Patient Acknowledgement or Receipt
Of the
Notice of Privacy Practices

Highland Wellness Center
5606 Wilson Mills Rd.
Highland Heights, OH 44143

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

By signing this document, I acknowledge that you have a provided me with a copy of your *Notice or Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

THE HIGHLAND WELLNESS CENTER

PATIENT INFORMATION/DEMOGRAPHIC FORM

Date: _____

PATIENT NAME: _____ Prefer to be called / Nickname

_____

Date of Birth: _____ Emergency Contacts Name: _____

Phone #_____

Patient Mailing Address:

Street: _____

City: _____ State: _____ Zip: _____

Living Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐ Domestic partner

Telephone / Contact Information

Home: _____ (Mobile # if no home phone) Work: _____ (If employed) Mobile: _____ (If you have a mobile #)

Email address: _____

Occupation: _____ Employer: _____

How did you hear about us?

- o Doctor Referral
- o Sign
- o Family or Friend
- o Facebook
- o Email
- o Insurance Company
- o Other _____

PLEASE READ & SIGN

**** *Failure to cancel appointments without 24-hour notice will result in full appointment fee.* ****

If my insurance covers a portion or none of my medical bills incurred at this office, I understand that I am responsible for the balance due. If my insurance benefits have been utilized or utilized else where, I understand that I am responsible for all accruing charges.

_____

Signature *Date*

I authorize release of any medical information necessary to process any insurance claims.

_____

Signature *Date*

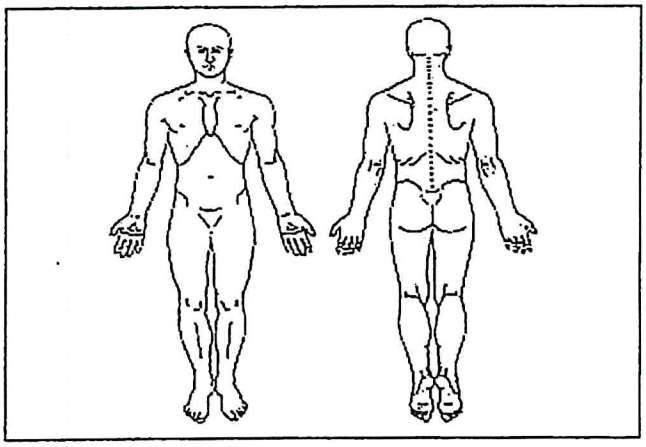
NAME_____ DATE_____

	PROBLEM #1	PROBLEM #2
List and describe major problems in order of importance.		
When did it occur? Date?		
Accident related? Give details.		
What makes it better? (Medications, position, hot, cold, etc.)		
What makes it worse?		
Have you had this before? When?		
Have you seen another physician for this problem? Who?		
Were X-rays taken? Of what?		

Were you disabled from work? Y N Date last worked? _____ Date Returned to work?_____

Please describe pain and location on the diagram.

Ache	Burn	Numbness	Pins & Needles	Stabbing	Other
XXX	ZZZ	OOO	. . .	/////	***



Place an "X" through the line indicating your current level of pain.

No Pain 0---1---2---3---4---5---6---7---8---9---10 Worst Possible Pain

Name: _____ Date:_____

PERSONAL HISTORY

Please mark the box with an X if it applies to you. In categories with multiple selections, please circle which applies to you, mark an X for all.

Has any blood relative ever had:

- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Kidney Problems
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Problems
- ☐ Cancer
- ☐ Hypoglycemia

Have you ever had problems with:

- ☐ Weight changes, gained or lost in past 5 years.
- ☐ Fever, chills, sweats.
- ☐ Allergy, asthma.
- ☐ Anemia, bleeding, bruising.
- ☐ Thyroid problems, heat or cold intolerance.
- ☐ Diabetes
- ☐ Eye problems (glasses, glaucoma etc.)
- ☐ Ear problems (ringing, deafness, ear infections).
- ☐ Nose/Throat problems (sinus, nosebleeds, hoarseness).
- ☐ Dizziness
- ☐ Jaw (TMJ) or dental problems
- ☐ Nausea or Vomiting.
- ☐ Stomach Problems (ulcer, indigestion, heartburn, hiatal hernia).
- ☐ Abdominal pain or swelling.
- ☐ Diarrhea or constipation.

