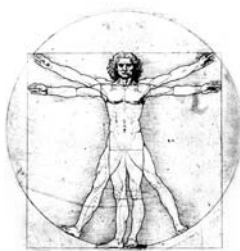


Chiropractic  
Physical Therapy  
Sports Injuries  
Auto Accidents  
Kinesiology  
Weight Loss  
Exercise Programs  
Physical Exams



## Well Being Chiropractic

1700 Eureka Rd Suite 190      Tel: (916)725-7533  
Roseville, Ca. 95661      Fax: (916)771-5939

Patient: \_\_\_\_\_

### **Consent for Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Applied Kinesiology and Wellbeing Chiropractic and his associates/employees for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Applied Kinesiology and Chiropractic. I understand that diagnosis or treatment of me by Applied Kinesiology and Wellbeing Chiropractic may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Wellbeing Chiropractic is not required to agree to the restrictions that I may request. However, if Wellbeing Chiropractic agrees to a restriction that I request, the restriction is binding on Wellbeing Chiropractic and his associates/employees.

I have the right to revoke this consent, in writing, at any time, except to the extent that Wellbeing Chiropractic or his associates/employees have taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Wellbeing Chiropractic's Notice of Privacy Practices prior to signing this document. The Wellbeing Chiropractic Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Wellbeing Chiropractic. The Notice of Privacy Practices for Wellbeing Chiropractic is also provided upon request in his office. This Notice of Privacy Practices also describes my rights and Wellbeing Chiropractic's duties with respect to my protected health information.

Wellbeing Chiropractic reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

\_\_\_\_\_  
Signature of Patient or Personal Representative

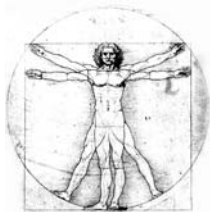
\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Personal Representative

\_\_\_\_\_  
Description of Personal Representative's Authority

Chiropractic  
Physical Therapy  
Sports Injuries  
Auto Accidents  
Kinesiology

Weight Loss



## Well Being Chiropractic

1700 Eureka Rd Suite 190  
Roseville, CA 95661

Tel: (916)771-4151  
Fax: (916)771-5939

### Patient Information

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) \_\_\_\_\_ Mobile Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Soc. Sec. #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Drivers License: State \_\_\_\_\_ # \_\_\_\_\_  
Married: Y / N Name of Spouse: \_\_\_\_\_ Children: Y / N How many: \_\_\_\_\_  
Occupation/Job: \_\_\_\_\_ How Long: \_\_\_\_\_  
Employer: \_\_\_\_\_ Supervisor's Phone (\_\_\_\_) \_\_\_\_\_  
Work Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail address \_\_\_\_\_

### Insurance Information

Insurance Company: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Claim #: \_\_\_\_\_ Policy/Group # \_\_\_\_\_  
Date of Injury: \_\_\_\_\_ Was this accident \_\_in an automobile? \_\_at work? \_\_other(\_\_\_\_)  
Has the accident been reported? Y / N To Whom? \_\_\_\_\_  
Insurance Adjustor: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Attorney Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

### Emergency Contact Information

Whom may we contact in case of an emergency? Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_, (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## CASE HISTORY

Name: \_\_\_\_\_  
Date of Last Physical Exam: \_\_\_\_\_ With whom: \_\_\_\_\_ Where: \_\_\_\_\_  
Report Findings: \_\_\_\_\_  
Surgeries, Hospitalization, Serious Illnesses (list YEAR in brackets): \_\_\_\_\_  
\_\_\_\_\_  
Fractures, Dislocations, Major Dental Work (list YEAR in brackets): \_\_\_\_\_  
\_\_\_\_\_  
Ever use Crutches: Y / N Why: \_\_\_\_\_  
Ever: Had Spinal Taps or Spinal Injections: Y / N Been knocked unconscious: Y / N Had a Lapse of Memory: Y / N  
**Purpose of this Appointment:** \_\_\_\_\_  
\_\_\_\_\_  
Other Doctors seen for this Condition: \_\_\_\_\_  
Are you currently on medication: Y / N If yes, which ones (put the reason for drug's use in brackets): \_\_\_\_\_  
\_\_\_\_\_  
Known Allergies: \_\_\_\_\_  
Suffer from any conditions other than the reason you are here today: \_\_\_\_\_

