THE NEURO CLINIC
Jon N. Chambers, DC
1014 NE 7th Street
Grants Pass, OR 97526
Phone (541) 479-1289 Fax (888) 640-1719

DISCLOSURE OF FEES AND POLICIES

Welcome to The Neuro Clinic! We believe in a whole body approach to health care, and are determined to help evaluate and identify any health condition(s) you may have through examination and testing. Our goal is to help treat your medical condition(s) with various therapies by creating an individual treatment plan that will best serve each patient. Due to the nature of care in our clinic, we ask that you read, understand, and sign the following disclosures of fees and policies.

I understand that I am responsible for payment in full at the time of service. I understand that the initial examination fee is **$225.00**, with payment at time of service. Treatment and therapy prices are based upon time spent with the treating doctor and/or chiropractic assistants, HBOT technician, and massage therapist. I understand that time spent with the doctor is **$50.00 for up to 10 minutes, $75.00 for up to 15 minutes, and $100.00 for up to 20 minutes and so on**. Dependent upon the specific recommendations of the doctor, other fees for services received apply. A complete list of services received is available to me upon request in the form of a super-bill. All fees are subject to change without notice.

I understand that if I arrive late for an appointment, the doctor will see me for the remainder of my scheduled visit, if any. However, full price for the scheduled time will be charged.

I acknowledge that the policy of The Neuro Clinic is to schedule only one person to a specific time slot for the doctor, chiropractic assistant, hyperbaric chamber, or massage therapist. This allows the provider to devote their undivided attention to each individual. By honoring my time as well as the provider's, I can obtain the maximum benefit during my treatment.

In the event of a no-show, for any reason, I will be charged for the full appointment time. By signing this form, I authorize The Neuro Clinic to fulfill this transaction.
If 24 hour cancellation notice is given, I will not be charged for the appointment.
Any nutritional supplements recommended to me, will be paid for at the time of service.

I fully understand and agree that health and motor vehicle accident policies are an arrangement between the carrier and myself. If prior authorization for billing such a plan has been approved but payment is not received, I accept full responsibility for the charges at the full rate, without discount for payment at time of service. I agree that if any expense is incurred in the collection of any monies due on my account, this amount will also become my responsibility. Furthermore, I understand that if I opt to pay at the time of service, The Neuro Clinic will prepare a superbill and clinical Notes, if needed, to assist me in seeking reimbursement from my insurance carrier should I make this request.

I have read, understand, and agree to the terms above.

_____
Patients Printed Name

_____ _____
Signature of Patient or Guardian Date

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FINANCIAL ARRANGEMENTS AND CONTACT INFORMATION

We believe that every person has the right to expect the very best professional care we can provide. In turn, we expect cooperation in establishing definite financial arrangements. Accordingly, we have established the following policies.

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1. The initial New Patient Examination requires payment in full at the time of service, $225.00. All subsequent visits are also payment at the time of service.
2. Patients involved in LITIGATION (LAWSUIT) are, just as other patients, responsible for payment at the time of service. Under no circumstances will we carry an account until settlement.
3. If you have not been seen within the last months, an examination will be necessary to reinstate proper treatment. This will require additional time with the doctor, please expect at least a 20 minute visit and the related fees. Each new injury you are treating for may require an additional examination as well.
4. Patients are seen in the order they are scheduled, not by waiting room seniority.
5. We reserve the right to bill for missed appointments. This time is set aside for your health care. 24-hour cancellation notice is required, so that time can be used by another patient in our schedule.
6. PERSONAL CLEANLINESS IS REQUIRED! Due to the close interpersonal nature of our work and for a comfortable environment for our staff and other patients please pay close attention to your personal hygiene prior to appointments.
7. SMOKING IS PROHIBITED WITHIN 20 FEET OF OUR BUILDING. We request that you refrain from smoking prior to your office visit on the day of your appointment.
8. I grant this office permission to seek all legal means necessary to collect delinquent monies that I owe. In addition to my outstanding balance, I will reimburse for legal and/or collections fees included in this process.

Patient Name _____ Cell Phone _____

Street Address _____ Home/other Phone _____

Mailing Address _____

City/State/Zip _____ Email _____

Date of Birth _____

Employer _____ Work Phone _____

Spouse/Significant Other _____

How did you here about our office _____

Emergency Contact _____ Phone# _____

Would you like us to send correspondence to your Primary Care Provider? ☐ Yes ☐ No

Dr.'s Name: _____

My signature is an acknowledgement that I have read the policies above and agree to abide by the same.