How often do you have a bowel movement? _____

Do you experience:

- ☐ Tarry/black stool or blood in stool.
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Liver or gall bladder problems.

Do you drink alcohol? _____ How many drinks per week? _____

Do you smoke? _____ How many years? _____ How many packs? _____

Do you currently experience:

- ☐ Shortness of breath, wheezing.
- ☐ Lung problems (coughing, phlegm, infection, pneumonia, tuberculosis).
- ☐ Occupational or environmental inhalation.

- ☐ Heart problems
- ☐ Chest pain
- ☐ Palpitations in heart
- ☐ High Blood Pressure
- ☐ Rheumatic fever
- ☐ Urinary problems (frequent, painful, or dribbling urination).
- ☐ Blood in urine.
- ☐ Bladder or kidney problems.
- ☐ Sexually transmitted disease.
- ☐ Testicle mass or pain.
- ☐ Breast lump, pain, or nipple discharge.

Have you ever experienced:

- ☐ Skin itching or rash.
- ☐ Skin Cancer
- ☐ Headaches
- ☐ Seizures
- ☐ Head trauma
- ☐ Stroke
- ☐ Joint pain, swelling, or stiffness
- ☐ Neck Pain
- ☐ Upper back pain
- ☐ Low back pain
- ☐ Arm or leg problems
- ☐ Fractures, dislocations, or sprains. Where and when? _____
- ☐ Car accidents, falls, or injuries. When? _____
- ☐ Drug abuse
- ☐ Psychiatric problems, anxiety, depression.
- ☐ Shoe lifts or inserts.
- ☐ Poor sleep quality. How many hours per night? _____

FOR FEMALES:

- ☐ Menstrual problems.
- ☐ Pelvic pain, abnormal vaginal discharge.
- ☐ Ovarian cyst.
- ☐ Menopause. At what age? _____
- ☐ Menstrual flow.
    - How many days does a typical period last? _____
    - How many days in between cycles? _____
    - Date of last period: _____
    - Date of last PAP: _____

List all hospitalizations, surgeries, or diseases and dates.

List current medications and vitamins/supplements.

Financial Responsibility

Payment is due at the time of service unless prior arrangement has been made with our billing department.

- We accept cash, Visa, Mastercard, American Express or Discover.
- We will process your insurance forms upon receipt of your insurance card (copy).
- You will be responsible for meeting your deductibles, co-pays or costs of non-covered services at the time of visit.
- Returned checks and balances due over 30 days will be subject to collection fees and interest charges of **3.0% per month.**
- Your insurance is a contract between you, your employer and your insurance company.
- Our fees are considered usual, customary and reasonable. (UCR)
- Insurance coverage vary widely.

Failure to cancel appointments without 24 hour notice will result in full appointment fee.

I have read and agree to the above terms.

Signature_____Date_____

Print Name:_____ Date of Birth: _____

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

GROUP TWO

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

GROUP THREE

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

GROUP FOUR

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

GROUP FIVE

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

GROUP SIX

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

GROUP SEVEN

(A)

107 – 1 2 3 Insomnia
108 – 1 2 3 Nervousness
109 – 1 2 3 Can't gain weight
110 – 1 2 3 Intolerance to heat
111 – 1 2 3 Highly emotional
112 – 1 2 3 Flush easily
113 – 1 2 3 Night sweats
114 – 1 2 3 Thin, moist skin
115 – 1 2 3 Inward trembling
116 – 1 2 3 Heart palpitates
117 – 1 2 3 Increased appetite without weight gain
118 – 1 2 3 Pulse fast at rest
119 – 1 2 3 Eyelids and face twitch
120 – 1 2 3 Irritable and restless
121 – 1 2 3 Can't work under pressure

