Doctor CAROL DC
Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

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 your health needs.

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 forms 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 the office policies:

APPOINTMENTS

Our office is located at 1704 Oliver Ave S, Minneapolis, MN 55405. Hours will vary from week to week and at various times throughout the year. When you arrive at the office please ring the doorbell and you will be buzzed in, as you will be seen on the intercom. Come down 3 stairs to the entrance of the waiting room. After you sign in, have a seat in the waiting room and relax while you wait for your appointment.

Please plan to arrive at your appointed time. To cancel an appointment, we ask that you 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 Thursday 9:00am to 7:00pm and 9:00am to 2:00pm on Fridays. 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 for adults and toys for children are available near the check-in counter. Tea and water are available while you wait. After you sign in, have a seat in the waiting room and relax while you wait for your appointment.

PAYMENTS

Payment is due at the time of your visit. If this presents a difficulty, we may discuss a payment plan with you. After each visit, upon your request, the receptionist will make a copy of the 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 with your insurance company.

Exceptions to this policy are visits covered by prior authorization from Worker's 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 will 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 and I look forward to working with you. If you have any questions, please do not hesitate to call me.

Sincerely,

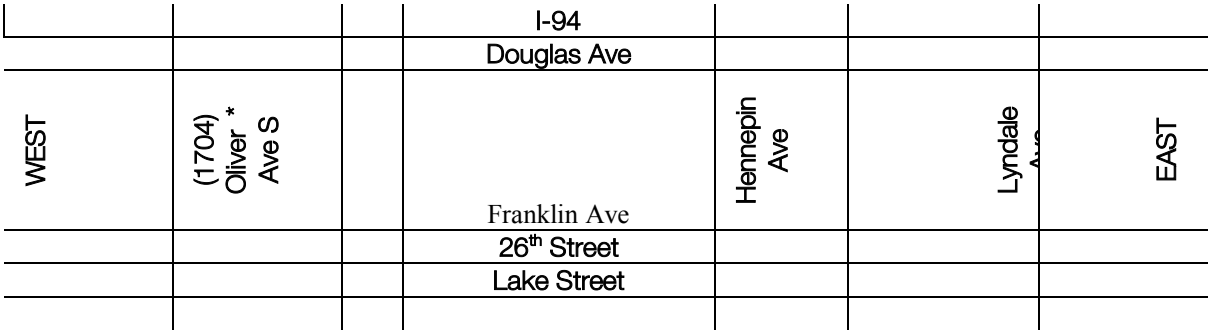
Dr. Carol H. Lipschultz, D.C., D.N.B.H.E., H.M.C., PLC

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

DIRECTIONS

The office is located at 1704 Oliver Ave S, about 5-minutes from I-94 using the Hennepin Ave Exit. From downtown St. Paul the travel time is approximately 30 minutes, depending on the time of day and traffic flow.

NORTH



SOUTH

From St. Paul on I-94W

I-94 W, Take the Hennepin South bound exit. Turn right on Franklin go past the Lake of the Isles – on the left and Kenwood Park – on your right. Turn right at the next block (Oliver Ave S). The office is located on the left hand side of the road – 1704 Oliver Ave S.

From Northwest Suburbs on I-94E

I-94E, Take the Hennepin/Lyndale Exit.. Merge onto Hennepin Ave. Turn right on Franklin go past the Lake of the Isles – on the left and Kenwood Park – on your right. Turn right at the next block (Oliver Ave S). The office is located on the left hand side of the road – 1704 Oliver Ave S.

From I-35W – South Bound

Take I-35 south, Exit onto 94W. Take the Hennepin South bound exit. Turn right on Franklin go past the Lake of the Isles – on the left and Kenwood Park – on your right. Turn right at the next block (Oliver Ave S). The office is located on the left hand side of the road – 1704 Oliver Ave S.

From I-35W – North Bound

Take I-35W north, Exit onto 94W. Take the Hennepin South bound exit. Turn right on Franklin go past the Lake of the Isles – on the left and Kenwood Park – on your right. Turn right at the next block (Oliver Ave S). The office is located on the left hand side of the road – 1704 Oliver Ave S.