_____

Patient Printed Name

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INFORMED CONSENT TO CHIROPRACTIC TREATMENT AND CARE

I hereby request and consent to the performance of procedures, which are the scope of practice for chiropractic neurology, including, but not limited to: examinations, testing, chiropractic adjustments, and various modes of physical therapy, neurologic rehabilitation therapy, and nutritional therapy. I also request and consent that the procedures are to be performed by Jon N. Chambers, D.C., DACNB or any other qualified doctor of chiropractic treating me while employed by, working for, or associated with the doctor named above. This includes those working at the clinic, whether signatories to this form or not.

I understand that results are not guaranteed.

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

I have read, or have had read to me, the above consent. I know I can ask questions about its contents and that 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 future condition(s) for which I seek treatment.

Original will be kept on file in EMR

_____ _____
Patient Printed Name Date

_____
Signature of Patient or Guardian

_____
Doctor's Initials

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Effective Date 01/15/2015

Notice of Patient Privacy Health Insurance Portability and Accountability Act

The Neuro Clinic is dedicated to preserving your personal health information. We are required by law to protect your personal medical information and to provide you with a notice describing how your medical information may be used and disclosed and how you can access this information.

Required by law: We must have your written consent before we use or disclose to others to your medical information for purposes of providing or arranging for your health care, the payment for or reimbursement of the care that we provide you, and the related administrative activities supporting your treatment. We may be required by law to use and disclose your medical information for other purposes without your consent or authorization. You are provided the right to inspect and receive a copy of your medical information that we maintain, amending or correcting that information, obtaining an accounting of or disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise our NOTICE from time to time. The effective date at the top of this page indicates the date of the most current NOTICE in effect.

You have the right to receive a copy of our most current NOTICE in effect. If you have not yet received a copy of our current NOTICE, please ask at the front desk and we will provide you with a copy. If you have any questions, concerns, or complaints about the NOTICE or your medical information, please contact The Neuro Clinic at (541) 479-1289. You may also send a written complaint to the US Department of Health and Human Services.

_____
Printed Name

_____ _____
Patient Signature Date

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NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires individually identifiable health information used or disclosed by us, whether electronically, on paper, or orally, be kept properly confidential. HIPAA gives the patient significant new rights to understand and control how health information is used. It also provides penalties for covered entities that misuse personal health information. We may use and disclose your medical records only for the following purposes:

- Treatment - Providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment- Obtaining reimbursement for services, confirming coverage, billing, and collection activities
- Health Care Operations - Conducting quality assessment and improvement activities, auditing, cost management analysis, and providing customer service.

We may also create and distribute de-identified health information by removing all individually identifiable Information.

We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services, which might be of interest to you.

Any other uses and disclosures may be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, except to the extent that we have already taken actions relying on your authorization.

<u>You have the following rights, which you can exercise by presenting a written request to our office.</u>

- To request restrictions on certain uses and disclosures of protected health information. This includes disclosures to family members, other relatives, and personal friends, or other persons identified by you. We are not required to agree to requested restrictions. However, if we do agree to a restriction, we are obligated to abide by it, unless you agree in writing to remove it.
- To a reasonable request to receive confidential communications from us by alternative means or at alternative locations.
- To inspect and copy your protected health information.
- To amend your protected health information.
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this notice upon request.

This notice is updated and effective January 15, 2015 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make new notice provision effective for all protected health information that we maintain.

Should you feel your privacy protections have been violated, you may file a written complaint about violations of the provision of the notice or of the policies and procedures of our office, with this office or the Department of Health and Human Services, Office of Civil Rights (address below). We will not retaliate against you for filing a complaint.

For more information about HIPAA contact: The US Department Of Health and Human Services, Office of Civil Rights,
200 Independence Ave. SW Washington DC 20201 Phone 202 619-0257 or toll free (877) 696-677

Brain Function Assessment Form™ (BFAF)

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

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 1

- A decrease in attention span **0 1 2 3**
- Mental fatigue **0 1 2 3**
- Difficulty learning new things **0 1 2 3**
- Difficulty staying focused and concentrating for extended periods of time **0 1 2 3**
- Experiencing fatigue when reading sooner than in the past **0 1 2 3**
- Experiencing fatigue when driving sooner than in the past **0 1 2 3**
- Need for caffeine to stay mentally alert **0 1 2 3**
- Overall brain function impairs your daily life **0 1 2 3**

