



Welcome to Powell Chiropractic Clinic's Health and Wellness program

*We are honored that you have chosen us
to help you in the overall improvement of your health!*

Dr. Robert Powell is a Board Certified Naturopath and the Director of the Health and Wellness Department. The purpose of consultation-evaluation appointment is to determine your primary nutritional needs and your personal goals. Additional testing may be recommended to help determine any underlying dysfunction you may be experiencing.

It is important that you are punctual for your appointments, and that any and all paperwork is completed before your scheduled appointment time to prevent unnecessary waiting for you and others. Typically, you will be here for one hour on the initial visit which includes a pre-screening appointment and consultation. As a courtesy to other scheduled patients, we make every effort not to exceed the scheduled time. Interim office visits are an average of 15-20 minutes.

In the event additional time is needed you will be scheduled for another visit. If you need to cancel an appointment please do so within 24-hours. If you have any questions or concerns, please ask for our Health and Wellness Department specifically, and you will have an answer with in a timely manner.

You can fill out the Toxicity Questionnaire and the Systems Survey either online or download it and bring it with you to your first appointment. This will give us an idea of your needs and how we may be able to help.

Again, welcome and *thank you* for having confidence in us, we will do our very best to see that your health care goals are met.

The Doctors and Staff of Powell Chiropractic Clinic, Inc.



Patient History

Name: _____

Date: _____

Past Medical History (Diagnosed Illnesses)

Diagnosis	Date of onset
1.	
2.	
3.	
4.	
5.	
6.	

Surgical History

Procedure	Date
1.	
2.	
3.	
4.	
5.	
6.	

Allergies

1.
2.
3.
4.



Name: _____

Date: _____

Family History

Diagnosed Illness	Family Member
1.	
2.	
3.	
4.	
5.	

Medication List

Prescription Name	Mg/Mcg/IU per tablet	Units per day
1.		
2.		
3.		
4.		
5.		
6.		

Number of children: _____

Are you pregnant at this time? _____ Month? _____

Smoking Status: _____

Date started: _____ Date quit: _____

Use of alcohol or coffee? Please circle any that apply.

Other substances: _____

PRACTICE'S REQUIREMENTS

The Practice:

- (a) Is required by federal law to maintain the privacy of your Personal Health Information and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your Personal Health Information.
- (b) Powell Chiropractic Clinic, Inc. adheres to Ohio law in those instances where Ohio law does not conflict with federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health Information that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

EFFECTIVE DATE

This Notice is in effect as of 04/15/03. If you would like to review our HIPPA agreement, please advise our staff and we will supply you with detailed information.

PATIENT ACKNOWLEDGEMENT

By subscribing my name below, I acknowledge that I have read this Notice, and that I understand and agree to its terms.

Patient Name

Patient Signature

Date



Explanation of Financial Policy and Care

Natural Healthcare that includes whole food supplementation, exercise and other remedies that we request are not generally covered by third party payers (insurance companies). In certain cases, there may be the opportunity for reimbursement according to special circumstances. Our financial policy is that fees are paid at the time of service and when products are provided they can be paid for by cash, check, or credit card. However, if applicable, we will provide you with the proper documentation for your reimbursement needs.

Our primary supplement brand is Standard Process. They are devoted to improving the quality of life by providing the safest, most effective, highest quality dietary supplements only through health care professionals. While seeking the nutritional guidance from our Health and Wellness Department, it is suggested that the recommended supplements are purchased from our facility to ensure efficacy of the product.

In addition, this office makes every effort to provide the highest quality of care and state of the art methods of assessing patient needs for nutritional support and lifestyle instruction. We make no claims to treat, cure or diagnose disease, but rely solely on the body's ability to heal itself through natural methods.

Our staff will provide you with a receipt with every transaction. We will only accept returns that are unopened, unexpired and accompanied by a receipt. Any credits will be applied to your account for further purchases.

*I have read and understand the policy of Powell Chiropractic Clinic, Inc. Health and Wellness Department and agree to its method of support and financial policy.

Patient Signature _____ Date _____

Witness Signature _____ Date _____



SYSTEMS SURVEY FORM
(Restricted to Professional Use)

PATIENT _____ AGE _____ DOCTOR _____ DATE _____

INSTRUCTIONS: Circle the number that applies to you. **If a symptom does not apply, leave it blank.**
Circle either: (1) for **MILD** symptoms (occurs rarely), (2) for **MODERATE** symptoms (occurs several times a month),
or (3) for **SEVERE** symptoms (occurs almost constantly).

