

Carol Harris Lipschultz, D.C., D.N.B.H.E.

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Doctor of Chiropractic
Homeopathy Master Clinician, H.M.C.
1866 Ashland Ave. • Saint Paul, MN 55104
651-644-9691
651-644-3815 (fax)

INFORMATION

Welcome to my office. My staff and I look forward to helping you achieve a greater sense of health and well-being, and assisting you with any future health problems.

This practice is designed to focus on you and your individual concerns. I take a comprehensive approach to your health care and ask that you carefully fill out the enclosed New Patient Form and Health Appraisal Questionnaire before your first office visit. Your cooperation in providing accurate and detailed information helps me to develop the most appropriate treatment program for you.

Since my office is located in a residential neighborhood, please park as close by as possible, between walkways. Enclosed is a map with directions to my office.

The following information will help acquaint you with my office policies.

APPOINTMENTS

Please do not ring the doorbell. Come in, hang up your coat, take off your boots and put them by the coat rack. Help yourself to the tea or water located near the coat rack. After you sign in, have a seat in the waiting room to your left and relax while you wait for your appointment.

Please plan to arrive at your appointed time. To cancel an appointment, call 24 hours or more in advance. Due to the length of the exam, a new patient appointment requires a 48-hour cancellation. Generally, someone will answer your phone call Monday through Friday, 9:00 am to 5:00 pm. Otherwise, a voice mail system will take your message, both during and after hours. Missed appointments without proper advance notice will be billed to the patient.

My hope is that all appointments will be on time, so that no one is delayed. In case you have to wait, I would like you to be as comfortable as possible. Magazines are near the check-in counter and the bathroom is upstairs and to the right of the stairwell.

INFORMATION

PAYMENT

Payment is due at the time of your visit. If this presents a difficulty, we would be happy to discuss a payment plan with you. After each visit, the receptionist will fill out a form for you to submit to your insurance company for reimbursement. The extent of reimbursement is based on your contract with your insurance company. If you have any questions about coverage of your visit, please consult your insurance representative.

Exceptions to this policy are visits covered by prior authorization from Workers' Compensation or automobile insurance.

EMERGENCIES

While I see persons of all ages with a variety of concerns, it is important to understand that this is not an emergency facility. I make every effort to either see established patients promptly in acute situations or give my patients appropriate referrals.

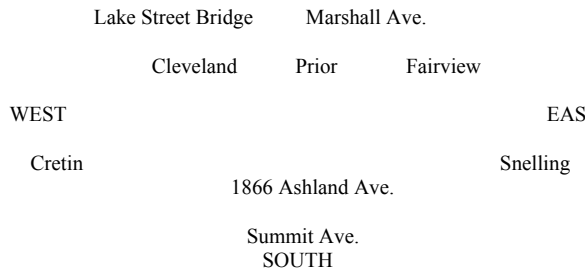
If you have an emergency and cannot reach me, please go to the nearest hospital emergency room or consult your family physician.

Thank you for contacting my office. I am glad you have decided to take this step in your health care, and I look forward to working with you. If you have any questions, please do not hesitate to call me.

Carol H. Lipschultz, D.C., D.N.B.H.E.
Homeopathy Master Clinician, H.M.C.

INFORMATION

NORTH
I-94



LOCATION

The clinic is at 1866 Ashland Avenue, about five minutes from I-94 using either the Cretin or Snelling exits. From downtown Minneapolis or St. Paul it takes about twenty minutes.

From Minneapolis on I-94

Take the Cretin/Vandalia exit (the first exit after the river).
Turn right (south) and go 6 blocks to Marshall.
Turn left on Marshall and go 5 blocks to Prior.
Turn right on Prior and go 4 blocks to Ashland.
Turn left on Ashland and go 2 blocks to 1866 Ashland.

From St. Paul on I-94

Exit I-94 onto southbound Snelling (left turn).
Take Snelling 6 blocks to Ashland.
Turn right on Ashland and go 4 blocks to 1866 Ashland.

From I-35E

Take I-35E to the Randolph exit.
Go north onto Randolph and go 2 blocks to Lexington Pkwy.
Turn right on Lexington and go 3-4 blocks to Jefferson.
Turn right on Jefferson 1 block to Ayd Mill Road.
Turn right (north) on Ayd Mill Road to Selby (Ayd Mill turns into Selby).
Continue west on Selby to Fairview.
Turn left on Fairview and go 2 blocks to Ashland.
Turn right on Ashland for 1 block to 1866 Ashland.

From the Ford Bridge

Take Ford Parkway to Fairview.
Turn left (north) on Fairview and continue 2 miles to Ashland.
Turn left on Ashland for 1 block to 1866 Ashland.

From the Lake Street Bridge

Go east on Marshall 9 blocks to Prior.
Turn right on Prior for 4 blocks to Ashland.
Turn left on Ashland for 2 blocks to 1866 Ashland.

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NEW PATIENT FORM

Patient Name _____

Patient Occupation _____

If Minor

Mother's Name _____

Father's Name _____

Patient Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell # (_____) _____ E-mail _____

Birth Date _____

Children's names and ages _____

Significant Other _____

Significant Other Phone # _____

Emergency Contact Name _____

Emergency Phone # _____

Insurance Information:

In our office we do not submit claims to insurance companies unless it is Medicare, a car accident or a worker's compensation incident.

We will give you a bill that you can submit to your insurance company.

NEW PATIENT FORM

Name _____ Date _____

Confidential Patient History:

I. Problems, Ailments, Complaints

	Why have you come to this office?	Date problem began
1.	_____	____ / ____ / ____

2.	_____	____ / ____ / ____

3.	_____	____ / ____ / ____

4.	_____	____ / ____ / ____

5.	_____	____ / ____ / ____

II. Accident History

Please list all accident-related problems you may have suffered. List all accidents, dates of occurrence, and nature of injuries (car accidents, fender-benders, falls, etc.).

1. _____

2. _____

3. _____

4. _____

5. _____

NEW PATIENT FORM

Name _____ Date _____

III. Surgical History

Please list all surgeries. Please include major, minor, out-patient, day surgery, and biopsy.

- 1. _____

- 2. _____

- 3. _____

- 4. _____

- 5. _____

- 5. _____

IV. Family Health History

List according to age and occurrence all sicknesses and diseases, please include major dental work.

Infant - Age 12:

Age 12 - Age 30:

Age 30 - Age 50:

NEW PATIENT FORM

Name _____ **Date** _____

Age 50 - Present:

V. Birth Information

Were there complications with your birth (forceps delivery, C-section, long labor, breech, premature)?