From I-394E

Take I-394 east, Take Dunwoody exit. Turn right at Grand Rounds (1st stoplight). Road comes to a T, turn right onto Kenwood Parkway. Turn left onto Douglas and immediately turn right onto Oliver Ave S. The office is located on the right hand side of the road. - 1704 Oliver Ave S.

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

NEW PATIENT FORM

Patient's Name _____

Patient's Occupation _____

If Minor Child:

Mother's Name _____

Father's Name _____

Patient's Address _____

Home Phone (____) _____ Work Phone (___) _____

Cell Phone (___) _____ E-mail _____

Birth Date _____

Children's names & ages _____

Significant Other _____

Significant Other Phone # _____

Emergency Contact Name _____

Emergency Phone # _____

INSURANCE INFORMATION:

Our office does not submit claims to insurance companies unless services rendered are the result of a car accident. It is your responsibility to submit receipts of services to your insurance company for reimbursement.

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.).

Date of Accident

1. _____ __/__/__
2. _____ __/__/__
3. _____ __/__/__
4. _____ __/__/__

NEW PATIENT FORM

Name _____ Date _____

III. SURGICAL HISTORY

Please list all surgeries. (Include major, minor, out-patient, day surgery, and biopsy)

		Date of Surgeries
1.	_____	__/__/__
2.	_____	__/__/__
3.	_____	__/__/__
4.	_____	__/__/__

IV. FAMILY HEALTH HISTORY

List according to age & occurrence all sicknesses and diseases. (Include major dental work)

Infant - Age 12:

_____

_____

_____

Age 12 - Age 30:

_____

_____

_____

Age 30 - Age 50:

_____

_____

_____

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: _____

_____

_____

Name _____ Date _____

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)

Age at Death

Mother: _____ _____

_____

_____

Maternal Grandmother: _____ _____

_____

_____

Maternal Grandfather: _____ _____

_____

_____

Father: _____ _____

_____

_____

Paternal Grandmother: _____ _____

_____

_____

_____

Paternal Grandfather: _____ _____

_____

_____

Your Sisters: _____ _____

_____

_____

Your Brothers: _____ _____

_____

_____

Your Children: _____ _____

_____

Name _____ Date _____

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).

Medication Type	Date Started	Date Completed
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

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

Medication Type	Date Started	Date Completed
1.		
2.		
3.		
4.		
5.		

VIII. CHEMICAL USE

A. Tobacco:

Do you currently use tobacco? Yes _____ No _____ For how many years? _____
Please indicate current amount consumed _____

Have you use tobacco in the past? Yes ____ No ____ When did you quite? _____
Please indicate current amount consumed _____

Name _____ Date _____

B. Alcohol:

Do you currently use alcohol? Yes ____ No _____ For how many years? _____
Please indicate current amount consumed _____

Have you use alcohol in the past? Yes ____ No _____ When did you quite? _____
Please indicate current amount consumed _____
Date started _____ Date stopped _____
Do/did you consume: *Beer* _____ *Hard liquor* _____ Wine _____

C. Substance Abuse:

Have you ever been in treatment for substance abuse? Yes _____ No _____
Where did you obtain treatment? _____
Year(s) you attended treatment? _____
Did you successfully complete treatment? Yes _____ No _____

D. Caffeine:

Do you use caffeine (include coffee, tea, chocolate)? Yes _____ No _____
Consumption per/week: *Coffee* _____ Tea _____ Chocolate _____

IX. VITAMINS

Are you taking any vitamins, minerals, or supplements? *Yes* ____ *No* _____ *If yes please list:*

Vitamin Type:	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* ____ *If Yes please list*

_____

_____

Do you take any medication for allergies? *Yes* _____ *No* _____ *If Yes please list type & time*

Medication Type	Dates of use
1. _____	_____
2. _____	_____

XII. BODY SYSTEMS

A. Urination:

Number of times you urinate during the *Day*? _____?
Number of times you urinate during the *Night*_____?

B. Bowel Movement:

How often do you have a bowel movement? _____

C. Systems:

Place and N if you experience any of these now.
Place a P if you have experienced these in the past.