GROUP ONE

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

GROUP TWO

- | | | |
|---|--|--|
| 21 – 1 2 3 Joint stiffness after arising | 29 – 1 2 3 Digestion rapid | 37 – 1 2 3 “Slow starter” |
| 22 – 1 2 3 Muscle-leg-toe cramps at night | 30 – 1 2 3 Vomiting frequent | 38 – 1 2 3 Get “chilled” infrequently |
| 23 – 1 2 3 “Butterfly” stomach, cramps | 31 – 1 2 3 Hoarseness frequent | 39 – 1 2 3 Perspire easily |
| 24 – 1 2 3 Eyes or nose watery | 32 – 1 2 3 Breathing irregular | 40 – 1 2 3 Circulation poor,
sensitive to cold |
| 25 – 1 2 3 Eyes blink often | 33 – 1 2 3 Pulse slow; feels “irregular” | 41 – 1 2 3 Subject to colds,
asthma, bronchitis |
| 26 – 1 2 3 Eyelids swollen, puffy | 34 – 1 2 3 Gagging reflex slow | |
| 27 – 1 2 3 Indigestion soon after meals | 35 – 1 2 3 Difficulty swallowing | |
| 28 – 1 2 3 Always seem hungry;
feels “lightheaded” often | 36 – 1 2 3 Constipation,
diarrhea alternating | |

GROUP THREE

- | | | |
|---|--|---|
| 42 – 1 2 3 Eat when nervous | 49 – 1 2 3 Heart palpitates if meals
missed or delayed | 53 – 1 2 3 Crave candy or coffee
in afternoons |
| 43 – 1 2 3 Excessive appetite | 50 – 1 2 3 Afternoon headaches | 54 – 1 2 3 Moods of depression -
“blues” or melancholy |
| 44 – 1 2 3 Hungry between meals | 51 – 1 2 3 Overeating sweets upsets | 55 – 1 2 3 Abnormal craving for
sweets or snacks |
| 45 – 1 2 3 Irritable before meals | 52 – 1 2 3 Awaken after few hours sleep
- hard to get back to sleep | |
| 46 – 1 2 3 Get “shaky” if hungry | | |
| 47 – 1 2 3 Fatigue, eating relieves | | |
| 48 – 1 2 3 “Lightheaded” if meals delayed | | |

GROUP FOUR

- | | | |
|---|---|--|
| 56 – 1 2 3 Hands and feet go to sleep
easily, numbness | 63 – 1 2 3 Get “drowsy” often | 68 – 1 2 3 Bruise easily, “black
and blue” spots |
| 57 – 1 2 3 Sigh frequently, “air
hunger” | 64 – 1 2 3 Swollen ankles
worse at night | 69 – 1 2 3 Tendency to anemia |
| 58 – 1 2 3 Aware of “breathing
heavily” | 65 – 1 2 3 Muscle cramps, worse
during exercise; get
“charley horses” | 70 – 1 2 3 “Nose bleeds” frequent |
| 59 – 1 2 3 High altitude discomfort | 66 – 1 2 3 Shortness of breath
on exertion | 71 – 1 2 3 Noises in head, or
“ringing in ears” |
| 60 – 1 2 3 Opens windows in
closed room | 67 – 1 2 3 Dull pain in chest or
radiating into left arm,
worse on exertion | 72 – 1 2 3 Tension under the
breastbone, or feeling
of “tightness”,
worse on exertion |
| 61 – 1 2 3 Susceptible to colds
and fevers | | |
| 62 – 1 2 3 Afternoon “yawner” | | |

GROUP FIVE

- | | | |
|---|--|---|
| 73 - 1 2 3 Dizziness | 83 - 1 2 3 Feeling queasy; headache over eyes | 91 - 1 2 3 Sneezing attacks |
| 74 - 1 2 3 Dry skin | 84 - 1 2 3 Greasy foods upset | 92 - 1 2 3 Dreaming, nightmare type bad dreams |
| 75 - 1 2 3 Burning feet | 85 - 1 2 3 Stools light-colored | 93 - 1 2 3 Bad breath (halitosis) |
| 76 - 1 2 3 Blurred vision | 86 - 1 2 3 Skin peels on foot soles | 94 - 1 2 3 Milk products cause distress |
| 77 - 1 2 3 Itching skin and feet | 87 - 1 2 3 Pain between shoulder blades | 95 - 1 2 3 Sensitive to hot weather |
| 78 - 1 2 3 Excessive falling hair | 88 - 1 2 3 Use laxatives | 96 - 1 2 3 Burning or itching anus |
| 79 - 1 2 3 Frequent skin rashes | 89 - 1 2 3 Stools alternate from soft to watery | 97 - 1 2 3 Crave sweets |
| 80 - 1 2 3 Bitter, metallic taste in mouth in mornings | 90 - 1 2 3 History of gallbladder attacks or gallstones | |
| 81 - 1 2 3 Bowel movements painful or difficult | | |
| 82 - 1 2 3 Worrier, feels insecure | | |

GROUP SIX

- | | | |
|--|--|--|
| 98 - 1 2 3 Loss of taste for meat | 101 - 1 2 3 Coated tongue | 104 - 1 2 3 Mucous colitis or "irritable bowel" |
| 99 - 1 2 3 Lower bowel gas several hours after eating | 102 - 1 2 3 Pass large amounts of foul-smelling gas | 105 - 1 2 3 Gas shortly after eating |
| 100 - 1 2 3 Burning stomach sensations, eating relieves | 103 - 1 2 3 Indigestion 1/2 - 1 hour after | 106 - 1 2 3 Stomach "bloating" eating; may be up to 3-4 hours after |