## HABITS

Smoke: Y / N What: \_\_\_\_\_ How many/Day: \_\_\_\_\_ Since when: \_\_\_\_\_  
Other Tobacco Products: Y / N What: \_\_\_\_\_ How many/Day: \_\_\_\_\_ Since when: \_\_\_\_\_  
Drink Coffee: Y / N Cups/Day: \_\_\_\_\_ Water – Cups/Day: \_\_\_\_\_  
Drink Caffeinated Tea: Y / N Cups/Day: \_\_\_\_\_ Other – Cups/Day: \_\_\_\_\_  
Colas/Soft Drinks: Y / N Avg/Week: \_\_\_\_\_ What kind(s): \_\_\_\_\_  
Alcoholic Beverages: Y / N Avg/Week: \_\_\_\_\_ What kind(s): \_\_\_\_\_  
Eat Red Meat: Y / N What kinds: \_\_\_\_\_  
Vegetarian: Y / N Since when: \_\_\_\_\_ White or Whole Wheat grains: \_\_\_\_\_  
Currently Dieting: Y / N If so, describe: \_\_\_\_\_  
Eat Fast Food: Y / N How often/Week: \_\_\_\_\_ How do you feel after these meals: \_\_\_\_\_  
Taking Supplements: Y / N If so, which ones: \_\_\_\_\_  
Sleep well at night: Y / N If no, describe: \_\_\_\_\_  
Exercise: \_\_\_ None \_\_\_ Light Activity \_\_\_ Moderate Activity \_\_\_ Active \_\_\_ Very Active \_\_\_ Elite Athlete  
Times/Week: \_\_\_\_\_ Describe Exercise Program: \_\_\_\_\_  
\_\_\_\_\_  
Use Heart Rate Monitor: Y / N If yes, target range: \_\_\_\_\_  
Frequent Bowel movements: Y / N Difficulty: Y / N Approximate times you urinate each Day: \_\_\_\_\_  
Have enough Energy for Normal Activities: Y / N If no, describe: \_\_\_\_\_  
Height: \_\_\_\_\_ Weight: \_\_\_\_\_ (Adult Max. Weight): \_\_\_\_\_ at Age \_\_\_\_\_ (Adult Min Weight): \_\_\_\_\_ at Age \_\_\_\_\_  
Has Vision changed recently: Y / N If yes, explain: \_\_\_\_\_  
Wear Heal Lifts / Foot Supports: Y / N If yes, explain: \_\_\_\_\_

## WOMEN ONLY

Age at onset: \_\_\_\_\_ Are your Periods regular: Y / N Cycle: \_\_\_\_\_ days (start to finish) Use Birth Control Pill: Y / N  
Your Flow is: heavy medium light Date of Last Period: \_\_\_\_\_ Are Cramps regular: Y / N Is PMS regular: Y / N  
If yes (to PMS), describe: \_\_\_\_\_  
Other Mentrual / Hormonal Symptoms: \_\_\_\_\_

## MEDICAL HISTORY

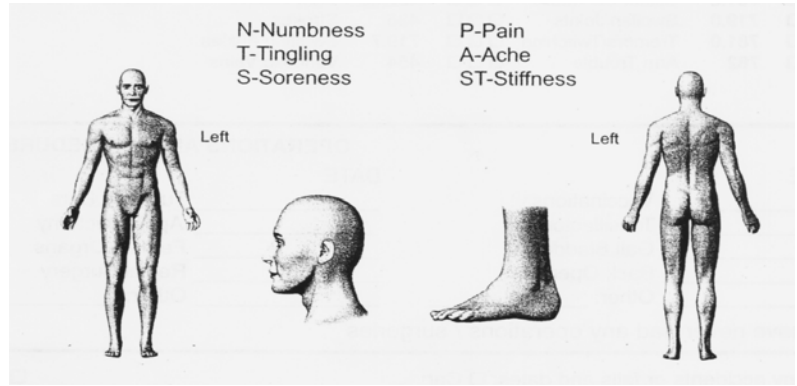
Please mark today's pain intensity level

Mark area & type of pain on the drawings using codes listed below

1 – LOW PAIN  
10 – HIGH PAIN

Example:

				Neck						
1.	1	2	3	4	5	6	7	8	9	10
2.	1	2	3	4	5	6	7	8	9	10
3.	1	2	3	4	5	6	7	8	9	10



## X-RAY HISTORY

Please include CAT / MRI / DYE STUDIES and DENTAL . . . When was most recent PROCEDURE performed?