Yes _____ No _____ If yes, please explain _____

VI. Family Health History

The causes of your health problems may be inherited. Please list all diseases, surgeries, hospitalizations, illnesses, cause of death, and age of death for each of the following members of your family. (please indicate if you are adopted)

Mother:

Mother's father:

Mother's mother:

Father:

Father's father:

NEW PATIENT FORM

Name _____ **Date** _____

Father's mother:

Your sisters:

Your brothers:

Your children:

VII. Medications

This information will help evaluate any possible nutritional deficiency which may occur from the long term use of medication. Please list all long term medication taken in the past (i.e. birth control pills, blood pressure or heart medication, and over-the-counter drugs).

<u>Medication type</u>	<u>Date started</u>	<u>Date completed</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		

List all medications you are presently taking (i.e. birth control pills, blood pressure and heart medications, and over-the-counter drugs, etc.).

<u>Medication type</u>	<u>Date started</u>	<u>Date completed</u>
1. _____		
2. _____		

NEW PATIENT FORM

Name _____ **Date** _____

3. _____

4. _____

5. _____

VIII. Chemical Use

A. Do you use tobacco? Yes _____ No _____ For how many years? _____

If yes, please indicate current amount consumed _____

Did you use tobacco in the past? Yes _____ No _____

If yes, indicate: amount consumed _____

date started _____

date completed _____

B. Do you use alcohol? Yes _____ No _____ For how many years? _____

If yes, indicate: amount consumed _____

date started _____

date completed _____

Did you/Do you consume:

Beer _____ Hard liquor _____ Wine _____

C. Have you ever been in treatment for substance abuse?

Yes _____ No _____

D. Do you use caffeine (include coffee, tea, chocolate)?

Yes _____ No _____

List weekly consumption: Coffee _____

Tea _____ Chocolate _____

NEW PATIENT FORM

Name _____ Date _____

IX. Vitamins

Are you taking any vitamins, minerals, or supplements?

Yes _____ No _____

Please list

Daily amounts

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

X. Stress

Are you under any undue stress presently? Yes _____ No _____

Please describe: _____

XI. Allergies

Do you have any known allergies? Yes _____ No _____

Please list: _____

Do you take any medication for allergies? Yes _____ No _____

If yes, please list type and period of time: _____

NEW PATIENT FORM

Name _____ Date _____

Place and **N** if you experience any of these now.

Place a **P** if you have experienced these in the past.

MUSCULO-SKELETAL SYSTEM

- ___ Low back problems
- ___ Pain between shoulders
- ___ Neck problems
- ___ Arm problems
- ___ Leg problems
- ___ Swollen joints
- ___ Painful joints
- ___ Stiff joints
- ___ Sore muscles
- ___ Weak muscles
- ___ Walking problems
- ___ Ruptures
- ___ Broken bones

GENITO-URINARY SYSTEM

- ___ Bladder trouble
- ___ Excessive urination
- ___ Scanty urination
- ___ Painful urination
- ___ Discolored urine

FEMALE

- ___ Vaginal discharge
- ___ Vaginal bleeding
- ___ Vaginal pain
- ___ Breast pain
- ___ Lumps on breast

Are you pregnant?
___ Yes ___ No

GASTRO-INTESTINAL SYSTEM

- ___ Poor appetite
- ___ Excessive hunger
- ___ Difficulty chewing
- ___ Difficulty swallowing
- ___ Excessive thirst
- ___ Nausea
- ___ Vomiting food
- ___ Vomiting blood
- ___ Abdominal pain
- ___ Diarrhea
- ___ Constipation
- ___ Black stool
- ___ Bloody stool
- ___ Hemorrhoids
- ___ Liver trouble
- ___ Gall bladder problems
- ___ Weight trouble

NERVOUS SYSTEM

- ___ Numbness
- ___ Loss of feeling
- ___ Paralysis
- ___ Dizziness
- ___ Fainting
- ___ Headaches
- ___ Muscle jerking
- ___ Convulsions
- ___ Forgetfulness
- ___ Confusion
- ___ Depression

CARDIO-VASCULAR-RESPIRATORY

- ___ Chest pain
- ___ Pain over heart
- ___ Difficulty breathing
- ___ Persistent cough
- ___ Coughing phlegm
- ___ Coughing blood
- ___ Rapid heartbeat
- ___ Bloodpressure problem
- ___ Heart problems
- ___ Lung problems
- ___ Varicose veins

EYE, EAR, NOSE, & THROAT

- ___ Eye strain
- ___ Eye inflammation
- ___ Vision problems
- ___ Ear pain
- ___ Ear noises
- ___ Hearing loss
- ___ Ear discharge
- ___ Nose pain
- ___ Nose bleeding
- ___ Nose discharge
- ___ Difficult breathing through nose
- ___ Sore gums
- ___ Dental problems
- ___ Sore mouth
- ___ Sore throat
- ___ Hoarseness
- ___ Difficult speech

Please mark your areas of pain on the figures below.

Number of times you urinate during the day _____ night _____ ?

How often do you have a bowel movement? _____

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HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

PART I

Circle any of the following medications you are taking:

Antacids	Aspirin/Tylenol	Hormones
Antibiotic/antifungal	Chemotherapy	Cortisone/anti-inflammatory
Antidepressants	Laxatives	Relaxant/sleeping pills
Anti-Diabetic/insulin	Heart Medication	Oral contraceptives
High blood pressure	Radiation	Ulcer medication
Lithium	Thyroid	
Other (please list):		

Circle if you eat, drink, or use:

Alcohol	Distilled water	Carbonated drinks
Candy	Refined sugar	Saccharine
Cigarettes	Fried foods	Fast food
Chew tobacco	Luncheon meats	Margarine
Coffee		
Vitamin/minerals (please list):		

Circle if you:

Are under excessive stress	Are exposed to cigarette smoke
Are exposed to chemicals at work	Salt food without tasting
Do not exercise regularly	Diet often

Instructions for Parts II - XIII: Circle the number which best describes the intensity of your symptoms.

If you don't know the answer to a question, leave it blank.

0 = symptom not present, 1 = mild, 2 = moderate, 3 = severe.