SECTION 2

- Twitching or tremor in your hands and legs when resting **0 1 2 3**
- Handwriting has gotten smaller and more crowded together **0 1 2 3**
- A loss of smell to foods **0 1 2 3**
- Difficulty sleeping or fitful sleep **0 1 2 3**
- Stiffness in shoulders and hips that goes away when you start to move **0 1 2 3**
- Constipation **0 1 2 3**
- Voice has become softer **0 1 2 3**
- Facial expression that is serious or angry **0 1 2 3**
- Episodes of dizziness or light-headedness upon standing **0 1 2 3**
- A hunched over posture when getting up and walking **0 1 2 3**

SECTION 3

- Memory loss that impacts daily activities **0 1 2 3**
- Difficulty planning, problem solving, or working with numbers **0 1 2 3**
- Difficulty completing daily tasks **0 1 2 3**
- Confusion about dates, the passage of time, or place **0 1 2 3**
- Difficulty understanding visual images and spatial relationships (addresses and locations) **0 1 2 3**
- Difficulty finding words when speaking **0 1 2 3**
- Misplacement of things and inability to retrace steps **0 1 2 3**
- Poor judgment and bad decisions **0 1 2 3**
- Disinterest in hobbies, social activities, or work **0 1 2 3**
- Personality or mood changes **0 1 2 3**

SECTION 4

- Reduced function in overall hearing **0 1 2 3**
- Difficulty understanding language with background or scatter noise **0 1 2 3**
- Ringing or buzzing in the ear **0 1 2 3**
- Difficulty comprehending language without perfect pronunciation **0 1 2 3**
- Difficulty recognizing familiar faces **0 1 2 3**
- Changes in comprehending the meaning of sentences, written or spoken **0 1 2 3**
- Difficulty with verbal memory and finding words **0 1 2 3**
- Difficulty remembering events **0 1 2 3**
- Difficulty recalling previously learned facts and names **0 1 2 3**
- Inability to comprehend familiar words when read **0 1 2 3**
- Difficulty spelling familiar words **0 1 2 3**
- Monotone, unemotional speech **0 1 2 3**
- Difficulty understanding the emotions of others when they speak (nonverbal cues) **0 1 2 3**
- Disinterest in music and a lack of appreciation for melodies **0 1 2 3**
- Difficulty with long-term memory **0 1 2 3**
- Memory impairment when doing the basic activities of daily living **0 1 2 3**
- Difficulty with directions and visual memory **0 1 2 3**
- Noticeable differences in energy levels throughout the day **0 1 2 3**

SECTION 5

- Difficulty coordinating visual inputs and hand movements, resulting in an inability to efficiently reach for objects **0 1 2 3**
- Difficulty comprehending written text **0 1 2 3**
- Floaters or halos in your visual field **0 1 2 3**
- Dullness of colors in your visual field during different times of the day **0 1 2 3**
- Difficulty discriminating similar shades of color **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Function Assessment Form™ (BFAF)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 6

- Difficulty with detailed hand coordination **0 1 2 3**
- Difficulty with making decisions **0 1 2 3**
- Difficulty with suppressing socially inappropriate thoughts **0 1 2 3**
- Socially inappropriate behavior **0 1 2 3**
- Decisions made based on desires, regardless of the consequences **0 1 2 3**
- Difficulty planning and organizing daily events **0 1 2 3**
- Difficulty motivating yourself to start and finish tasks **0 1 2 3**
- A loss of attention and concentration **0 1 2 3**

SECTION 7

- Hypersensitivities to touch or pain **0 1 2 3**
- Difficulty with spatial awareness when moving, laying back in a chair, or leaning against a wall **0 1 2 3**
- Frequently bumping into the wall or objects **0 1 2 3**
- Difficulty with right-left discrimination **0 1 2 3**
- Handwriting has become sloppier **0 1 2 3**
- Difficulty with basic math calculations **0 1 2 3**
- Difficulty finding words for written or verbal communication **0 1 2 3**
- Difficulty recognizing symbols, words, or letters **0 1 2 3**

SECTION 8

- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Bowel motility and movements slow **0 1 2 3**
- Bloating after meals **0 1 2 3**
- Dry eyes or dry mouth **0 1 2 3**
- A racing heart **0 1 2 3**
- A flutter in the chest or an abnormal heart rhythm **0 1 2 3**
- Bowel or bladder incontinence, resulting in staining your underwear **0 1 2 3**

