APPLIED HEALTH
PROFESSIONAL APPLIED KINESIOLOGY

# Welcome to Applied Health Professional Kinesiology

Please fill out this confidential health history form as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask one of our qualified chiropractic assistants for help.

Today's Date: ____/____/____ Whom may we thank for referring you to our office?_____

## PERSONAL HISTORY

Last Name:_____ First Name:_____MI_____

Address:_____ City:_____ State:

Zip Code:_____ Home Phone: (__) ____ - _____ Cell phone: (__) ____ - _____ Email:_____

Birth Date: ___/___ /___ Age: ____Gender: ❑Female ❑Male

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed

Drivers License Number:_____

Employer:_____ Type of Work: _____

Address: _____City:_____ State:_____

Zip Code:_____ Work Phone: (__) ____ - _____

Spouse's Name:_____ Work Place:_____ Phone: (__) ____ - ____

Name & Ages of Children (if applicable):_____

In an emergency, whom do we contact? _____Phone: (__) ____ - _____

## CURRENT HEALTH CONDITIONS

Primary health complaint(s): _____

How long have you suffered with this problem? _____

How often does this problem currently bother you? _____

Does anyone else in your family have the same or similar problem? ❑Yes ❑No

If yes, who? _____

Before you began to suffer with this problem, was there an earlier accident, injury, or other condition that could have brought this about or be related to it? ❑Yes ❑No

If yes, was it: ❑Job related ❑Auto Accident ❑Other:

If work related, has the accident been reported to your employer? ❑Yes ❑No

If auto related, what is the date and time of accident? _____

What other health practitioners have you consulted for this/these complaints?_____

_____

Have you become discouraged that this problem has not been resolved? ❑Yes ❑No

Patient Name: _____ Date: _____

When this problem is at its worst, how does it make you feel? _____

When this problem is at its worst, how does it interfere with your: _____

Work? _____ Family Life? _____

Recreation/Hobbies? _____

What effect is this problem having on other people in your life? _____

_____

What effect is this problem having on your level of stress? _____

What daily habits do you have that could make this worse? _____

On a scale of 1-10 (ten highest) rate your commitment to getting rid of this problem: _____

Is getting rid of this problem, and what caused it, a top priority for you? _____

**PAST HEALTH HISTORY**

Surgeries/Operations: Appendix_____ Tonsils_____ Hernia_____ Spinal_____ Cosmetic_____ Other:_____

Major accidents or falls since birth: _____

Hospitalizations (other than above): _____

Please list all medications you presently take: (please include all medications, including over the counter and vitamins): __

_____

Are you currently under the care of a physician? ❑Yes ❑No If yes, please indicate for what condition: _____

_____

Please list the physician's name, phone number, and approximate date of last treatment: _____

_____

Have you had previous chiropractic care? ❑Yes ❑No Please list doctor's name and approx. date of last visit: _____

_____

Are you presently under the care of any other healthcare practitioners?

❑Acupuncturist ❑Massage Therapist ❑Nutritionist ❑Other: _____

Is there anything else that you would like the doctor to know about your health? _____

_____

Please check any of the following conditions that you have had in the past:

- ❑ Pneumonia
- ❑ Mumps
- ❑ Arthritis
- ❑ Heart Disease
- ❑ Measles
- ❑ Pleurisy
- ❑ Tuberculosis
- ❑ Thyroid Disorder
- ❑ Influenza
- ❑ Polio
- ❑ Cancer
- ❑ Anemia
- ❑ Rheumatic Fever
- ❑ Small Pox
- ❑ Eczema/Psoriasis
- ❑ Whooping Cough

Patient Name: _____ Date: _____

Please check any of the following that you have had in the past six months:

**Musculoskeletal**
- ❑ Low back pain
- ❑ Pain b/w the shoulders
- ❑ Neck pain
- ❑ Shoulder/arm/wrist pain
- ❑ Hip/knee/ankle pain
- ❑ Joint pain or stiffness
- ❑ Difficulty walking
- ❑ Jaw/head pain