MUSCULO-SKELETAL SYSTEM	GENITO-URINARY SYSTEM	GASTRO -INTESTINAL SYSTEM	CARDIO-VASCULAR-RESPIRATORY
___ Arm problems	___ Bladder trouble	___ Abdominal pain	___ Blood pressure problem
___ Broken bones	___ Discolored urine	___ Black stool	___ Chest pain
___ Leg problems	___ Excessive urination	___ Bloody stool	___ Coughing blood
___ Low back problems	___ Painful urination	___ Constipation	___ Coughing phlegm
___ Neck problems	___ Scanty urination	___ Diarrhea	___ Difficulty breathing
___ Pain between shoulders		___ Difficulty chewing	___ Heart problems
___ Painful joints	**Female**	___ Difficulty swallowing	___ Lung problems
___ Ruptures	Are you pregnant?	___ Excessive hunger	___ Pain over heart
___ Sore muscles	____ Yes ____ No	___ Excessive thirst	___ Persistent cough
___ Stiff joints	___ Breast pain	___ Gall bladder problems	___ Rapid heartbeat
___ Swollen joints	___ Lumps on breast	___ Hemorrhoids	___ Varicose veins
___ Walking problems	___ Vaginal bleeding	___ Liver trouble	
___ Weak muscles	___ Vaginal discharge	___ Nausea	**Eye, Ear, Nose, & Throat**
	___ Vaginal pain	___ Poor appetite	___ Dental problems
		___ Vomiting blood	___ Difficult breathing through nose
		___ Vomiting food	___ Difficult speech
		___ Weight trouble	___ Ear discharge
		Nervous System	___ Ear noises
		___ Confusion	___ Ear pain
		___ Convulsions	___ Eye inflammation
		___ Depression	___ Eye strain
		___ Dizziness	___ Hearing loss
		___ Fainting	___ Hoarseness
		___ Forgetfulness	___ Nose bleeding
		___ Headaches	___ Nose discharge
		___ Loss of feeling	___ Nose pain
		___ Muscle jerking	___ Sore gums
		___ Numbness	___ Sore mouth
		___ Paralysis	___ Sore throat
			___ Vision problems

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

PART I

Circle any of the following medications you are taking:

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

Circle if you eat, drink, or use:

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

Circle if you:

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

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

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

Acne	0.....1.....2.....3	History of constipation	0.....1.....2.....3
Bloating	0.....1.....2.....3	Known food allergies	0.....1.....2.....3
Burping	0.....1.....2.....3	Mucous in stool	0.....1.....2.....3
Difficulty gaining weight	0.....1.....2.....3	Pain in left side (under rib cage)	0.....1.....2.....3
Dry brittle hair	0.....1.....2.....3	Poor appetite	0.....1.....2.....3
Dry flaky skin	0.....1.....2.....3	Shiny stool	0.....1.....2.....3
Food allergies	0.....1.....2.....3	Stomach upsets easily	0.....1.....2.....3
Foul smelling stool	0.....1.....2.....3	Stool poorly formed	0.....1.....2.....3
Fullness for extended time after meals	0.....1.....2.....3	3 or more large bowel movements daily	0.....1.....2.....3

Section B

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

Section C

Black stool when not taking iron sups	Yes.....No	Relief of symptoms w/ carbonated bev.	Yes.....No
Butterfly sensation in stomach	0.....1.....2.....3	Stomach pains	0.....1.....2.....3
Chronic abdominal pain	0.....1.....2.....3	Stomach pains just before/after meals	0.....1.....2.....3
Current ulcer	Yes.....No	Stomach pain relieved by drinking milk	Yes.....No
Dependency on antacids	0.....1.....2.....3	Stomach pain when emotionally upset	0.....1.....2.....3
Difficulty belching	0.....1.....2.....3	Sudden, acute indigestion	Yes.....No
History or ulcer or gastritis	Yes.....No		

HEALTH APPRAISAL QUESTIONNAIRE
Page 3

Name _____ **Date** _____

Section D

Abdominal cramps	0.....1.....2.....3	Meat eater	Yes.....No
Alternating diarrhea/constipation	0.....1.....2.....3	Rapidly failing vision	Yes.....No
Bladder and kidney infections	0.....1.....2.....3	Seasonal diarrhea	0.....1.....2.....3
Constipation	0.....1.....2.....3	Toe and fingernail fungus	0.....1.....2.....3
Frequent/recurrent infections, such as colds	0.....1.....2.....3	Vaginal yeast infections	0.....1.....2.....3
History of antibiotic use	Yes.....No		