GROUP SEVEN

- | | | |
|---|---|---|
| (A) | | (E) |
| 107 - 1 2 3 Insomnia | | 150 - 1 2 3 Dizziness |
| 108 - 1 2 3 Nervousness | | 151 - 1 2 3 Headaches |
| 109 - 1 2 3 Can't gain weight | | 152 - 1 2 3 Hot flashes |
| 110 - 1 2 3 Intolerance to heat | (C) | 153 - 1 2 3 Increased blood pressure |
| 111 - 1 2 3 Highly emotional | 137 - 1 2 3 Failing memory | 154 - 1 2 3 Hair growth on face or body (female) |
| 112 - 1 2 3 Flush easily | 138 - 1 2 3 Low blood pressure | 155 - 1 2 3 Sugar in urine (not diabetes) |
| 113 - 1 2 3 Night sweats | 139 - 1 2 3 Increased sex drive | 156 - 1 2 3 Masculine tendencies (female) |
| 114 - 1 2 3 Thin, moist skin | 140 - 1 2 3 Headaches, "splitting or rendering" type | |
| 115 - 1 2 3 Inward trembling | 141 - 1 2 3 Decreased sugar tolerance | (F) |
| 116 - 1 2 3 Heart palpitates | | 157 - 1 2 3 Weakness, dizziness |
| 117 - 1 2 3 Increased appetite without weight gain | (D) | 158 - 1 2 3 Chronic fatigue |
| 118 - 1 2 3 Pulse fast at rest | 142 - 1 2 3 Abnormal thirst | 159 - 1 2 3 Low blood pressure |
| 119 - 1 2 3 Eyelids and face twitch | 143 - 1 2 3 Bloating of abdomen | 160 - 1 2 3 Nails, weak, ridged |
| 120 - 1 2 3 Irritable and restless | 144 - 1 2 3 Weight gain around hips or waist | 161 - 1 2 3 Tendency to hives |
| 121 - 1 2 3 Can't work under pressure | 145 - 1 2 3 Sex drive reduced or lacking | 162 - 1 2 3 Arthritic tendencies |
| | 146 - 1 2 3 Tendency to ulcers, colitis | 163 - 1 2 3 Perspiration increase |
| (B) | 147 - 1 2 3 Increased sugar tolerance | 164 - 1 2 3 Bowel disorders |
| 122 - 1 2 3 Increase in weight | 148 - 1 2 3 Women: menstrual disorders | 165 - 1 2 3 Poor circulation |
| 123 - 1 2 3 Decrease in appetite | 149 - 1 2 3 Young girls: lack of menstrual function | 166 - 1 2 3 Swollen ankles |
| 124 - 1 2 3 Fatigue easily | | 167 - 1 2 3 Crave salt |
| 125 - 1 2 3 Ringing in ears | | 168 - 1 2 3 Brown spots or bronzing of skin |
| 126 - 1 2 3 Sleepy during day | | 169 - 1 2 3 Allergies - tendency to asthma |
| 127 - 1 2 3 Sensitive to cold | | 170 - 1 2 3 Weakness after colds, influenza |
| 128 - 1 2 3 Dry or scaly skin | | 171 - 1 2 3 Exhaustion - muscular and nervous |
| 129 - 1 2 3 Constipation | | 172 - 1 2 3 Respiratory disorders |
| 130 - 1 2 3 Mental sluggishness | | |
| 131 - 1 2 3 Hair coarse, falls out | | |
| 132 - 1 2 3 Headaches upon arising wear off during day | | |
| 133 - 1 2 3 Slow pulse, below 65 | | |
| 134 - 1 2 3 Frequency of urination | | |
| 135 - 1 2 3 Impaired hearing | | |
| 136 - 1 2 3 Reduced initiative | | |

Name:

Date:

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a purification program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloating feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total: _____

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches or ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears or hearing loss	0	1	2	3	4

Total: _____

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, or nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Uncaring or disinterested	0	1	2	3	4

Total: _____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total: _____

5. EYES

a. Watery or itchy eyes	0	1	2	3	4
b. Swollen, reddened, or sticky eyelids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred or tunnel vision	0	1	2	3	4

Total: _____

6. HEAD

a. Headaches	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total: _____

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma or bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total: _____

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total: _____

9. MOUTH/THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging or frequent need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums, lips	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total: _____

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total: _____

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, or dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total: _____

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total: _____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness or limited movement	0	1	2	3	4

Total: _____

e. Pain or aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tiredness	0	1	2	3	4

Total: _____

14. WEIGHT

a. Binge eating or drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total: _____

15. OTHER:

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total: _____

Section I Total: _____