**Nervous System**
- ❑ Cold/tingling extremities
- ❑ Numbness/loss of sensation
- ❑ Dizziness
- ❑ Seizures
- ❑ Paralysis
- ❑ Nervousness/Stress

**Cardiovascular**
- ❑ Chest pain
- ❑ Shortness of breath
- ❑ High blood pressure
- ❑ Irregular heart beat
- ❑ Stroke
- ❑ Lung congestion
- ❑ Varicose veins
- ❑ Ankle swelling
- ❑ Lung symptoms

**General**
- ❑ Allergies
- ❑ Fatigue
- ❑ Loss of sleep
- ❑ Unexplained fevers
- ❑ Headaches

**Gastrointestinal**
- ❑ Poor Appetite/Underweight
- ❑ Excessive Thirst
- ❑ Frequent nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver problems
- ❑ Colitis/Crohn's/IBS
- ❑ Gall bladder problems
- ❑ Abdominal Cramps
- ❑ Gas/bloating after meals
- ❑ Heartburn
- ❑ Blood in stool

**Male Only**
- ❑ Prostate dysfunction
- ❑ Loss of libido
- ❑ Sexual dysfunction

**Women Only**
- ❑ Menstrual cramps
- ❑ Irregular/absent periods
- ❑ Vaginal pain/infection
- ❑ PMS
- ❑ Loss of libido
- ❑ Menopausal symptoms
- ❑ Breast pain
- ❑ Uterine/ovarian fibroids
- ❑ Date of last period?

_____/_____/_____

Are you pregnant?

❑ Yes ❑ No ❑ Not sure

**Genitourinary**
- ❑ Painful/excessive urination
- ❑ Discolored urine
- ❑ Bladder infections
- ❑ Urinary leakage

**EENT**
- ❑ Vision problems
- ❑ Dental problems
- ❑ Earache/infection
- ❑ Difficult hearing
- ❑ Ringing in Ears
- ❑ Cold/Flu
- ❑ Sinus problems
- ❑ Sore throat

**Other Health Issues**

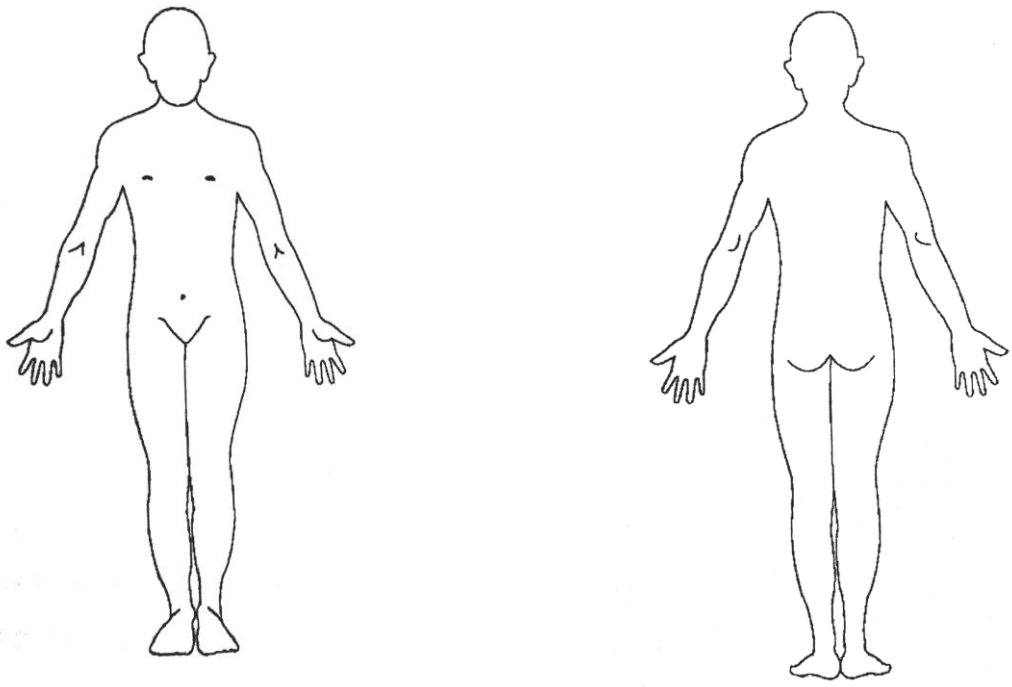
Patient Name: _____ Date: _____

**PAIN CHART:**

Use the appropriate symbols. Mark areas of radiation. Include all affected areas.