(B)

122 – 1 2 3 Increase in weight
123 – 1 2 3 Decrease in appetite
124 – 1 2 3 Fatigue easily
125 – 1 2 3 Ringing in ears
126 – 1 2 3 Sleepy during day
127 – 1 2 3 Sensitive to cold
128 – 1 2 3 Dry or scaly skin
129 – 1 2 3 Constipation
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

(C)

137 – 1 2 3 Failing memory
138 – 1 2 3 Low blood pressure
139 – 1 2 3 Increased sex drive
140 – 1 2 3 Headaches, "splitting or rendering" type
141 – 1 2 3 Decreased sugar tolerance

(D)

142 – 1 2 3 Abnormal thirst
143 – 1 2 3 Bloating of abdomen
144 – 1 2 3 Weight gain around hips or waist
145 – 1 2 3 Sex drive reduced or lacking
146 – 1 2 3 Tendency to ulcers, colitis
147 – 1 2 3 Increased sugar tolerance
148 – 1 2 3 Women: menstrual disorders
149 – 1 2 3 Young girls: lack of menstrual function

(E)

150 – 1 2 3 Dizziness
151 – 1 2 3 Headaches
152 – 1 2 3 Hot flashes
153 – 1 2 3 Increased blood pressure
154 – 1 2 3 Hair growth on face or body (female)
155 – 1 2 3 Sugar in urine (not diabetes)
156 – 1 2 3 Masculine tendencies (female)

(F)

157 – 1 2 3 Weakness, dizziness
158 – 1 2 3 Chronic fatigue
159 – 1 2 3 Low blood pressure
160 – 1 2 3 Nails, weak, ridged
161 – 1 2 3 Tendency to hives
162 – 1 2 3 Arthritic tendencies
163 – 1 2 3 Perspiration increase
164 – 1 2 3 Bowel disorders
165 – 1 2 3 Poor circulation
166 – 1 2 3 Swollen ankles
167 – 1 2 3 Crave salt
168 – 1 2 3 Brown spots or bronzing of skin
169 – 1 2 3 Allergies - tendency to asthma
170 – 1 2 3 Weakness after colds, influenza
171 – 1 2 3 Exhaustion - muscular and nervous
172 – 1 2 3 Respiratory disorders

GROUP EIGHT

173 – 1 2 3 Muscle weakness
174 – 1 2 3 Lack of Stamina
175 – 1 2 3 Drowsiness after eating
176 – 1 2 3 Muscular soreness
177 – 1 2 3 Rapid heart beat
178 – 1 2 3 Hyper-irritable
179 – 1 2 3 Feeling of a band around your head
180 – 1 2 3 Melancholia (feeling of sadness)
181 – 1 2 3 Swelling of ankles
182 – 1 2 3 Diminished urination
183 – 1 2 3 Tendency to consume sweets or carbohydrates
184 – 1 2 3 Muscle spasms
185 – 1 2 3 Blurred vision
186 – 1 2 3 Loss of muscular control
187 – 1 2 3 Numbness
188 – 1 2 3 Night sweats
189 – 1 2 3 Rapid digestion
190 – 1 2 3 Sensitivity to noise
191 – 1 2 3 Redness of palms of hands and bottom of feet
192 – 1 2 3 Visible veins on chest and abdomen
193 – 1 2 3 Hemorrhoids
194 – 1 2 3 Apprehension (feeling that something bad is going to happen)
195 – 1 2 3 Nervousness causing loss of appetite
196 – 1 2 3 Nervousness with indigestion
197 – 1 2 3 Gastritis
198 – 1 2 3 Forgetfulness
199 – 1 2 3 Thinning hair