PART III

Section A

Bad breath	0.....1.....2.....3	Intolerance to greasy foods	0.....1.....2.....3
Big toe painful	0.....1.....2.....3	23. Is your cholesterol level above 200?	Yes.....No ..Unknown..
Body odor	0.....1.....2.....3	Is your triglyceride level above 115?	Yes.....No ..Unknown..
Constipation	0.....1.....2.....3	Less than one bowel movement daily	0.....1.....2.....3
Dry skin or hair	0.....1.....2.....3	Light colored stool	0.....1.....2.....3
Fatigue and sleepiness after eating	0.....1.....2.....3	Painful to pass stool	0.....1.....2.....3
Foul smelling stool	0.....1.....2.....3	Pain in right side under rib cage	0.....1.....2.....3
Gray colored skin	0.....1.....2.....3	Pain radiates along outside of leg	0.....1.....2.....3
Hard stool	0.....1.....2.....3	Red blood in stool	Yes.....No
Have you had jaundice or hepatitis?	Yes.....No	Retain water	0.....1.....2.....3
Headaches after eating	0.....1.....2.....3	Sour taste in mouth	0.....1.....2.....3
High blood cholesterol and low HDL?	Yes.....No ..Unknown..	Yellow in whites of eyes	0.....1.....2.....3

HEALTH APPRAISAL QUESTIONNAIRE
Page 4

Name _____ **Date** _____

Section B

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

PART IV
Section A

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

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

Section B

Bumpy skin on back of arms	0.....1.....2.....3	Loss of smell	0.....1.....2.....3
Catch colds or flu easily	0.....1.....2.....3	Loss of taste	0.....1.....2.....3
Cold sores, fever blisters	0.....1.....2.....3	Nose bleeds	0.....1.....2.....3
Ear infection	0.....1.....2.....3	Poor wound healing	0.....1.....2.....3
Get boils or sties	0.....1.....2.....3	Running nose	0.....1.....2.....3
Hair falls out	0.....1.....2.....3	Slow to recover from cold or flu	0.....1.....2.....3
Hair grows slowly	0.....1.....2.....3	Swollen lymph glands	0.....1.....2.....3
Inflamed or bleeding gums	0.....1.....2.....3	Throat infections	0.....1.....2.....3

Section C

Alternating constipation and diarrhea	0.....1.....2.....3	Migraine headaches	0.....1.....2.....3
Bedwetting	0.....1.....2.....3	Mucous in throat	0.....1.....2.....3
Breath through mouth	0.....1.....2.....3	Nasal congestion	0.....1.....2.....3
Certain foods make you sick, depressed, jittery	0.....1.....2.....3	Painful stomach and/or intestines	0.....1.....2.....3
Chronic pain	0.....1.....2.....3	Post nasal drip	0.....1.....2.....3
Difficulty swallowing	0.....1.....2.....3	Puffiness or dark circles under eyes	0.....1.....2.....3
Discharge from eyes	0.....1.....2.....3	Runny nose	0.....1.....2.....3
Ear discharge or ears stuffed up	0.....1.....2.....3	Skin rashes	0.....1.....2.....3
Entire body aches, painful to touch	0.....1.....2.....3	Sneezing	0.....1.....2.....3
Food sensitivity or allergy	0.....1.....2.....3	Swollen joints	0.....1.....2.....3
Hyperactivity	0.....1.....2.....3	Swollen tongue	0.....1.....2.....3
Itching of nose or eyes	0.....1.....2.....3	Use aspirin, Tylenol regularly	0.....1.....2.....3
Itching of roof of mouth or throat	0.....1.....2.....3	Watery eyes	0.....1.....2.....3
Lung congestion	0.....1.....2.....3	Wheezing	0.....1.....2.....3