PART II

SECTION A

1. Burping	0	1	2	3
2. Fullness for extended time after meals	0	1	2	3
3. Bloating	0	1	2	3
4. Poor appetite	0	1	2	3
5. Stomach upsets easily	0	1	2	3
6. History of Constipation	0	1	2	3
7. Known food allergies	0	1	2	3

SECTION B

1. Abdominal cramps	0	1	2	3
2. Indigestion 1-3 hours after eating	0	1	2	3
3. Fatigue after eating	0	1	2	3
4. Lower bowel	0	1	2	3
5. Alternating constipation and diarrhea	0	1	2	3
6. Diarrhea	0	1	2	3
7. Roughage and fiber causes constipation	0	1	2	3

8. Mucous in stools	0	1	2	3
9. Stool poorly formed	0	1	2	3
10. Shiny stool	0	1	2	3
11. 3 or more large bowel movements daily	0	1	2	3
12. Foul smelling stool	0	1	2	3
13. Dry, flaky skin and/or dry brittle hair	0	1	2	3
14. Pain in left side under rib cage	0	1	2	3
15. Acne	0	1	2	3
16. Food allergies	0	1	2	3
17. Difficulty gaining weight	0	1	2	3

SECTION C

1. Stomach pains	0	1	2	3
2. Stomach pains just before/after meals	0	1	2	3
3. Dependency on antacids	0	1	2	3
4. Chronic abdominal pain	0	1	2	3
5. Butterfly sensations in stomach	0	1	2	3

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

6. Difficulty belching	0	1	2	3	2. Frequent and recurrent infections (colds)	0	1	2	3
7. Stomach pain when emotionally upset	0	1	2	3	3. Bladder and kidney infections	0	1	2	3
8. Sudden, acute indigestion	No		Yes		4. Vaginal yeast infections	0	1	2	3
9. Relief of symptoms w/ carbonated bev.	No		Yes		5. Abdominal cramps	0	1	2	3
10. Stomach pain relieved by drinking milk	No		Yes		6. Toe and fingernail fungus	0	1	2	3
11. History or ulcer or gastritis	No		Yes		7. Alternating diarrhea/constipation	0	1	2	3
12. Current ulcer	No		Yes		8. Constipation	0	1	2	3
13. Black stool when not taking iron sups.	No		Yes		9. History of antibiotic use	No		Yes	
					10. Meat eater	No		Yes	
					11. Rapidly failing vision	No		Yes	

SECTION D

1. Seasonal diarrhea	0	1	2	3
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PART III

SECTION A

1. Intolerance to greasy foods	0	1	2	3
2. Headaches after eating	0	1	2	3
3. Light colored stool	0	1	2	3
4. Foul smelling stool	0	1	2	3
5. Less than one bowel movement daily	0	1	2	3
6. Constipation	0	1	2	3
7. Hard stool	0	1	2	3
8. Sour taste in mouth	0	1	2	3
9. Gray colored skin	0	1	2	3
10. Yellow in whites of eyes	0	1	2	3
11. Bad breath	0	1	2	3
12. Body odor	0	1	2	3
13. Fatigue and sleepiness after eating	0	1	2	3
14. Pain in right side under rib cage	0	1	2	3
15. Painful to pass stool	0	1	2	3
16. Retain water	0	1	2	3
17. Big toe painful	0	1	2	3
18. Pain radiates along outside of leg	0	1	2	3
19. Dry skin or hair	0	1	2	3
20. Red blood in stool	No		Yes	
21. Have you had jaundice or hepatitis?	No		Yes	
22. High blood cholesterol and low HDL?	No	Unknown	Yes	
23. Is your cholesterol level above 200?	No	Unknown	Yes	

24. Is your triglyceride level above 115?	No	Unknown	Yes
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SECTION B

1. Swollen eyes (bulging)	0	1	2	3
2. Strong smelling urine	0	1	2	3
3. Thick skin and finger nails	0	1	2	3
4. Dry skin	0	1	2	3
5. Sensitive to the cold	0	1	2	3
6. Cold hands and feet	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3
8. Chronic fatigue	0	1	2	3
9. Trouble waking up in the morning	0	1	2	3
10. Depressed, apathetic	0	1	2	3
11. Low sex drive	0	1	2	3
12. Puffy, wrinkly skin	0	1	2	3
13. Sugar causes irritability/mood swings	0	1	2	3
14. Premenstrual tension	0	1	2	3
15. Constipation	0	1	2	3
16. Thinning/loss of outside portion of eyebrows	No		Yes	
17. Gain weight easily	No		Yes	
18. Anemia unaffected by iron	No		Yes	
19. Axillary (armpit) temperature below 97.6° F	No		Yes	
20. Slow reflexes	No		Yes	
21. Infertility	No		Yes	

PART IV

SECTION A

1. Sensitive to exhaust fumes, smoke, smog, chemicals	0	1	2	3
2. Periodic constipation	0	1	2	3
3. Cannot tolerate much exercise	0	1	2	3
4. Depression or rapid mood swings	0	1	2	3
5. Dark circles under the eyes	0	1	2	3
6. Dizziness upon standing	0	1	2	3
7. Lack of mental alertness	0	1	2	3
8. Catch colds easily when weather changes	0	1	2	3
9. Headaches	0	1	2	3
10. Difficulty breathing	0	1	2	3
11. Water retention	0	1	2	3
12. Eyes sensitive to bright light	0	1	2	3
13. Feel weak and shaky	0	1	2	3

3. Get boils or sties	0	1	2	3
4. Nose bleeds	0	1	2	3
5. Loss of smell	0	1	2	3
6. Throat infections	0	1	2	3
7. Cold sores, fever blisters	0	1	2	3
8. Loss of taste	0	1	2	3
9. Poor wound healing	0	1	2	3
10. Hair falls out	0	1	2	3
11. Swollen lymph glands	0	1	2	3
12. Ear infection	0	1	2	3
13. Hair grows slowly	0	1	2	3
14. Slow to recover from cold or flu	0	1	2	3
15. Catch colds or flu easily	0	1	2	3
16. Bumpy skin on back of arms	0	1	2	3

