Runnerstrum Chiropractic Confidential Health History

Welcome

Name: _____ Date:____/____/____

Home Phone: ____/_____/_____ Cell Phone: ____/_____/_____ Work phone: ____/_____/_____

Home Address: _____

City: _____State: _____ Zip: _____Email: _____

____Yes, I would like to receive our FREE e-newsletter. In case of Emergency call:_____

Date of Birth: ____/____/_____ Age:___ Marital Status: S M D W Your Occupation: _____ #of Children: ____

Referred By:_____ Employer Name: _____ Previous Chiropractic care? (Yes or No) ___ When? _____
Is your condition due to an auto accident?___ or work related?___ Date of Injury_____ Claim#_____

PRESENT COMPLAINTS

1._____Date Started: ____/____/____ Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating (shooting) Numbness Tingling Weakness Spasm

What makes it better? _____Worse?_____

What times of day is it worse or better? _____

Does it interfere with certain activities? _____Work Sleep Daily Routine Other: _____

Have you seen other doctors for this condition? _____Who?_____

Other Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/____ _____ 2.____/____/____ _____

3.____/____/____ _____ 4. ____/____/____ _____

Other Complaints

2._____Date Started: ____/____/____ Caused by: _____

Circle all that apply: Sharp Dull Constant Intermittent Radiating (shooting) Numbness Tingling Weakness Spasm

What makes it better? _____What makes it worse? _____

What times of day is it worse or better? _____

Does it interfere with certain activities? _____Work Sleep Daily Routine Other: _____

Have you seen other doctors for this condition? _____ Who?_____ Treatment? _____

Please list any tests and their dates. (MRI, CT, X-Ray, Lab, Ultrasound, etc.)

1.____/____/____ _____ 2.____/____/____ _____

3.____/____/____ _____ 4. ____/____/____ _____

PAST HEALTH HISTORY

Please list all hospitalizations, surgeries, broken bones and injuries and car accidents and the year they occurred.

_____

There are some herbs that should not be taken in conjunction with prescription medications. Please list <u>all</u> current medications and <u>duration of use</u> including birth control pills/injections/patches and over the counter medications.

_____

List all past, including childhood, medications, and duration of use, including oral contraceptives and antibiotics. _____

_____

List all current vitamins, herbs, homeopathy and any other supplements.

_____

Family History: Cancer:___ Stroke:____ Diabetes:____Arthritis:____Heart Disease:____ AutoImmunne:_____ Other:__

Metabolic Assessment Form

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number on all questions below.**
0 as the least/never to 3 as the most/always.

Category I				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relieved by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue or "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul-smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3
Category II				
Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3
Category III				
Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc.	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3
Category IV				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movement	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested food found in stools	0	1	2	3
Category V				
Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3
Category VI				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3

Category VI (continued)				
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucous like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3
Category VII				
Greasy or high-fat foods cause distress	0	1	2	3
Lower bowel gas and/or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed?	Yes		No	
Category VIII				
Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3
Category IX				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory/forgetful	0	1	2	3
Blurred vision	0	1	2	3
Category X				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amount of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

Tired/sluggish	0	1	2	3
Feel cold—hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression/lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face, or genitals, or excessive hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XVII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" - type headaches	0	1	2	3

Category XVIII *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XIX *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XX *(Menstruating Females Only)*

Perimenopausal	Yes	No		
Alternating menstrual cycle lengths	Yes	No		
Extended menstrual cycle (greater than 32 days)	Yes	No		
Shortened menstrual cycle (less than 24 days)	Yes	No		
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XXI *(Menopausal Females Only)*

How many years have you been menopausal?	_____ years			
Since menopause, do you ever have uterine bleeding?	Yes	No		
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness, or itching	0	1	2	3

PART III

How many alcoholic beverages do you consume per week? _____

How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____

How many times do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

Runnerstrum Chiropractic
Informed Consent

CHIROPRACTIC

Welcome to our office! It is very important to acknowledge the difference between the health care specialties of Chiropractic and Medicine. Chiropractic strives to enhance your health by natural means, without the use of drugs or surgery. Our job, if you are accepted as a patient, will be to help you raise your levels of health, not merely suppress your symptoms. As your health levels go up, very often your symptoms will go down. This is because the body is a self-healing organism, and Chiropractic assists the natural recuperative powers of the body to heal itself. The success of Chiropractic procedures often depend upon environment, underlying causes, and your physical, emotional, mental and spinal conditions. It is important to understand what to expect from our chiropractic health care services.