| **Numbness** | **Pins & Needles** | **Burning** | **Aching** | **Stabbing** |
|---|---|---|---|---|
| ---------- | 000000000000000 | XXXXXXXXX | ********** | ////////// |

Please mark on the pain scale from 1-10 the pain you feel with this condition, 10 being the worst pain you have felt with this condition.



**DIET/NUTRITIONAL HEALTH HISTORY**

What you eat and what you supplement your diet with has a direct effect on your health. Please help us help you by providing us with the following information:

What do you commonly eat for breakfast? _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you regularly take nutritional supplements? ❑Yes ❑No If yes, please list them: _____

_____

Patient Name: _____ Date: _____

Do you have allergies? ❑Yes ❑No If yes, what kind? _____

Do you smoke cigarettes, cigars, or chew tobacco? ❑Yes ❑No If yes, how much? _____

Do you drink alcohol? ❑Yes ❑No If yes, how much? _____

Do you drink coffee? ❑Yes ❑No If yes, how much? _____

Do you drink soda/soft drinks? ❑Yes ❑No If yes, how much? _____

Do you eat fried foods? ❑Yes ❑No If yes, how much? _____

Do you use white sugar/artificial sweeteners? ❑Yes ❑No If yes, how much? _____

Your doctor will be making specific dietary recommendations and prescribing an individual supplementation program just for you. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to follow the recommended dietary and nutritional supplementation program. _____

## ERGONOMIC HEALTH HISTORY

How you treat and support your body on a daily basis has a direct impact on your health. Please help us help you by providing us with the following information:

**Exercise Habits**

Do you currently exercise? _____

Do you wear orthotics/foot inserts? _____

Your doctor may recommend a cardiovascular, strength training, and/or stretching program. Please rate, on a scale of 1-10 (with 10 being the highest), your willingness to incorporate the prescribed exercise into your health care program.

1 2 3 4 5 6 7 8 9 10

**Sleep Habits**

What is your most common sleep position? ❑Back ❑Side ❑Stomach

Do you use a pillow? ❑Yes ❑No What type? ❑Regular ❑Cervical (neck)

What type of mattress do you sleep on and how old is it? _____

How many hours of sleep do you average per night? _____

**Work Habits**

How many hours per day are you:

Sitting: _____ Standing: _____ Crouching or bending over: _____

Lifting: _____ Walking: _____ Working at a computer: _____

**Electronic Radiation Exposure**

Do you use any of the following daily? Check all that apply.

❑Blow dryer/curling iron ❑Microwave ❑Sleep within 3 feet of an electrical outlet

❑Cell phone/cordless phone ❑Electric razor/toothbrush ❑Spend more than 1 hour/day in the car

Scientific studies are now showing that repeated exposure to the above items can be extremely hazardous to your health. Your doctor will discuss with you ways to reduce your exposure to these harmful elements.

Patient Name: _____ Date: _____

**MENTAL/EMOTIONAL HEALTH HISTORY**

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please answer the following questions as accurately and completely as possible.

