($199) and usually lasts approximately an hour. If your situation calls for longer than an hour your fee will be adjusted accordingly, for further pricing contact the office.*

An Even Vída Clinic is NOT responsible for submitting claims to ANY insurance entity included but not limited to health, auto, worker's compensation or personal injury. If I intend to submit receipts acquired at An Even Vída Clinic to an insurance entity I must notify the front desk before payment.

I agree to the above fee schedule Initial_____

WE MISS YOU WHEN YOU MISS YOUR APPOINTMENT

We kindly ask that any changes or cancellations are made 24 hours prior to your appointment. A notice of less than 24 hours impacts our opportunity to serve other patients. Simply give the office a ring when you need to modify, change, or cancel an appointment. Our office coordinator is a scheduling guru.

We understand "life happens," and you may miss an appointment without notice. However, if you miss multiple appointments, we reserve the right to charge a fee of up to 100% of the cost of the scheduled services. We also reserve the right to ask for pre-payment via credit card to book future appointments.

If copies of medical records are needed, a charge of $10.00 for copy charge and an additional 10 cents per page over 15 pages will be billed to you.

I have read and understand how my patient information will be used and how the payments are due, and I agree to these policies and procedures. Please sign before your appointment.

_____ _____

Signature Today's Date