AGE	BODY AREA	TYPE (NORMAL X-RAY / CAT / MRI / etc.)	# of STUDIES

## FAMILY MEDICAL HISTORY

	Living	Age or Age at Death	Allergies	Arthritis	Alcoholism	Cancer	Depression	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Stroke	Other Description
Father													
Father's Mother													
Father's Father													
Father's Grandmas													
Father's Grandpas													
Father's Siblings													
Mother													
Mother's Mother													
Mother's Father													
Mother's Grandmas													
Mother's Grandpas													
Mother's Siblings													
Your Siblings													
Your Children													

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company, and any amount authorized to be paid directly to the Doctor's Office will be credited to my account upon receipt. However, I understand and agree that I am personally responsible to pay for all services I receive that are not covered by my insurance. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I hereby authorize the Doctor to examine and treat my condition as he deems appropriate using Chiropractic Health Care. It is understood and agreed the amount paid the Doctor for X-Ray negatives will remain the property of this office, and may be seen at any time while I am a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's/Guardian's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUSTIN KINESIOLOGY & CHIROPRACTIC CENTER**  
**CONTEXT OF CARE OVERVIEW**

Thank you for your time and willingness to fill out this brief survey. It helps us serve you better!

1. **Why did you choose our clinic to support your health needs?**  
o Family/Friend \_\_\_\_\_ o Other \_\_\_\_\_
  
2. **What do you know about our approach (Kinesiology/Chiropractic)?**
  
3. **Can you envision yourself healthy, happy and free from present health challenges at some point in the future? o YES  
o NO**  
(If YES, how long do you feel process will take? If NO, what are the obstacles?)
  
4. **What do you perceive as your role or responsibility with respect to your healthcare?**
  
5. **Do you believe there is any purpose to your present signs and symptoms? Ie: Is there a possible message or positive intent with them? Could your body's inherent wisdom be trying to alert you to something?**
  
8. **Do you believe your body's inherent wisdom has the ability to heal or significantly improve your present health changes? o YES o NO**
  
9. **What is your present level of commitment to learn and implement the healthy changes which will improve your health and well-being. (Rate from 1-10)**  
  
If below 8, what will it take to increase your level of commitment?
  
10. **What resources do you currently allocate to your health and well-being?  
i.e. How much time, money and energy do you invest in your health?**
  
11. **How much time, energy and money are you willing to invest in your health and happiness? I.e. What limits do you place here?**

## SYMPTOM SURVEY

Patient Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Instructions: Put a number by those symptoms that apply to you with a **1, 2, or 3**. (Leave the slot blank if it does not apply to you!)

**1 = Last Year**

**2 = Last 6 Months**

**3 = Now**

### Group 1

- 1 \_\_\_ Acid foods upset
- 2 \_\_\_ Get chilled often
- 3 \_\_\_ "Lump" in throat
- 4 \_\_\_ Dry mouth/eyes/nose
- 5 \_\_\_ Pulse speeds after meals
- 6 \_\_\_ Keyed up – Fail to calm
- 7 \_\_\_ Cuts heal slowly
- 8 \_\_\_ Gag easily
- 9 \_\_\_ Unable to relax/startles easily
- 10 \_\_\_ Extremities cold/clammy
- 11 \_\_\_ Strong light irritates
- 12 \_\_\_ Urine amount reduced
- 13 \_\_\_ Heart pounds after retiring
- 14 \_\_\_ "Nervous" stomach
- 15 \_\_\_ Appetite reduced
- 16 \_\_\_ Cold sweats often
- 17 \_\_\_ Fever easily raised
- 18 \_\_\_ Neuralgia-like pains
- 19 \_\_\_ Staring, blinks little
- 20 \_\_\_ Frequent sour stomach

### Group 2

- 21 \_\_\_ Joint stiffness after rising
- 22 \_\_\_ Muscle-leg-toe night cramps
- 23 \_\_\_ "Butterfly" stomach/cramps
- 24 \_\_\_ Eyes or nose watery
- 25 \_\_\_ Eyes blink often
- 26 \_\_\_ Eyelids swollen/puffy
- 27 \_\_\_ Indigestion soon after meals
- 28 \_\_\_ Always seem hungry; feels "lightheaded" often
- 29 \_\_\_ Digestion rapid
- 30 \_\_\_ Vomiting frequent
- 31 \_\_\_ Hoarseness frequent
- 32 \_\_\_ Breathing irregular
- 33 \_\_\_ Pulse slow; feels "irregular"
- 34 \_\_\_ Gagging reflex slow
- 35 \_\_\_ Difficulty swallowing
- 36 \_\_\_ Constipation & diarrhea alternate
- 37 \_\_\_ "Slow" starter