ANALYSIS

We will be conducting a clinical analysis for the express purpose of determining whether or not you have one or more Vertebral Subluxation Complex(s)(VSC) or Vertebral Subluxation Syndrome(s)(VSS). If a VSC or VSS is in evidence, then Chiropractic adjustments and ancillary procedures may be given to you in an effort to stabilize and restore spinal integrity. It is a main Chiropractic premise that proper spinal alignment allows optimal nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no ethical doctor, chiropractic or medical, can promise specific results. The results you receive will depend upon the natural inherent recuperative powers of your body.

DIAGNOSIS

Chiropractors are not medical doctors, and just as a medical doctor is not trained to render a chiropractic opinion because they have not had the proper training to do so, too, Dr. Runnerstrum will not make a medical diagnosis or opinion. She will provide the very finest Chiropractic diagnosis, opinion, and care for you that she may see fit for his/her optimal health. Dr. Runnerstrum may express her opinion to you in an effort to help you understand your situation better, but your health is your responsibility and you are responsible for the final decision.

INFORMED CONSENT REGARDING CHIROPRACTIC CARE

Chiropractic provides a specialized non-duplicating health care service by the location, analysis, and stabilization of VSC or VSS. No other health care provider does this. If you are accepted as a patient, you are giving Dr. Runnerstrum permission and authority to care for you in accordance with Chiropractic tests, analyses, and procedures. The Chiropractic adjustment or any other of our procedures are usually beneficial. In very rare cases, underlying physical defects, deformities, or pathologies may render the patient susceptible to injury. No adjustment or any other procedure will be performed if they are not indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from, be it latent pathological defects, illnesses, deformities, or other problems which would otherwise not come to the attention of Dr. Runnerstrum. Careful attention must be taken to accurately complete our case history and any other forms required. Help us help you- please give us the information we request. Your attendance at one Health Seminar within the first 4-6 weeks of care is required so we may assist you completely as possible once you are accepted as a patient at our clinic.

RESULTS

Our purpose is to help you by the location, analysis, and stabilization of VSC or VSS. This will assist in the natural promotion of health. Since there are many variables, it is difficult to predict results or the time necessary for them. Sometimes the results are exceptional! Sometimes not. Usually there will be a gradual satisfactory response. In any case, the fact is that no science, medical or chiropractic, is so exact as to have all the answers to all problems. Both have made great strides in helping millions of people and helping to alleviate pain and suffering.

PLEASE DISCUSS ANY QUESTIONS YOU MAY HAVE WITH DR. RUNNERSTRUM BEFORE YOU SIGN THIS STATEMENT OF POLICY.

Date:_____ Signature:_____

HEALTH CARE AUTHORIZATION FORM

Patient's Name: _____
Patient's (Last 4 digits only)SS#:_____Date of Birth: _____

THE PATIENT IDENTIFIED ABOVE AUTHORIZES A. AMBER RUNNERSTRUM, D.C. AND STAFF TO USE AND OR DISCLOSE PROTECTED HEALTH INFORMATION IN ACCORDANCE WITH THE FOLLOWING:

Specific Authorizations : Please Initial All That Apply

_____I give permission to A. Amber Runnerstrum, D.C. and staff to use my address, phone number, email and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, information about treatment alternatives or other health related information.

_____If A. Amber Runnerstrum, D.C. and staff contacts me by phone, I give them permission to leave a phone message on my answering machine or voicemail.

_____By signing this form you are giving A. Amber Runnerstrum, D.C. and staff permission to use and disclose your protected health information in accordance with the directives listed above.

Print Name of Patient: _____

Signature of Patient: _____

Date: _____

The Patient has the Right to Expire this Authorization.
The Authorization shall expire on the following date: _____

Right To Revoke Authorization

You have the right to revoke this Authorization, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of A. Amber Runnerstrum, D.C. The written notice must contain the following information:

Your name, social security number and date of birth; A clear statement of your intent to revoke this Authorization; The date of your request; and your signature. The revocation is not effective until received by the Privacy Official.

THIS AUTHORIZATION IS REQUESTED BY A. AMBER RUNNERSTRUM, D.C. FOR HER OWN USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION.

You have the right to refuse to sign this AUTHORIZATION. If you refuse to sign this AUTHORIZATION, A. Amber Runnerstrum, D.C. will not refuse to provide treatment.

You have the right to inspect or copy the PHI to be used/disclosed.
*A copy of the signed AUTHORIZATION will be provided to you upon request.

Patient Signature:_____Date:_____
Signature of Personal Representative:_____
Description of Representative's Authority to Act for Patient:_____

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