SECTION B

1. Inflamed or bleeding gums	0	1	2	3
2. Running nose	0	1	2	3

SECTION C

1. Itching of nose or eyes	0	1	2	3
2. Itching of roof of mouth or throat	0	1	2	3

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

3. Migraine headaches	No	Yes	16. Ear discharge or ears stuffed up	0	1	2	3		
4. Entire body aches, painful to touch	0	1	2	3	17. Nasal congestion	0	1	2	3
5. Swollen joints	0	1	2	3	18. Runny nose	0	1	2	3
6. Food sensitivity or allergy	0	1	2	3	19. Breath through mouth	0	1	2	3
7. Certain foods make you sick, depressed, jittery	0	1	2	3	20. Swollen tongue	0	1	2	3
8. Chronic pain	0	1	2	3	21. Difficulty swallowing	0	1	2	3
9. Painful stomach and/or intestines	0	1	2	3	22. Bedwetting	No	Yes		
10. Alternating constipation and diarrhea	0	1	2	3	23. Hyperactivity	0	1	2	3
11. Mucous in throat	0	1	2	3	24. Lung congestion	0	1	2	3
12. Post nasal drip	0	1	2	3	25. Use aspirin, Tylenol regularly	No	Yes		
13. Discharge from eyes	0	1	2	3	26. Wheezing	0	1	2	3
14. Watery eyes	0	1	2	3	27. Skin rashes	0	1	2	3
15. Puffiness or dark circles under eyes	0	1	2	3	27. Sneezing	0	1	2	3

PART V

SECTION A

1. Difficulty breathing at night	0	1	2	3
2. Chest pain while walking	0	1	2	3
3. Heaviness in legs	0	1	2	3
4. Calf muscles cramp while walking	0	1	2	3
5. Heart pounds easily	0	1	2	3
6. Feel jittery	0	1	2	3
7. Heart misses beats or has extra beats	0	1	2	3
8. Swelling of feet and ankles	0	1	2	3
9. Rapid beating heart	0	1	2	3
10. Heartburn after eating	0	1	2	3
11. Pain in left arm	0	1	2	3
12. Exhaustion with minor exertion	0	1	2	3
13. Do you do aerobic exercise?	No	Yes		
14. Have you ever exercised regularly?	No	Yes		
15. Do you drink 5 or more cups of coffee daily?	No	Yes		
16. Severe cough?	No	Yes		
17. Do you have heart trouble?	No	Yes		

SECTION B

1. Cold hands and feet	0	1	2	3
2. Slurred speech	0	1	2	3
3. Calf muscles cramp while walking	0	1	2	3
4. Headaches	0	1	2	3
5. Numbness in extremities	0	1	2	3
6. Poor concentration	0	1	2	3
7. Ringing in ears	0	1	2	3
8. Ear canal hair	No	Yes		
9. Tingling and/or burning in hands or feet	No	Yes		
10. Spider veins on nose and/or face	No	Yes		

SECTION C

1. Pain in back of head and neck upon arising	0	1	2	3
2. Dizziness	0	1	2	3
3. Vertigo	0	1	2	3
4. Blushing with no apparent cause	0	1	2	3
5. Is your blood pressure high?	No	Yes		

PART VI

SECTION A

1. Dizziness when standing suddenly	0	1	2	3
2. Loss of vision when standing suddenly	0	1	2	3
3. Crave sweets	0	1	2	3
4. Headaches relieved by eating sweets or alcohol	0	1	2	3
5. Feel shaky or jittery	0	1	2	3
6. Irritable if a meal is missed	0	1	2	3
7. Wake up in the middle of night craving sweets	0	1	2	3
8. Feel tired or weak if a meal is missed	0	1	2	3
9. Heart palpitations after eating sweets	0	1	2	3
10. Need to drink coffee to get started	0	1	2	3
11. Impatient, moody, nervous	0	1	2	3
12. Feel tired 1 to 3 hours after eating	0	1	2	3
13. Poor memory	0	1	2	3
14. Feel faint	0	1	2	3
15. Poor concentration	0	1	2	3

16. Forgetful	0	1	2	3
17. Calmer after eating	No	Yes		

SECTION B

1. Night sweats	0	1	2	3
2. Increased thirst	0	1	2	3
3. Lowered resistance to infection	0	1	2	3
4. Fatigue	0	1	2	3
5. Boils and leg sores	0	1	2	3
6. Lesions, cuts take a long time to heal	0	1	2	3
7. Overweight	0	1	2	3
8. Feel pick up from exercise	0	1	2	3
9. Failing eyesight	0	1	2	3
10. Crave sweets but doesn't relieve symptoms	0	1	2	3
11. Family history of diabetes	0	1	2	3
12. Sugar in urine	No	Yes		

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

PART VII

1. Chest pain	0	1	2	3	8. Rattling mucous when you breathe	0	1	2	3
2. Chronic cough	0	1	2	3	9. Sensitive to smog	0	1	2	3
3. Difficulty breathing	0	1	2	3	10. Infections settle in lungs	0	1	2	3
4. Cough up blood	0	1	2	3	11. Live or work around people who smoke	0	1	2	3
5. Coughing up phlegm	0	1	2	3	12. Bronchitis	No	Yes		
6. Pain around ribs	0	1	2	3	13. Exposed to chemicals and radiation	No	Yes		
7. Shortness of breath	0	1	2	3	14. Smoker	No	Yes		

PART VIII

1. Frequent urination	0	1	2	3	10. Cloudy urine	0	1	2	3
2. Frequent bladder infections	0	1	2	3	11. Strong smelling urine	0	1	2	3
3. Rarely need to urinate	0	1	2	3	12. Back/leg pain assoc. w/ dripping after urination	0	1	2	3
4. Urination when you cough or sneeze	0	1	2	3	13. History of kidney or bladder infections	No	Yes		
5. Painful/burning when passing urine	0	1	2	3	14. Have used antibiotics for urinary tract infection	No	Yes		
6. Difficulty passing urine	0	1	2	3	IF YES, WHEN?				
7. Dripping after urine	0	1	2	3	TREATMENT DURATION?				
8. Can't hold urine	0	1	2	3	15. Back pain in the kidney area	0	1	2	3
9. Rose colored (bloody) urine	0	1	2	3	16. General water retention	0	1	2	3

PART IX (males only)

SECTION A

1. Difficulty urinating	0	1	2	3	2. Low sexual drive	0	1	2	3
2. A sense of bladder fullness	0	1	2	3	3. Premature ejaculation	0	1	2	3
3. Increased straining with less urine passed	0	1	2	3	4. Pain/coldness in genital area	0	1	2	3
4. Rose colored (bloody) urine	0	1	2	3	5. Infertile	No	Yes		
5. Pain or burning while urinating	0	1	2	3	6. Varicose veins on scrotum	No	Yes		
6. Wake up to urinate at night	0	1	2	3	7. Low sperm count	No	Yes		
7. Dripping after urination	0	1	2	3					
8. Pain or fatigue in the legs or back	0	1	2	3	SECTION C				
9. Lack of sex drive	0	1	2	3	1. Discharge from penis	0	1	2	3
10. Ejaculation causes pain	0	1	2	3	2. Past or present rash on penis	0	1	2	3