HEALTH APPRAISAL QUESTIONNAIRE

Name _____ **Date** _____

PART V

Section A

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

Section B

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

Section C

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

HEALTH APPRAISAL QUESTIONNAIRE
Page 7

Name _____ **Date** _____

PART VI
Section A

Calmer after eating	Yes……No	Heart palpitations after eating sweets	0…..1…..2…..3
Crave sweets	0…..1…..2…..3	Impatient, moody, nervous	0…..1…..2…..3
Dizziness when standing suddenly	0…..1…..2…..3	Irritable if a meal is missed	0…..1…..2…..3
Feel faint	0…..1…..2…..3	Loss of vision when standing suddenly	0…..1…..2…..3
Feel tired 1 to 3 hours after eating	0…..1…..2…..3	Need to drink coffee to get started	0…..1…..2…..3
Feel tired or weak if a meal is missed	0…..1…..2…..3	Poor concentration	0…..1…..2…..3
Feel shaky or jittery	0…..1…..2…..3	Poor memory	0…..1…..2…..3
Forgetful	0…..1…..2…..3	Wake up in the middle of night craving sweets	0…..1…..2…..3
Headaches relieved by eating sweets or alcohol	0…..1…..2…..3		

Section B

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

HEALTH APPRAISAL QUESTIONNAIRE
Page 8

Name _____ **Date** _____

PART VII

Bronchitis	Yes……No	Infections settle in lungs	0…..1…..2…..3
Chest pain	0…..1…..2…..3	Live/work around people who smoke	0…..1…..2…..3
Chronic cough	0…..1…..2…..3	Pain around ribs	0…..1…..2…..3
Cough up blood	0…..1…..2…..3	Rattling mucous when you breathe	0…..1…..2…..3
Coughing up phlegm	0…..1…..2…..3	Sensitive to smog	0…..1…..2…..3
Difficulty breathing	0…..1…..2…..3	Shortness of breath	0…..1…..2…..3
Exposed to chemicals and radiation	Yes……No	Smoker	Yes……No

PART VIII

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

PART IX (males only)
Section A

A sense of bladder fullness	0…..1…..2…..3	Lack of sex drive	0…..1…..2…..3
Ejaculation causes pain	0…..1…..2…..3	Wake up to urinate at night	0…..1…..2…..3
Increased straining with less urine passed	0…..1…..2…..3		

HEALTH APPRAISAL QUESTIONNAIRE
Page 9

Name _____ **Date** _____

Section B

Difficulty attaining and/or maintaining erection	0.....1.....2.....3	Pain/coldness in genital area	0.....1.....2.....3
Infertile	Yes.....No	Premature ejaculation	0.....1.....2.....3
Low sexual drive	0.....1.....2.....3	Varicose veins on scrotum	Yes.....No
Low sperm count	Yes.....No		

Section C

Discharge from penis	0.....1.....2.....3	Swollen genitals	0.....1.....2.....3
Past or present rash on penis	0.....1.....2.....3	Venereal disease (gonorrhea, syphilis, herpes, or other	Yes.....No
Swelling in groin	0.....1.....2.....3	Have VD now?___ Had VD in past? ___	0.....1.....2.....3

PART X (Female only)
Section A (1-2 week before menstruation only)

Anger	0.....1.....2.....3	Low backache	0.....1.....2.....3
Anxiety	0.....1.....2.....3	Monthly weight gain	0.....1.....2.....3
Asthma attacks	Yes.....No	Moodiness or irritability	0.....1.....2.....3
Bloating and swelling	0.....1.....2.....3	Nausea and/or vomiting	0.....1.....2.....3
Depression	0.....1.....2.....3	Suicidal feeling	Yes.....No
Easily distracted	0.....1.....2.....3	Tender breasts	0.....1.....2.....3
Headaches	0.....1.....2.....3	Other _____	0.....1.....2.....3
Leg cramps	0.....1.....2.....3	Other _____	0.....1.....2.....3

Section B (Anytime)

Abortions. If so, how many?	Yes ____ No	Over 15 years & have not begun menstruating	Yes.....No
Dislike for intercourse	0.....1.....2.....3	Unable to get pregnant	Yes.....No
Low or no desire for sex	0.....1.....2.....3	Vaginal discharge	0.....1.....2.....3
Miscarriages. If so, how many?	Yes ____ No	Vaginal itching	0.....1.....2.....3
Missed periods	Yes.....No		