- 38 \_\_\_ Get "chilled" infrequently
- 39 \_\_\_ Perspire easily
- 40 \_\_\_ Circulation poor/sensitive to cold
- 41 \_\_\_ Frequent colds/asthma/bronchitis

### Group 3

- 42 \_\_\_ Eat when nervous
- 43 \_\_\_ Excessive appetite
- 44 \_\_\_ Hungry between meals
- 45 \_\_\_ Irritable before meals
- 46 \_\_\_ Get "shaky" if hungry
- 47 \_\_\_ Fatigue, eating relieves
- 48 \_\_\_ "Lightheaded" if meal delays
- 49 \_\_\_ Heart palpitates if meals missed or delayed
- 50 \_\_\_ Afternoon headaches
- 51 \_\_\_ Overeating sweets upsets
- 52 \_\_\_ Awaken after a few hours sleep - hard to get back to sleep
- 53 \_\_\_ Crave candy or coffee in afternoons
- 54 \_\_\_ Moods of depression, "blues" or melancholy
- 55 \_\_\_ Abnormal craving for sweets or snacks

### Group 4

- 56 \_\_\_ Hands & feet go to sleep easily; numbness
- 57 \_\_\_ Sigh frequently, "air hunger"
- 58 \_\_\_ Aware of "breathing heavily"
- 59 \_\_\_ High altitude discomfort
- 60 \_\_\_ Open windows in closed room
- 61 \_\_\_ Susceptible to colds & fevers
- 62 \_\_\_ Afternoon "yawner"
- 63 \_\_\_ Get "drowsy" often
- 64 \_\_\_ Swollen ankles at night
- 65 \_\_\_ Muscle cramps worse during exercise; get "charley horses"
- 66 \_\_\_ Shortened breath on exertion

- 67 \_\_\_ Dull pain in chest or radiating into left arm, worse on exertion
- 68 \_\_\_ Bruise easily; black/blue spots
- 69 \_\_\_ Tendency to anemia
- 70 \_\_\_ "Nose bleeds" frequent
- 71 \_\_\_ Noises in head/ringing ears
- 72 \_\_\_ Tension under the breastbone, or feeling of "tightness", worse on exertion

### Group 5

- 73 \_\_\_ Dizziness
- 74 \_\_\_ Dry Skin
- 75 \_\_\_ Burning feet
- 76 \_\_\_ Blurred vision
- 77 \_\_\_ Itching skin & feet
- 78 \_\_\_ Excessive falling hair
- 79 \_\_\_ Frequent skin rashes
- 80 \_\_\_ Bitter, metallic taste in mouth in mornings
- 81 \_\_\_ Bowel movements painful/difficult
- 82 \_\_\_ Worrier, feels insecure
- 83 \_\_\_ Feeling queasy; headache over eyes
- 84 \_\_\_ Greasy foods upset
- 85 \_\_\_ Stools light colored
- 86 \_\_\_ Skin peels on foot soles
- 87 \_\_\_ Pain between shoulder blades
- 88 \_\_\_ Use laxatives
- 89 \_\_\_ Stools alternate from soft to watery
- 90 \_\_\_ History of gallbladder attacks or gallstones
- 91 \_\_\_ Sneezing attacks
- 92 \_\_\_ Dreaming, nightmare/bad dreams
- 93 \_\_\_ Bad breath (halitosis)
- 94 \_\_\_ Milk products cause distress
- 95 \_\_\_ Sensitive to hot weather
- 96 \_\_\_ Burning or itching anus
- 97 \_\_\_ Crave sweets

**Group 6**

- 98 \_\_\_ Loss of tast for meat
- 99 \_\_\_ Lower bowel gas, several hours after eating
- 100\_\_\_ Burning stomach sensations, eating relieves
- 101\_\_\_ Coated toungue
- 102\_\_\_ Pass large amounts of foul smelling gas
- 103\_\_\_ Indigestion ½-1 hour after eating; may be up to 3 – 4 hours
- 104\_\_\_ Mucus Colitis or IBS
- 105\_\_\_ Gas shortly after eating
- 106\_\_\_ Stomach “bloats” after eating