SECTION C

3. Swollen genitals	0	1	2	3
4. Swelling in groin	0	1	2	3
5. Venereal disease (gonorrhea, syphilis, herpes, or other)	No	Yes		

SECTION B

1. Difficulty attaining and/or maintaining erection	0	1	2	3	Have VD now? _____ Had VD in past? _____
---	---	---	---	---	--

PART X (females only)

SECTION A (1-2 WEEKS BEFORE MENSTRUATION ONLY)

1. Monthly weight gain	0	1	2	3	3. Low or no desire for sex	0	1	2	3
2. Depression	0	1	2	3	4. Dislike for intercourse	0	1	2	3
3. Moodiness or irritability	0	1	2	3	5. Missed periods	No	Yes		
4. Bloating and swelling	0	1	2	3	6. Over 15 years and have not begun menstruating	No	Yes		
5. Nausea and/or vomiting	0	1	2	3	7. Unable to get pregnant	No	Yes		
6. Suicidal feeling	No	Yes			8. Miscarriages. If so, how many?	No	Yes	_____	
7. Anxiety	0	1	2	3	9. Abortions. If so, how many?	No	Yes	_____	
8. Leg cramps	0	1	2	3					
9. Asthma attacks	No	Yes			SECTION C (DURING MENSTRUATION ONLY)				
10. Headaches	0	1	2	3	1. Low abdominal pain	0	1	2	3
11. Easily distracted	0	1	2	3	2. Dull ache radiating to low back or legs	0	1	2	3
12. Anger	0	1	2	3	3. Increased urinary frequency	0	1	2	3
13. Tender breasts	0	1	2	3	4. Pelvic soreness	0	1	2	3
14. Low backache	0	1	2	3	5. Diarrhea	0	1	2	3
15. Other _____					6. Headaches	0	1	2	3

SECTION B (ANY TIME DURING THE MONTH)

1. Vaginal itching	0	1	2	3	8. Menstrual pain	0	1	2	3
2. Vaginal discharge	0	1	2	3	9. Nausea and/or vomiting	0	1	2	3
					10. Must lie down on first 1 or 2 days of period	0	1	2	3
					11. Craving for sweets	0	1	2	3

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

- | | | | | | | | |
|--|---|---|---|---|--|------------------|-----|
| 12. Insomnia | 0 | 1 | 2 | 3 | 12. Mother used D.E.S. (hormones) while pregnant | No | Yes |
| 13. Light scant blood flow | 0 | 1 | 2 | 3 | 13. Recent pap smear positive | No | Yes |
| 14. Pain and cramps without blood flow | 0 | 1 | 2 | 3 | 14. Family history of breast cancer | No | Yes |
| 15. Heavy menstrual bleeding | 0 | 1 | 2 | 3 | 15. Form of birth control: <u>None</u> <u>Pill</u> | <u>Diaphragm</u> | |
| 16. Anxiety about menstrual cycle | 0 | 1 | 2 | 3 | <u>Sponge</u> <u>IUD</u> <u>Foam</u> <u> </u> | Other _____ | |
| 17. Pain during period progressively getting worse | 0 | 1 | 2 | 3 | SECTION E | | |

SECTION D

- | | | | | | | | | | |
|--|----|-----|---|---|--|----|-----|---|---|
| 1. Vaginal bumps and sores | 0 | 1 | 2 | 3 | 1. Hot flashes | 0 | 1 | 2 | 3 |
| 2. Pubic area sore | 0 | 1 | 2 | 3 | 2. Night sweats | 0 | 1 | 2 | 3 |
| 3. Ovarian cysts | No | Yes | | | 3. Hysterectomy | No | Yes | | |
| 4. Uterine cysts | No | Yes | | | 4. Depression/mood swings | 0 | 1 | 2 | 3 |
| 5. Pain in ovaries | 0 | 1 | 2 | 3 | 5. Insomnia | 0 | 1 | 2 | 3 |
| 6. Breast lumps | No | Yes | | | 6. Craving for sweets | 0 | 1 | 2 | 3 |
| 7. Breasts sore to touch | 0 | 1 | 2 | 3 | 7. Heavy bleeding two weeks out of the month | 0 | 1 | 2 | 3 |
| 8. Breasts painful | 0 | 1 | 2 | 3 | 8. Sweating throughout the day | 0 | 1 | 2 | 3 |
| 9. Water retention | 0 | 1 | 2 | 3 | 9. Dryness of skin, hair, and vagina | 0 | 1 | 2 | 3 |
| 10. Swollen | 0 | 1 | 2 | 3 | 10. Painful intercourse | 0 | 1 | 2 | 3 |
| 11. Premenstrual breast pain or discomfort | 0 | 1 | 2 | 3 | 11. Vaginal pain | 0 | 1 | 2 | 3 |
| | | | | | 12. Vaginal itching | 0 | 1 | 2 | 3 |
| | | | | | 13. Osteoporosis (bone loss) | No | Yes | | |

PART XI

SECTION A

- | | | | | | | | | | |
|------------------------------------|-------|--------|-----|---|--|---|---|---|---|
| 1. Pain in fingers | 0 | 1 | 2 | 3 | 4. Pain in arms or hands | 0 | 1 | 2 | 3 |
| 2. Bones sore and painful | 0 | 1 | 2 | 3 | 5. Leg cramps at night | 0 | 1 | 2 | 3 |
| 3. Eat meat | 0 | 1 | 2 | 3 | 6. Stiff all over | 0 | 1 | 2 | 3 |
| 4. Cavities | 0 | 1 | 2 | 3 | 7. Stiff in morning | 0 | 1 | 2 | 3 |
| 5. Arthritis | 0 | 1 | 2 | 3 | 8. Unable to sit straight | 0 | 1 | 2 | 3 |
| 6. Drink carbonated beverages/soda | _____ | oz./wk | Yes | | 9. Pain in neck and/or shoulders | 0 | 1 | 2 | 3 |
| 7. Gum disease | No | Yes | | | 10. Pain in back | 0 | 1 | 2 | 3 |
| 8. Bone loss | No | Yes | | | | | | | |
| 9. Calcium deposits | No | Yes | | | SECTION C | | | | |
| 10. Use antacids | _____ | #/wk. | Yes | | 1. Over flexible joints (double-jointed) | 0 | 1 | 2 | 3 |
| 11. Dentures | No | Yes | | | 2. Back pain | 0 | 1 | 2 | 3 |
| 12. Bone deformity | No | Yes | | | 3. Swollen knees/elbows | 0 | 1 | 2 | 3 |
| 13. Osteoporosis/osteomalacia | No | Yes | | | 4. Athletic injury | 0 | 1 | 2 | 3 |
| 14. Recent bone fracture | No | Yes | | | 5. Bursitis | 0 | 1 | 2 | 3 |
| | | | | | 6. Tendonitis | 0 | 1 | 2 | 3 |
| 15. Are you post menopausal | No | Yes | | | 7. Joint pain | 0 | 1 | 2 | 3 |