HEALTH APPRAISAL QUESTIONNAIRE
Page 10

Name _____ **Date** _____

Section C (During Menstruation Only)

Abdominal bloating	0.....1.....2.....3	Light scant blood flow	0.....1.....2.....3
Anxiety about menstrual cycle	0.....1.....2.....3	Low abdominal pain	0.....1.....2.....3
Craving for sweets	0.....1.....2.....3	Menstrual pain	0.....1.....2.....3
Diarrhea	0.....1.....2.....3	Must lie down on days 1 or 2 days of period	0.....1.....2.....3
Dull ache radiating to low back or legs	0.....1.....2.....3	Nausea and/or vomiting	0.....1.....2.....3
Headaches	0.....1.....2.....3	Pain & cramps without blood flow	0.....1.....2.....3
Heavy menstrual bleeding	0.....1.....2.....3	Pain during period progressively getting worse	0.....1.....2.....3
Increased urinary frequency	0.....1.....2.....3	Pelvic soreness	0.....1.....2.....3
Insomnia	0.....1.....2.....3		

Section D

Breast lumps	Yes.....No	Pain in ovaries	0.....1.....2.....3
Breasts painful	0.....1.....2.....3	Premenstrual breast pain or discomfort	0.....1.....2.....3
Breasts sore to touch	0.....1.....2.....3	Pubic area sore	0.....1.....2.....3
Family history of breast cancer	Yes.....No	Recent pap smear positive	Yes.....No
Form of birth control:	None	Swollen	0.....1.....2.....3
If yes, which kind of birth control is used	_____	Uterine cysts	Yes.....No
Mother used D.E.S. (hormones) while pregnant	Yes.....No	Vaginal bumps and sores	0.....1.....2.....3
Ovarian cysts	Yes.....No	Water retention	0.....1.....2.....3

HEALTH APPRAISAL QUESTIONNAIRE
Page 11

Name _____ **Date** _____

Section E

Craving for sweets	0.....1.....2.....3	Night sweats	0.....1.....2.....3
Depression/mood swings	0.....1.....2.....3	Osteoporosis (bone loss)	Yes.....No
Dryness of skin, hair, & vagina	0.....1.....2.....3	Painful intercourse	0.....1.....2.....3
Heavy bleeding 2 weeks/month	0.....1.....2.....3	Sweating throughout the day	0.....1.....2.....3
Hot flashes	0.....1.....2.....3	Vaginal itching	0.....1.....2.....3
Hysterectomy	Yes.....No	Vaginal pain	0.....1.....2.....3
Insomnia	0.....1.....2.....3	Are you post menopausal	Yes.....No

PART XI
Section A

Arthritis	0.....1.....2.....3	Drink carbonated beverages/soda	No ....Yes, _____oz./wk
Bone deformity	Yes.....No	Eat meat	0.....1.....2.....3
Bones sore and painful	0.....1.....2.....3	Gum disease	Yes.....No
Bone loss	Yes.....No	Osteoporosis/osteomalacia	Yes.....No
Calcium deposits	Yes.....No	Pain in fingers	0.....1.....2.....3
Cavities	0.....1.....2.....3	Recent bone fracture	Yes.....No
Dentures	Yes.....No	Use antacids	No ....Yes, _____#./wk

Section B

Leg cramps at night	0.....1.....2.....3	Pain in neck and/or shoulders	0.....1.....2.....3
Muscle cramps	0.....1.....2.....3	Stiff in morning	0.....1.....2.....3
Muscle spasms	0.....1.....2.....3	Stiff all over	0.....1.....2.....3
Pain in arms or hands	0.....1.....2.....3	Tightness in shoulder muscles	0.....1.....2.....3
Pain in back	0.....1.....2.....3	Unable to sit straight	0.....1.....2.....3

HEALTH APPRAISAL QUESTIONNAIRE
Page 12

Name _____ **Date** _____

Section C

Athletic injury	0.....1.....2.....3	Loss in height	Yes.....No
Back pain	0.....1.....2.....3	Over flexible joints (double-jointed)	0.....1.....2.....3
Bursitis	0.....1.....2.....3	Slipped disc	Yes.....No
Herniated disc	Yes.....No	Swollen knees/elbows	0.....1.....2.....3
Injure easily	Yes.....No	Tendonitis	0.....1.....2.....3
Joint pain	0.....1.....2.....3		

PART XII

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

PART XIII

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

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

_____

_____

_____

_____

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

ACTIVITY RANGE MONITOR
- Idea List for Usual Activities –
Part 1

Name _____ **Date** _____

Use this list to help you remember activities that you normally do with or without pain or difficulty.