**Group 7****( A )**

- 107\_\_\_ Insomnia
- 108\_\_\_ Nervousness
- 109\_\_\_ Can’t gain weight
- 110\_\_\_ Intolerance to heat
- 111\_\_\_ Highly emotional
- 112\_\_\_ Flush easily
- 113\_\_\_ Night sweats
- 114\_\_\_ Thin, moist skin
- 115\_\_\_ Inward trembling
- 116\_\_\_ Heart palpitates
- 117\_\_\_ Increased appetite w/o weight gain
- 118\_\_\_ Pulse fast at rest
- 119\_\_\_ Eyelids and face twitch
- 120\_\_\_ Irritable & restless
- 121\_\_\_ Can’t work under pressure

**( B )**

- 122\_\_\_ Increase in weight
- 123\_\_\_ Decrease in appetite
- 124\_\_\_ Fatigue easily
- 125\_\_\_ Ringin in ears
- 126\_\_\_ Sleepy during the day
- 127\_\_\_ Sensitive to cold
- 128\_\_\_ Dry/scaly skin
- 129\_\_\_ Constipation
- 130\_\_\_ Mental sluggishness
- 131\_\_\_ Hair coarse, falls out
- 132\_\_\_ Headaches upon arising & wear off during the day
- 133\_\_\_ Slow pulse, below 65
- 134\_\_\_ Frequency of urination
- 135\_\_\_ Impaired hearing

\_\_\_ Reduced initiative

**Group 7 (con’t)****( C )**

- 136\_\_\_ Failing memory
- 137\_\_\_ Low blood pressure
- 138\_\_\_ Increased sex drive
- 139\_\_\_ Headaches, splitting/rending type
- 140\_\_\_ Decrease sugar tolerance

**( D )**

- 141\_\_\_ Abnormal thirst
- 142\_\_\_ Bloating of abdomen
- 143\_\_\_ Weight gain around hips/waist
- 144\_\_\_ Sex drive reduced/lacking
- 145\_\_\_ Tendency to ulcers, colitis
- 146\_\_\_ Increased sugar tolerance
- 147\_\_\_ Women: Menstrual disorders
- 148\_\_\_ Young girls: Lack of menstrual function

**( E )**

- 149\_\_\_ Dizziness
- 150\_\_\_ Headaches
- 151\_\_\_ Hot flushes
- 152\_\_\_ Increased blood pressure
- 153\_\_\_ Hair growth of face/body (female)
- 154\_\_\_ Sufar in urine (not diabetes)
- 155\_\_\_ Masculine tendencies (female)

**( F )**

- 156\_\_\_ Weakness, diziness
- 157\_\_\_ Chronic fatigue
- 158\_\_\_ Low blood pressure
- 159\_\_\_ Nails weak, rigid
- 160\_\_\_ Tendency to hives
- 161\_\_\_ Arthritic tendencies
- 162\_\_\_ Persperation increase
- 163\_\_\_ Bowel disorders
- 164\_\_\_ Poor circulation
- 165\_\_\_ Swollen ankles
- 166\_\_\_ Crave salt
- 167\_\_\_ Brown spots/bronzing of skin
- 168\_\_\_ Allergies-tendency to asthma
- 169\_\_\_ Weakness after colds/influenza
- 170\_\_\_ Exhaustion: muscular & nervous
- 171\_\_\_ Respiratory disorders

**FEMALE ONLY**

- 172\_\_\_ Very easily fatigued
- 173\_\_\_ Pre-menstrual tension
- 174\_\_\_ Painful menses
- 175\_\_\_ Depressed feelings before menstruation
- 176\_\_\_ Menstruation excessive & prolonged
- 177\_\_\_ Painful breast
- 178\_\_\_ Mentruate too frequently
- 179\_\_\_ Vaginal discharge
- 180\_\_\_ Hysterectomy/ovaries removed
- 181\_\_\_ Menopausal hot flashes
- 182\_\_\_ Menses scanty/missed
- 183\_\_\_ Acne worse at menses
- 184\_\_\_ Depression of long standing

**MALE ONLY**

- 185\_\_\_ Prostrate trouble
- 186\_\_\_ Urination difficult/dribbling
- 187\_\_\_ Night urination frequent
- 188\_\_\_ Depression
- 189\_\_\_ Pain on, or inside legs/heels
- 190\_\_\_ Feeling of incomplete bowel evacuation
- 191\_\_\_ Lack of energy
- 192\_\_\_ Migrating aches & pains
- 193\_\_\_ Tire too easily
- 194\_\_\_ Avoids activity
- 195\_\_\_ Leg nervousness at night
- 196\_\_\_ Diminished sex drive

**IMPORTANT**

To the Patient: Please list below 5 main health complaints in order of importance.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