SECTION B

- | | | | | | | | |
|----------------------------------|---|---|---|---|--------------------|----|-----|
| 1. Muscle spasms | 0 | 1 | 2 | 3 | 8. Slipped disc | No | Yes |
| 2. Tightness in shoulder muscles | 0 | 1 | 2 | 3 | 9. Herniated disc | No | Yes |
| 3. Muscle cramps | 0 | 1 | 2 | 3 | 10. Loss in height | No | Yes |
| | | | | | 11. Injure easily | No | Yes |

PART XII

- | | | | | | | | | | |
|--|---|---|---|---|-----------------------------------|----|-----|---|---|
| 1. Head feels heavy | 0 | 1 | 2 | 3 | 10. Loss of grip strength | 0 | 1 | 2 | 3 |
| 2. Light headedness/fainting | 0 | 1 | 2 | 3 | 11. Tingling pain sensation | 0 | 1 | 2 | 3 |
| 3. Loss of balance | 0 | 1 | 2 | 3 | 12. Convulsions | No | Yes | | |
| 4. Dizziness | 0 | 1 | 2 | 3 | 13. Lack of coordination | 0 | 1 | 2 | 3 |
| 5. Ringing/buzzing in ears | 0 | 1 | 2 | 3 | 14. Nervousness | 0 | 1 | 2 | 3 |
| 6. Trembling hands | 0 | 1 | 2 | 3 | 15. Accident prone | No | Yes | | |
| 7. Loss of feeling in hands and/or feet (toes) | 0 | 1 | 2 | 3 | 16. Loss of muscle tone | No | Yes | | |
| 8. Exhaustion on slightest effort | 0 | 1 | 2 | 3 | 17. Need for 10-12 hours of sleep | No | Yes | | |
| 9. Limbs feel too heavy to hold up | 0 | 1 | 2 | 3 | 18. Have had shingles | No | Yes | | |

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ Date _____

PART XIII

1. Nightmares	0	1	2	3	5. Restless, uneasy sleeper	0	1	2	3
2. Can't fall asleep	0	1	2	3	6. Awake frequently throughout the night	No	Yes		
3. Intense dreams	0	1	2	3	7. Wake up at night, can't fall back to sleep	No	Yes		
4. Leg cramps/restless legs at night	0	1	2	3	8. Sleep walk	No	Yes		

Do you have any other symptoms that have not been covered in this questionnaire?

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ACTIVITY RANGE MONITOR

Name _____

Date _____

Indicate your ability to perform the following activities. **Circle what best applies. "OK" means that you can perform the activity without pain.**
Add any comments you like after the activity. Use the blank lines to fill in activities that are bothering you and not on the list.

radiating pain		local pain		OK	Coughing or Sneezing
unable	pain	difficult	limited	OK	Getting in or out of car
unable	pain	difficult	limited	OK	Riding in a car for short distances
unable	pain	difficult	limited	OK	Driving several hours
unable	pain	difficult	limited	OK	Bending forward to brush teeth
unable	pain	difficult	limited	OK	Washing/drying hair
unable	pain	difficult	limited	OK	Turning over in bed
unable	pain	difficult	limited	OK	Sleep
unable	pain	difficult	limited	OK	Standing for 10 minutes
unable	pain	difficult	limited	OK	Standing for 1 hour or more
unable	pain	difficult	limited	OK	Sitting for 10 minutes
unable	pain	difficult	limited	OK	Sitting for 1 hour or more
unable	pain	difficult	limited	OK	Lying on your back
unable	pain	difficult	limited	OK	Lying on your side with knees bent
unable	pain	difficult	limited	OK	Bending forward
unable	pain	difficult	limited	OK	Climbing stairs (Pain with how many steps___ or flights__)
unable	pain	difficult	limited	OK	Kneeling
unable	pain	difficult	limited	OK	Dressing Self
unable	pain	difficult	limited	OK	Stooping
unable	pain	difficult	limited	OK	Gripping objects
unable	pain	difficult	limited	OK	Carrying objects
unable	pain	difficult	limited	OK	Turning door knobs
unable	pain	difficult	limited	OK	Pushing
unable	pain	difficult	limited	OK	Pulling
unable	pain	difficult	limited	OK	Reaching for objects in front of you
unable	pain	difficult	limited	OK	Reaching overhead
unable	pain	difficult	limited	OK	Handwriting
unable	pain	difficult	limited	OK	Sexual activity

ACTIVITY RANGE MONITOR

Name _____

Date _____

House Work/Home Maintenance

unable	pain	difficult	limited	OK	Washing dishes
unable	pain	difficult	limited	OK	Changing sheets
unable	pain	difficult	limited	OK	Vacuuming
unable	pain	difficult	limited	OK	Sweeping
unable	pain	difficult	limited	OK	Washing floor
unable	pain	difficult	limited	OK	Washing windows
unable	pain	difficult	limited	OK	Scrubbing tub
unable	pain	difficult	limited	OK	Grocery shopping
unable	pain	difficult	limited	OK	Carrying groceries
unable	pain	difficult	limited	OK	Painting
unable	pain	difficult	limited	OK	Snow shoveling
unable	pain	difficult	limited	OK	Gutter cleaning
unable	pain	difficult	limited	OK	Pet care
unable	pain	difficult	limited	OK	Mowing
unable	pain	difficult	limited	OK	Raking
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____

Work Related

unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____

Recreational (Usual Activities)

List frequent activities first, then occasional

unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____
unable	pain	difficult	limited	OK	_____

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ALLERGY QUESTIONNAIRE

Name _____ **Date** _____

Please fill in the blanks and circle applicable answers. Feel free to add additional comments. Base your answers on your own observations, NOT on what you have been told by friends or other physicians.