SECTION 9

- A decrease in movement speed **0 1 2 3**
- Difficulty initiating movement **0 1 2 3**
- Stiffness in your muscles (not joints) **0 1 2 3**
- A stooped posture when walking **0 1 2 3**
- Cramping of your hand when writing **0 1 2 3**

SECTION 10

- Abnormal body movements (such as twitching legs) **0 1 2 3**
- Desires to flinch, clear your throat, or perform some type of movement **0 1 2 3**
- Constant nervousness and a restless mind **0 1 2 3**
- Compulsive behaviors **0 1 2 3**
- Increased tightness and tone in specific muscles **0 1 2 3**

SECTION 11

- Difficulty with balance, or balance that is noticeably worse on one side **0 1 2 3**
- A need to hold the handrail or watch each step carefully when going down stairs **0 1 2 3**
- Episodes of dizziness **0 1 2 3**
- Nausea, car sickness, or seasickness **0 1 2 3**
- A quick impact after consuming alcohol **0 1 2 3**
- A slight hand shake when reaching for something **0 1 2 3**
- Back muscles that tire quickly when standing or walking **0 1 2 3**
- Chronic neck or back muscle tightness **0 1 2 3**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Health and Nutrition Assessment Form™ (BHNAF)

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

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 1

- Low brain endurance for focus and concentration **0 1 2 3**
- Cold hands and feet **0 1 2 3**
- Must exercise or drink coffee to improve brain function **0 1 2 3**
- Poor nail health **0 1 2 3**
- Fungal growth on toenails **0 1 2 3**
- Must wear socks at night **0 1 2 3**
- Nail beds are white instead of pink **0 1 2 3**
- The tip of the nose is cold **0 1 2 3**

SECTION 2

- Irritable, nervous, shaky, or light-headed between meals **0 1 2 3**
- Feel energized after meals **0 1 2 3**
- Difficulty eating large meals in the morning **0 1 2 3**
- Energy level drops in the afternoon **0 1 2 3**
- Crave sugar and sweets in the afternoon **0 1 2 3**
- Wake up in the middle of the night **0 1 2 3**
- Difficulty concentrating before eating **0 1 2 3**
- Depend on coffee to keep going **0 1 2 3**

SECTION 3

- Fatigue after meals **0 1 2 3**
- Sugar and sweet cravings after meals **0 1 2 3**
- Need for a stimulant, such as coffee, after meals **0 1 2 3**
- Difficulty losing weight **0 1 2 3**
- Increased frequency of urination **0 1 2 3**
- Difficulty falling asleep **0 1 2 3**
- Increased appetite **0 1 2 3**

SECTION 4

- Always have projects and things that need to be done **0 1 2 3**
- Never have time for yourself **0 1 2 3**
- Not getting enough sleep or rest **0 1 2 3**
- Difficulty getting regular exercise **0 1 2 3**
- Feel that you are not accomplishing your life's purpose **0 1 2 3**

SECTION 5

- Dry and unhealthy skin **0 1 2 3**
- Dandruff or a flaky scalp **0 1 2 3**
- Consumption of processed foods that are bagged or boxed **0 1 2 3**
- Consumption of fried foods **0 1 2 3**
- Difficulty consuming raw nuts or seeds **0 1 2 3**
- Difficulty consuming fish (not fried) **0 1 2 3**
- Difficulty consuming olive oil, avocados, flax seed oil, or natural fats **0 1 2 3**

SECTION 6

- Difficulty digesting foods **0 1 2 3**
- Constipation or inconsistent bowel movements **0 1 2 3**
- Increased bloating or gas **0 1 2 3**
- Abdominal distention after meals **0 1 2 3**
- Difficulty digesting protein-rich foods **0 1 2 3**
- Difficulty digesting starch-rich foods **0 1 2 3**
- Difficulty digesting fatty or greasy foods **0 1 2 3**
- Difficulty swallowing supplements or large bites of food **0 1 2 3**
- Abnormal gag reflex **Yes or No**

SECTION 7

- Brain fog (unclear thoughts or concentration) **Yes or No**
- Pain and inflammation **Yes or No**
- Noticeable variations in mental speed **Yes or No**
- Brain fatigue after meals **0 1 2 3**
- Brain fatigue after exposure to chemicals, scents, or pollutants **0 1 2 3**
- Brain fatigue when the body is inflamed **0 1 2 3**