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

| Please circle the appropriate number: | Low | | | | | | | | | High |
|---|---|---|---|---|---|---|---|---|---|---|
| Financial/Money matters | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Relationship/Family | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Job/Career/Education | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Current level of health | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Spiritual/Religious/Ethical | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Overall level of life stress | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Please check all of the following life events that you currently (or previously) experience stress with:

- ❑ Birth of siblings
- ❑ Toilet training
- ❑ Babysitters
- ❑ Death of a pet
- ❑ First year of school
- ❑ Teachers
- ❑ Peer relationships
- ❑ Onset of puberty
- ❑ Fights
- ❑ Romance/dating
- ❑ Illness/operations
- ❑ Parental conflict/separation
- ❑ Divorce
- ❑ Prom
- ❑ College
- ❑ Abortion/miscarriages
- ❑ Any betrayal
- ❑ Marriage
- ❑ Moving
- ❑ Accidents
- ❑ Loss of job/layoff
- ❑ Financial disruptions
- ❑ Illness of a loved one
- ❑ Diagnosis of a fatal condition
- ❑ Death of a loved one
- ❑ Other: _____

The doctors of Applied Health P.A.K. are specialists in NET (Neuro-emotional technique). They are able to determine through this method if stress is affecting your present condition and overall health. They will discuss this with you in your consultation. If your doctor can show you how your health can improve and your level of stress can be dramatically reduced, would you be interested in learning more about this technique? ❑Yes ❑No

Patient Name: _____ Date: _____

**SENSITIVE HEALTH INFORMATION**

The following items have been listed as sensitive health information and, therefore, will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

1) History of alcohol use/abuse: ❑Yes ❑No If yes, how much, what kind, and for how long have you consumed these?

_____

2) History of recreational drug use/abuse: ❑Yes ❑No If yes, what kind, how much, and how long? _____

_____

3) Have you been diagnosed with a mental illness? ❑Yes ❑No Diagnosis? _____When? _____
Treatment? _____

4) Have you ever been tested for the HIV virus? ❑Yes ❑No Results? _____

5) Have you ever been diagnosed with HIV or an HIV related illness? ❑Yes ❑No If yes, what type of treatment are you under? _____

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**GOALS FOR YOUR CARE**

Thank you for choosing Applied Health – P.A.K. for your healthcare, chiropractic and wellness needs. We at Applied Health – P.A.K. serve patients as individuals, work towards educating and improving health while shifting the health paradigm. We support each person during their journey to achieving optimal wellness. The doctor at Applied Health – P.A.K. is a natural healthcare provider who uses cutting-edge, sustainable methods and specializes in assisting patients who have hard to treat health issues or have been unable to find relief through a standard course of treatment.

People come to Applied Health – P.A.K. for a variety of reasons. Some come in just for pain relief; some go further and want to correct the CAUSE of their pain/ symptoms; and most patients go even further by choosing complete health and wellness by correcting all mean of dysfunction going on in their bodies even before symptoms are present.

Please check the type of care desired so that we can best serve your health needs.

❑ Relief Care: Pain/Symptom relief only

❑ Corrective Care: Correction of the CAUSE of the pain/symptoms as well as relief of pain/symptoms.

❑ Comprehensive Care: Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing pain/symptom relief to the areas of complaint.

❑ I want the doctor to select the type of care appropriate for my health and condition.

Patient Name: _____ Date: _____

## OUR OFFICE POLICIES

**Payment Policy**

Our office is not affiliated with HMO's, PPO's, or Health/Medical insurance companies. Patients who carry any form of medical or health insurance should know that ALL services rendered by this office are charged directly to the patient. Payment in full is due and payable at time of service. This office does not carry balances. If payment is not received, the office uses outside sources to collect balances due.

Initials _____

**Health Medical Insurance**

If you have insurance that offers chiropractic benefits or other benefits in our office, and you intend to submit bills, please let us know. As a courtesy we will electronically submit your bill to your medical insurance company for services rendered. Depending on which medical insurance plan you chose you may or may not have coverage for an out of network provider. If coverage is denied by your medical insurance plan, Applied Health – P.A.K. will not normally resubmit the forms or supply supporting documentation to the medical insurance for possible reimbursement. However, a charge of $25 will be applied for statements that need to be resubmitted by your request of the request of your medical insurance company.

Should your reimbursement check be mistakenly issued to Applied Health – P.A.K. from your medical insurance company, the check will be voided and sent to you (the patient). It will be your responsibility to contact your insurance company for reissuance.