SYMPTOMS:

SNEEZING	YES	NO	SHORTNESS OF BREATH	YES	NO	HEADACHES	YES	NO
RUNNY NOSE	YES	NO	WHEEZING	YES	NO	BRONCHITIS	YES	NO
EAR CONGESTION	YES	NO	SINUSITIS	YES	NO	OTITIS	YES	NO
ITCHY EYES	YES	NO	HIVES	YES	NO	DIZZINESS	YES	NO
PUFFY EYES	YES	NO	ECZEMA	YES	NO			

ARE YOU WORSE IN ANY SEASON? **SPRING** **SUMMER** **FALL** **WINTER**

HAVE YOU EVER HAD:

AN ALLERGIC REACTION TO AN ANTIBIOTIC? YES NO TO WHAT? _____

AN ALLERGIC REACTION TO ANY OTHER DRUG? YES NO TO WHAT? _____

AN ALLERGIC REACTION TO A BEE STING? YES NO WHICH KIND OF BEE? _____

A SEVERE ALLERGIC REACTION TO ANYTHING? YES NO TO WHAT? _____

A ANAPHYLACTIC REACTION TO ANYTHING? YES NO TO WHAT? _____

A PREVIOUS ALLERGY WORKUP? YES NO
BY WHOM? _____ WHEN? _____

OCCUPATION _____

DO YOU WORK AROUND:

DUST AND DIRT?	YES	NO
CHEMICALS?	YES	NO
ANIMALS?	YES	NO

DO YOU HAVE ANY PROBLEMS AT WORK? YES NO
IF YES, PLEASE DESCRIBE:

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

HOUSING:

TYPE OF HOUSING

- ___ APARTMENT
- ___ SINGLE FAMILY TWO STORY
- ___ SINGLE FAMILY SPLIT ENTRY
- ___ CONDOMINIUM
- ___ TRAILER

AGE OF HOUSING

- ___ NEW
- ___ 5-10 YEARS
- ___ 11-20 YEARS
- ___ 21-50 YEARS
- ___ OVER 50 YEARS

HEATING SYSTEM

- ___ GAS, FORCED AIR
- ___ GRAVITY
- ___ RADIATORS-HOT WATER
- ___ ELECTRIC
- ___ WOOD
- ___ SPACE HEATERS

BASEMENT

- ___ NONE (SLAB)
- ___ CRAWL SPACE ONLY
- ___ CONCRETE FLOOR
- ___ DIRT FLOOR
- ___ STONE WALLS
- ___ CONCRETE BLOCK WALLS
- ___ FINISHED
- ___ CARPETED

BEDDING & LINEN

- ___ DOWN COMFORTERS
- ___ WOOL BLANKETS
- ___ COTTON BLANKETS
- ___ WINDOW TREATMENTS
- ___ DRAPES-DRY CLEAN
- ___ WASHABLE DRAPES OR CURTAINS
- ___ BLINDS-FABRIC
- ___ BLINDS-METAL OR WOOD

HOUSEHOLD PRODUCTS USED

- ___ LYSOL/PINESOL
- ___ AIR FRESHENERS
- ___ PERFUMES/AFTERSHAVE LOTIONS
- ___ SHEET-TYPE DRYER SOFTENERS

KITCHEN

- ___ GAS STOVE
- ___ ELECTRIC RANGE
- ___ SELF-DEFROSTING REFRIDGERATOR

BEDROOM

- #### MATTRESS-LIST AGES
- ___ INNERSPRING
 - ___ FOAM RUBBER

PILLOWS

- ___ POLYESTER
- ___ FEATHER
- ___ DOWN
- ___ FOAM

LIST THE NUMBERS AND TYPES BELOW:

- ___ NUMBER OF ADULTS LIVING TOGETHER
- ___ NUMBER OF CHILDREN
- ___ NUMBER OF SMOKERS (FREQUENT)
- ___ NUMBER OF SMOKERS (OCCASIONAL)
- ___ NUMBER OF HORSES (OUTSIDE)
- ___ NUMBER OF OTHER ANIMALS (OUTSIDE)
- ___ MOST RECENT YEAR FURNACE DUCTS WERE PROFESSIONALLY CLEANED
- ___ HAVE THERE BEEN MAJOR HOUSING PROBLEMS (FLOODING, FIRE, ETC.)
- ___ NUMBER OF CATS
- ___ NUMBER OF DOGS
- ___ NUMBER OF BIRDS
- ___ NUMBER OF OTHER PETS (INSIDE)
- ___ IS THE BASEMENT DRY OR DAMP?

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

FLOORING: List age where appropriate.

	CARPET	WOOD	VINYL	TILE	CONCRETE
LIVING ROOM					
DINING ROOM					
KITCHEN					
MASTER BEDROOM					
2 ND BEDROOM					
3 RD BEDROOM					
FAMILY ROOM					
BASEMENT					
BATHROOM #1					
BATHROOM #2					

ARE YOU WORSE IN ANY OF THE FOLLOWING LOCATIONS/CONDITIONS?

OUTDOORS	YES	NO	INDOORS	YES	NO
IN AIR CONDITIONING	YES	NO	AFTER THE FURNACE		
IN A BASEMENT	YES	NO	HAS BEEN TURNED ON	YES	NO
WITH CEILING FANS ON	YES	NO	IN CERTAIN ROOMS	YES	NO
WHILE DUSTING/SWEEPING	YES	NO	IN DAMP PLACES	YES	NO
WHILE MOWING GRASS	YES	NO	WHEN EXPOSED TO HAY	YES	NO
WHILE NEAR A BARN	YES	NO	WHILE NEAR A CIRCUS	YES	NO
AFTER AUGUST 15	YES	NO	WHILE RAKING LEAVES	YES	NO
AROUND COMPOST	YES	NO	IN COOL EVENING AIR	YES	NO
IN THE LATE EVENING	YES	NO	BETWEEN 1 AND 5 AM	YES	NO
WHEN EATING CHEESE	YES	NO	WHILE DRINKING BEER	YES	NO
WHILE EATING MUSHROOMS	YES	NO	WHILE DRINKING WINE	YES	NO

FOODS: Please state how often you eat these:

FRUITS

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
APPLES						
BANANAS						
GRAPES						
ORANGES						
PEACHES						
PEARS						
PINEAPPLE						
STRAWBERRIES						
RASPBERRIES						

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

GRAINS

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
BARLEY						
MILLET						
OATS						
RICE						
RYE						
WHEAT						

OILS

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
ALMOND						
CANOLA						
CORN						
COTTONSEED						
PEANUT						
SAFFLOWER						
SESAME						
SOY						
SUNFLOWER						
WALNUT						