SECTION 8

- Grain consumption leads to tiredness **0 1 2 3**
- Grain consumption makes it difficult to focus and concentrate **0 1 2 3**
- Feel better when bread and grains are avoided **0 1 2 3**
- Grain consumption causes the development of any symptoms **0 1 2 3**
- A 100% gluten-free diet **Yes or No**

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Brain Health and Nutrition Assessment Form™ (BHNAF)

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

SECTION 9

- A diagnosis of celiac disease, gluten sensitivity, hypothyroidism, or an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with an autoimmune disease — **Yes or No**
- Family members who have been diagnosed with celiac disease or gluten sensitivity — **Yes or No**
- Changes in brain function with stress, poor sleep, or immune activation — **0 1 2 3**

SECTION 10

- A loss of pleasure in hobbies and interests — **0 1 2 3**
- Feel overwhelmed with ideas to manage — **0 1 2 3**
- Feelings of inner rage or unprovoked anger — **0 1 2 3**
- Feelings of paranoia — **0 1 2 3**
- Feelings of sadness for no reason — **0 1 2 3**
- A loss of enjoyment in life — **0 1 2 3**
- A lack of artistic appreciation — **Yes or No**
- Feelings of sadness in overcast weather — **0 1 2 3**
- A loss of enthusiasm for favorite activities — **0 1 2 3**
- A loss of enjoyment in favorite foods — **0 1 2 3**
- A loss of enjoyment in friendships and relationships — **0 1 2 3**
- Inability to fall into deep, restful sleep — **0 1 2 3**
- Feelings of dependency on others — **0 1 2 3**
- Feelings of susceptibility to pain — **0 1 2 3**

SECTION 11

- Feelings of worthlessness — **0 1 2 3**
- Feelings of hopelessness — **0 1 2 3**
- Self-destructive thoughts — **0 1 2 3**
- Inability to handle stress — **0 1 2 3**
- Anger and aggression while under stress — **0 1 2 3**
- Feelings of tiredness, even after many hours of sleep — **0 1 2 3**
- A desire to isolate yourself from others — **0 1 2 3**
- An unexplained lack of concern for family and friends — **0 1 2 3**
- An inability to finish tasks — **0 1 2 3**
- Feelings of anger for minor reasons — **0 1 2 3**

SECTION 12

- A decrease in visual memory (shapes and images) — **Yes or No**
- A decrease in verbal memory — **0 1 2 3**
- Occurrence of memory lapses — **0 1 2 3**
- A decrease in creativity — **0 1 2 3**
- A decrease in comprehension — **0 1 2 3**
- Difficulty calculating numbers — **0 1 2 3**
- Difficulty recognizing objects and faces — **0 1 2 3**
- A change in opinion about yourself — **0 1 2 3**
- Slow mental recall — **0 1 2 3**

SECTION 13

- A decrease in mental alertness — **0 1 2 3**
- A decrease in mental speed — **0 1 2 3**
- A decrease in concentration quality — **0 1 2 3**
- Slow cognitive processing — **0 1 2 3**
- Impaired mental performance — **0 1 2 3**
- An increase in the ability to be distracted — **0 1 2 3**
- Need coffee or caffeine sources to improve mental function — **0 1 2 3**

SECTION 14

- Feelings of nervousness or panic for no reason — **0 1 2 3**
- Feelings of dread — **0 1 2 3**
- Feelings of a “knot” in your stomach — **0 1 2 3**
- Feelings of being overwhelmed for no reason — **0 1 2 3**
- Feelings of guilt about everyday decisions — **0 1 2 3**
- A restless mind — **0 1 2 3**
- An inability to turn off the mind when relaxing — **0 1 2 3**
- Disorganized attention — **0 1 2 3**
- Worry over things never thought about before — **0 1 2 3**
- Feelings of inner tension and inner excitability — **0 1 2 3**

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CONFIDENTIAL PATIENT INFORMATION

PATIENT NAME:_____ DATE: _____

Purpose of this appointment (major concern) _____

Next Top Concerns_____

Is the condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No

Date of onset_____ Was it? ☐ Sudden ☐ Gradual

For patients dealing with pain.