Daily Activities

- Activities relating to driving
- Caring for children
- _____
- _____
- _____

Recreational Activities

(Rate the following activities beginning with the more frequently performed activities (1) and then those that are performed occasionally. Include any that are not on the list.)

___ Aerobics
___ Backpacking
___ Bicycling
___ Canoeing
___ Camping
____Dancing
___ Gardening
___ Golf
___ Lifting Weights
___ Rollerblading
___ Skiing - Downhill/Cross Country
___ Softball
___ Swimming
___ Walking: _____ miles or _____ minutes
___ Water skiing
___ _____
___ _____

ACTIVITY RANGE MONITOR
- Idea List for Usual Activities –
Part 2

Mental and Mood Effects

(These represent a change from your usual state of functioning. Here are some possibilities.)

- Hard to think clearly (at times, frequently, always)
- Poor concentration
- Lowered stress tolerance
- Irritability
- Anxiety
- Depression
- _____
- _____

Work

(Think about your usual work tasks. Has anything affected your ability to do these? List the specific task that is important to your work that is now a problem. These are some ideas.)

- Sitting in meetings
- Typing or computer work
- Phone work
- Doing work with arms out in front of body (you can list the specific task)
- Carrying things (tools, books/files, etc.)
- Bending over for tasks (list if there is something specific)
- Lifting, carrying, reaching or other movements
- _____
- _____

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

ACTIVITY RANGE MONITOR

Name _____ Date _____

Indicate your ability to perform the following activities. Circle the answers which 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.

Physical Abilities

Coughing or Sneezing	☐ Local pain	☐ Radiating pain	☐ Okay		
Getting in or out of car	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Riding in a car for short distances	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Driving several hours unable.	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Bending forward to brush teeth	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Washing/drying hair	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Turning over in bed	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Sleep	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Standing for 10 minutes	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Standing for 1 hour or more	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Sitting for 10 minutes	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Sitting for 1 hour or more	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Lying on your back	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Lying on your side with knees bent	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Bending forward	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Climbing stairs (Pain after __ steps/flights)	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Kneeling	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Dressing Self	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Stooping	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Gripping objects	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Carrying objects	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Turning door knobs	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Pushing	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Pulling	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Reaching for objects in front of you	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Reaching overhead	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Handwriting	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay
Sexual activity	☐ Unable	☐ Pain	☐ Difficult	☐ Limited	☐ Okay

ACTIVITY RANGE MONITOR

Name _____ Date _____

House Work/Home Maintenance

Washing dishes	□ Unable	□ Pain	□ Difficult	□ Limited.	□ Okay
Changing sheets	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Vacuuming	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Sweeping.	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Washing floor.	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Washing windows.	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Scrubbing tub	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Grocery shopping	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Carrying groceries	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Snow shoveling	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Gutter cleaning	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Pet care.	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Mowing.	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
Raking	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay

Work Related

_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay

Recreational (Usual Activities)

List frequent activities first, then occasional

_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay
_____	□ Unable	□ Pain	□ Difficult	□ Limited	□ Okay

Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

ALLERGY QUESTIONNAIRE

Name _____ Date _____

Please circle or fill in the blank with 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	Bronchites	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 Beestings? Yes No Which Kind Of Bee? _____

A Severe Allergic Reaction To Anything? Yes No To What? _____

An 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

Basement

____ None (Slab)
____ Crawl Space Only
____ Concrete Floor
____ Dirt Floor
____ Stone Floor
_____ Concrete Block Walls
_____ Finished
_____ Carpeted
_____ Is The Basement Dry/Damp

Bedding & Linen

_____ Down Comforters
_____ Wool Blankets
_____ Cotton Blankets
_____ Window Treatments
_____ Drapes/Curtains - Dry Clean
_____ Drapes/Curtains – Washable
_____ Blinds – Fabric
_____ Blinds – Metal or Wood