MEATS

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
BEEF						
CHICKEN						
CODFISH						
PORK						
SALMON						
SHRIMP						
TURKEY						

VEGETABLES

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
ASPARAGUS						
CABBAGE						
CARROTS						
CELERY						
CORN						
CUCUMBER						
GREEN BEANS						
GREEN PEAS						
KIDNEY BEANS						
LETTUCE						
ONION						
POTATO						

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

SPINACH						
SQUASH						
TOMATO						

MISCELLANEOUS

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
ALMONDS						
BEET SUGAR						
CANE SUGAR						
CASHEWS						
CHEESE						
CHOCOLATE						
CINNAMON						
COCONUT						
COFFEE						
EGG						
GARLIC						
GINGER						
MALT						
MILK						
MUSHROOM						
MUSTARD						
NUTS-OTHER						
PEANUT						
PECANS						
POP						
POPCORN						
SOY SAUCE						
TEA						
VITAMIN PILLS						
WALNUTS						

FOODS CONTINUED:

LIST ANY FOOD THAT EVER CAUSED ANY OF THE FOLLOWING REACTIONS:

ALLERGIC/ANAPHYLACTIC: _____

THEY DISAGREE WITH YOU: _____

YOU AVOID THEM FOR WHATEVER REASON (IF SO SPECIFY) _____

YOU CRAVE THEM: _____

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

CHEMICALS: Place one check mark next to any chemical that bothers you and two check marks next to any chemical that makes you really sick.

- _____ ODOR OF ESCAPING OR BURNING UTILITY GAS
- _____ ODOR OF GASOLINE, GARAGE FUMES AND ODORS
- _____ AUTOMOBILE OR BOAT EXHAUSTS
- _____ ODOR OF NAPHTHA, CLEANING FLUIDS, OR LIGHTER FLUIDS
- _____ ODOR OF RECENTLY CLEANED CLOTHING, UPHOLSTERY OR RUGS
- _____ ODOR OF NAIL POLISH OR POLISH REMOVER
- _____ ODOR OF FRESH NEWSPAPER
- _____ ODOR OF KEROSENE
- _____ ODOR OF FUEL OIL, BURNING SPACE HEATER, OR FURNACES
- _____ DIESEL ENGINE FUMES FROM TRAINS, BUSES, TRUCKS, OR BOATS
- _____ LUBRICATING GREASES OR CRUDE OIL
- _____ FUMES FORM AUTOMOBILES BURNING EXCESSIVE AMOUNTS OF OIL
- _____ ODOR OF FLOOR OR FURNITURE WAX
- _____ ODOR OF GLASS WAX OR GLASS CLEANERS
- _____ FUMES FORM BURNING WAX CANDLES
- _____ FUMES FORM TARRING ROOFS AND ROADS
- _____ ASPHALT PAVEMENT IN HOT WEATHER
- _____ TAR-CONTIAING SOAPS, SHAMPOOS, OINTMENTS
- _____ ODOR OF INK, CARBON PAPER, OR TYPEWRITER RIBBON
- _____ DYES IN CLOTHING AND SHOES
- _____ DYES IN COSMETICS
- _____ ODOR OF PUBLIC OR HOUSEHOLD DISINFECTANTS OR DEODORANTS

ALLERGY QUESTIONNAIRE

Name _____ DATE _____

_____ FUMES FROM BURNING CREOSOTE TREATED WOOD (RAILROAD TIES)

_____ HOUSEHOLD DETERGENTS

_____ ODOR OF SPONGE RUBBER BEDDING, RUG PADS, TYPEWRITER PADS

_____ NYLON HOSIERY OR OTHER NYLON CLOTHING

_____ DACRON OR ORLON CLOTHING OR UPHOLSTRY

_____ RAYON OR CELLULOSE ACETATE CLOTHING OR UPHOLSTRY

_____ ODOR OF RUBBING ALCOHOL

_____ ODOR OF VARNISH, LACQUER, OR SHELLAC

_____ ODOR OF AFTER-SHAVE LOTION, HAIR SPRAYS, OR HAIR DRESSINGS

_____ ODOR OF PAINT OR VARNISH THINNED WITH MINERAL SOLVENTS

_____ ODOR OF SCENTED SOAP AND SHAMPOO

_____ ODOR OF PERFUME AND COLOGNES

_____ ODOR OF CHRISTMAS TREES AND EVERGREEN DECORATION

_____ ODOR OF SHEET-TYPE FABRIC SOFTNERS (FOR DRYER)

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PATIENT HEALTH INFORMATION CONSENT FORM

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of our PHI we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their PHI for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be Assured that this office will limit the release of all PHI to the minimum needed for the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
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 affect the use of those records for the care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, our office has the right to refuse to give care.

I have read and understand how my PHI will be used and I agree to these policies and procedures.

Signature

Date

Carol Harris Lipschultz, D.C., D.N.B.H.E.

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PATIENT INFORMATION AND CONSENT FORM

You have agreed to a Chiropractic evaluation, which in this office utilizes Applied Kinesiology in conjunction with other standard chiropractic testing procedures.

The practice of Applied Kinesiology was started by Dr. George Goodheart of Detroit, Michigan in 1964 and is today used by some doctors of Medicine, Osteopathy, Dentistry, and Psychology, as well as Chiropractic, for diagnosis and therapy.

Applied Kinesiology utilizes muscle testing as a supplemental procedure for diagnosis, treatment and/or nutritional recommendations. This procedure is experimental in nature and, while there has been some peer review research and publication in professional journals, Applied Kinesiology techniques have not yet been supported by a body of evidence using standard scientific research methodologies.

The Doctor of Chiropractic in this office has received education and training in the use of Applied Kinesiology diagnosis and therapy.

I have read and understand that the use of muscle testing as a diagnostic tool is experimental in nature. I agree to an examination utilizing both Applied Kinesiology muscle testing and other standard testing procedures, and to treatment and therapy as agreed upon by myself and the doctor. I also assume responsibility for the acceptance or rejection of any recommendations based on the use of muscle testing.

Name (Printed)

Signature

Date

Carol Harris Lipschultz, D.C., D.N.B.H.E.

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Doctor of Chiropractic
Homeopathy Master Clinician, H.M.C.
1866 Ashland Ave. • Saint Paul, MN 55104
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FINANCIAL AGREEMENT

I am the responsible party for payment of all expenses and services incurred with this office. I will pay for nutritional supplements at the time I receive them.

This office will not bill my insurance.

Name (Printed)

Signature

Date