Initials _____

**Nutritional Supplements/Health Supplies**

Nutritional supplements and other health supplies must be paid for at time of service.

Initials _____

**Returned Checks**

There will be a $35.00 charge on all returned checks. If multiple checks are returned during the course of your care, check privileges will be revoked. Future payment of your account will only be accepted in cash, credit card, or care credit.

Initials _____

**Missed Appointments**

Should the need arise to reschedule your appointment please give the office a minimum of 24 hours notice otherwise you will be charged $25.

Late Arrivals - Due to the high demand of our services at Applied Health – P.A.K. it is imperative that you arrive on time for your appointment. Patients who arrive 10 minutes after their scheduled appointment time will need to reschedule and will be charged for 50% of their full appointment fee.

Missed Appointments – Appointments that are completely missed will be charged for a full appointment. The staff is unable to fill your time slot without an appropriate notice in advance. By missing your appointment you take away the opportunity for someone on our waiting list to become well through care at Applied Health – P.A.K.

Initials _____

Any questions you have regarding our policies are welcome at any time.

Patient Name: _____ Date: _____

I hereby authorize the doctor to provide me with a consultation and examination in order to determine if my case can be helped by chiropractic and the care provided here at Applied Health P. A. K. I also understand that other exams and tests such as X-rays, lab tests, etc. may be necessary to gain more information regarding my health. I understand that if I am accepted as a patient here at Applied Health P. A. K., the doctor will discuss with me which course of care would be best for my case.

_____ _____

Patient Signature Patient Name

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Date

Patient Name: _____ Date: _____

**CONFIDENTIALITY AGREEMENT**

To Our Valued Patients:

We at Applied Health P. A. K. have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to ensure your rights of patient privacy (in accordance with HIPAA).

The following have been incorporated to secure your private patient information:
1. We do not obtain your social security number for the purpose of patient identification. By removing this part of your private information it becomes much less likely that in the unlikely event of a security breach your personal or professional finances will not be at risk. You are automatically assigned a randomized patient number when your patient chart is created.
2. All of your information is kept on cloud based medical software specifically designed to be in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
3. All employees and contractors at Applied Health –P.A.K. undergo training regarding HIPAA prior to having access to private information. Once the training is complete, employees and contractors sign a strict confidentiality agreement that requires all patient information, including but limited verbal, written or other information, within the confines of our secure software at all times.
4. All computers with patient data are password secure and require multiple logins prior to accessing patient data. Access to the computers is restricted and each employee has a unique, identifiable user identification that is logged during use of patient information.
5. Only one person may access a patient account at any given time. The software restricts multiple users from accessing the same patient information at the same time.
6. Patients are not allowed behind the desk at any time. At no time are unauthorized, non-employees allowed into the front desk area. Please ask for help with product that you may be interested in.
7. Once you arrive in the clinic you are securely checked into our secure, HIPAA compliant, software and at this time there is no need to write your name on a sign in sheet for regular appointments.

We communicate with our patients through mail, e-mail, and by phone. Below is a list of how we correspond with you. Please indicate any items that you do NOT wish to receive:

**Mailers:** ❑Birthday greetings ❑Holiday cards ❑Health newsletters ❑US Post Mailings ❑Healthcare maintenance reminders ❑Thank you cards for your referrals ❑Electronic

**Phone Calls:** ❑Missed appointment rescheduling ❑Healthcare maintenance reminders

**In Office (Board):** ❑"Thank you for referring" board

In the event that we are unable to speak with you directly, please indicate ALL the ways that are acceptable for us to leave a courtesy message for you:
- ❑ On your home/cell phone answering machine or with your family
- ❑ Office voicemail or with the receptionist.

We will do our best to honor your requests when communicating with you.

Yours in Health,

The doctors and staff at Applied Health P. A. K.

| _____ | _____ | _____ | _____ |
|---|---|---|---|
| Patient Signature | Date | Witness | Date |