Household Products Used

_____ Lysol/Pine sol
_____ Air Fresheners
_____ Perfumes/Aftershave Lotions
_____ Dryer Softeners (Sheets)

Kitchen

_____ Gas Stove
_____ Electric Range
_____ Refrigerator – Self Defrosting
_____ Space Heaters

Bedroom

Mattress (List Ages)

_____ Innerspring
_____ Foam Rubber

PILLOWS

_____ Polyester
_____ Feather
_____ Down
_____ Foam

_____ Most Recent Year Furnace Ducts Were Professionally Cleaned
_____ Have There Been Major Housing Problems (Flooding, Fire, Etc.)

LIST THE NUMBERS AND TYPES BELOW:

_____ Number of Adults Living Together
_____ Number of Children
_____ Number of Smokers (Frequent)
_____ Number of Smokers (Occasional)
_____ Number of Other Pets(Inside)
_____Number of Cats
_____ Number of Dogs
_____ Number of Birds
_____ Number of Horses
_____ Number Of Other Animals (Outside)

ALLERGY QUESTIONNAIRE
Page 3

Name _____ Date _____

FLOORING: (*List age where appropriate)*

	CARPET	WOOD	VINYL	TILE	CONCRETE
LIVING ROOM					
DINING ROOM					
KITCHEN					
MASTER BEDROOM					
2ND BEDROOM					
3RD 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 Has Been Turned on	Yes	No
In a Basement	Yes	No	In Certain Rooms	Yes	No
With Ceiling Fans On	Yes	No	In Damp Places	Yes	No
While Dusting/Sweeping	Yes	No	When Exposed to Hay	Yes	No
While Mowing Grass	Yes	No	While Near a Circus	Yes	No
While Near a Barn	Yes	No	While Raking Leaves	Yes	No
After August 15	Yes	No	In Cool Evening Air	Yes	No
Around Compost	Yes	No	Between 1 And 5 Am	Yes	No
In the Late Evening	Yes	No	While Drinking Beer	Yes	No
When Eating Cheese	Yes	No	While Drinking Wine	Yes	No
While Eating Mushrooms	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						

ALLERGY QUESTIONNAIRE

Name _____ Date _____

VEGETABLES *(Continued)*

	DAILY	1-2 / WK	1-2 / MO	1 / MO	RARELY	NEVER
KIDNEY BEANS						
LETTUCE						
ONION						
POTATO						
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? _____

Do they disagree with you? _____

Do you avoid them for whatever reason (If so specify) _____

_____

You Crave Them: _____

ALLERGY QUESTIONNAIRE

Name _____ Date _____

CHEMICALS: Place indicate the chemicals that bother you and/or that make you really sick.

Bother You	Make You 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
☐	☐	Lubrication 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-Containing 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
☐	☐	Odor of Lysol/Pine Sol
☐	☐	Fumes Form 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 Upholstery
☐	☐	Rayon or Cellulose Acetate Clothing or Upholstery
☐	☐	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 Softeners (Dryer Sheets)

Doctor CAROL DC
Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

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 you 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 before 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

Doctor CAROL DC
Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

PATIENT INFORMATION AND CONSENT

- You have agreed to a Chiropractic evaluation, which in this office utilizes Applied Kinesiololgy 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 assume responsibility for the acceptance or rejection of any recommendations based on the use of muscle testing.

_____

Name *(Printed)*

_____

Signature

_____

Date

Doctor CAROL DC
Dr. Carol H. Lipschultz DC DNBHE HMC CTN PLC
1704 Oliver Av S Mpls Mn 55405 t: 612.977.9691 f : 612.377.2372
carol@drcaroldc.com www.drcaroldc.com

FINANCIAL AGREEMENT

☐ I acknowledge that 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.

☐ I acknowledge that Dr. Carol Lipschultz's Office does not bill insurance companies for services provided. I acknowledge that it is my responsibility to submit claims to my insurance for reimbursement, if I should so choose.

☐ I acknowledge that I am responsible to submitting all receipts for supplements or services to my Flex/Health Savings Account for reimbursement, if I should so choose.

_____
Name (Printed)

_____
Signature

_____
Date