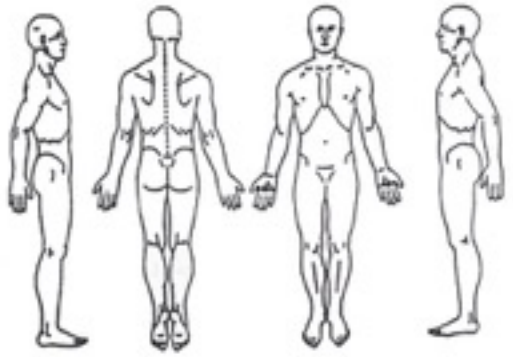
1. How bad is your pain or ache? Please circle a number: (0 is no pain, 10 is unbearable pain) 1 2 3 4 5 6 7 8 9 10
2. Describe your pain or complaint:
   - ☐ Dull ☐ Sharp ☐ Ache ☐ Stabbing
   - ☐ Deep ☐ Superficial ☐ Spasm/Tension ☐ Numbness
   - ☐ Tingling ☐ Burning ☐ Other_____
3. Radiation: Does the pain travel to other parts of your body?
   - ☐ Yes ☐ No Where?_____
4. Frequency: ☐ Occasional ☐ Intermittent ☐ Constant
5. Duration: How long does the pain last?_____
6. What make the pain/problem worse?
   - ☐ Standing ☐ Sitting ☐ Bending ☐ Twisting
   - ☐ Walking ☐ Lifting ☐ Sleeping ☐ Heat
   - ☐ Cold ☐ Stooping ☐ Sex
   - ☐ Other_____
7. What makes the pain/problem better?
   - ☐ Standing ☐ Sitting ☐ Rest ☐ Heat
   - ☐ Cold ☐ Aspirin/Med ☐ Other_____
8. Other problems related to your main complaint

   _____
9. What treatment have you received for this condition?_____
10. Have you lost any days from work? ☐ Yes ☐ No How many?_____
11. What do you believe is wrong with you? _____
12. What operations have you had?_____
13. Do you have any scars? ☐ Yes ☐ No Do you have any mouth sores or tooth pain? ☐ Yes ☐ No
14. What medications or drugs are you taking? _____

    _____
15. Have you ever been under chiropractic care? ☐ Yes ☐ No Doctor's name_____

Remarks and additional information _____

Show on the drawings where your problem is located



Have you ever suffered from: (read from top to bottom as a list)

☐ Allergies	☐ Swollen joints	☐ Hay Fever	☐ Itching
☐ Dizziness	☐ Colon trouble	☐ Nosebleeds	☐ Varicose Veins
☐ Fatigue	☐ Diarrhea	☐ Sinus infections	☐ Bed-wetting
☐ Headache	☐ Hemorrhoids	☐ High blood pressure	☐ Frequent urination
☐ Loss of Sleep	☐ Nausea	☐ Low blood pressure	☐ Kidney infection or stones
☐ Ulcers	☐ Asthma	☐ Pain over heart	☐ Prostate trouble
☐ Nervousness/Depression		☐ Poor circulation	☐ Cramps or backache
☐ Numbness	☐ Deafness	☐ Rapid heartbeat	☐ Excessive menstrual flow
☐ Arthritis	☐ Ear noises	☐ Slow heartbeat	☐ Hot flashes
☐ Bursitis	☐ Jaw pain	☐ Anemia	☐ Irregular cycle
☐ Foot Trouble	☐ Eye pain	☐ Stroke	☐ Lumps in breasts
☐ Low back pain	☐ Failing vision	☐ Chest pain	☐ Alcoholism
☐ Poor posture	☐ Venereal Disease	☐ Difficulty breathing	☐ Addiction
☐ Sciatica	☐ Tuberculosis	☐ Pleurisy	☐ Polio
☐ Spinal Curvatures	☐ Bruise easily	☐ Spitting	☐ Swelling of ankles
☐ Diabetes	☐ Cancer	☐ Hiatal Hernia	☐ Colds

Tingling or numbness in: ☐ Shoulders ☐ Hips ☐ Arms ☐ Legs ☐ Elbows ☐ Knees ☐ Hands ☐ Feet

Habits:	Heavy	Moderate	Light	None
Alcohol	_____	_____	____	____
Coffee	_____	_____	____	____
Tobacco	_____	_____	____	____
Drugs	_____	_____	____	____
Marijuana	_____	_____	____	____
Exercise	_____	_____	____	____
Sleep	_____	_____	____	____
Appetite	_____	_____	____	____

Are you currently taking vitamins or minerals? Yes or No

Do you think you may need to take vitamins and minerals? Yes or No

Are you wearing: ☐ Heel lifts ☐ Sole lifts ☐ Inner soles ☐ Arch supports