FEMALE ONLY

200 – 1 2 3 Very easily fatigued
201 – 1 2 3 Premenstrual tension
202 – 1 2 3 Painful menses
203 – 1 2 3 Depressed feelings before menstruation
204 – 1 2 3 Menstruation excessive and prolonged
205 – 1 2 3 Painful breasts
206 – 1 2 3 Menstruate too frequently
207 – 1 2 3 Vaginal discharge
208 – 1 2 3 Hysterectomy/ovaries removed
209 – 1 2 3 Menopausal hot flashes
210 – 1 2 3 Menses scanty or missed
211 – 1 2 3 Acne, worse at menses
212 – 1 2 3 Depression of long standing

MALE ONLY

213 – 1 2 3 Prostate trouble
214 – 1 2 3 Urination difficult or dribbling
215 – 1 2 3 Night urination frequent
216 – 1 2 3 Depression
217 – 1 2 3 Pain on inside of legs or heels
218 – 1 2 3 Feeling of incomplete bowel evacuation
219 – 1 2 3 Lack of energy
220 – 1 2 3 Migrating aches and pains
221 – 1 2 3 Tire too easily
222 – 1 2 3 Avoids activity
223 – 1 2 3 Leg nervousness at night
224 – 1 2 3 Diminished sex drive

IMPORTANT

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

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

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent _____ Standing _____ Pulse _____

Hema-Combistix Urine readings: pH _____ Albumin per cent _____ Glucose per cent _____

Occult Blood _____ pH of Saliva _____ pH of Stool specimen _____ Weight _____

Hemoglobin _____ Blood Clotting Time _____

BARNES THYROID TEST

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES
Any two days during the month
FEMALES HAVING MENSTRUAL CYCLES
The 2nd and 3rd day of flow OR any 5 days in a row.
MALES
Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____
Date: _____ Temperature: _____

Name_____ Date_____

Diet History

Approximately how many of the following foods do you consume EACH WEEK? When possible put Figures in blank spaces. If a food is eaten on only an occasion write OCC in the blank. If you do not consume a certain food write NONE in the blank. If a YES or NO answer is required, check the appropriate box.

Glasses of:
Whole milk _____
Skim milk _____
Buttermilk _____
Half & half _____
Servings of cheese _____
Kind of cheese? _____

Servings of:
Eggs _____
Beef _____
Pork _____
Bacon _____
Liver _____
Fowl _____
Fish _____
Lunch meat_____
Canned meat_____
Cereals _____
Pancakes _____
Waffles _____
Crackers _____
Rice _____
Macaroni_____
Spaghetti_____
Soup _____

Servings or portions of:
Pie/cake _____
Jell-O _____
Candy _____
Cookies _____
Doughnuts_____
Ice cream_____
Other desserts most commonly eaten:_____
_____

Servings of Vegetables:
Potatoes: white, red or sweet_____
Carrots_____
Beans_____
Corn _____
Parsley_____
Squash_____
Spinach_____
Greens_____
Lettuce_____
Celery_____
Green Peas_____
Broccoli_____
Asparagus_____
Cole Slaw_____
Onions_____
Tomatoes_____
Green Peppers_____
Cabbage_____
Turnips_____
Others:_____
_____

Servings of fruit:
Oranges_____
Grapefruit_____
Pineapple_____
Apples_____
Bananas_____
Prunes_____
Dates_____
Raisins_____
Figs_____
Grapes_____
Dried Apricots_____
Apple Sauce_____
Canned fruits_____
What dried or frozen fruits?_____
Other fruits?_____
_____

Popcorn_____
Peanut butter_____
Nuts_____
Honey_____
Soda_____
Orange juice_____
Grapefruit juice_____
Tomato juice_____
Other juices?_____
_____
What vegetable oils, fats or compounds do you use in cooking?_____
_____
What vegetable oil do you use in salads?_____

What did you eat for breakfast yesterday?_____
_____
_____
What did you eat for lunch yesterday?_____
_____
_____
What did you have for supper yesterday?_____
_____
_____

What beverages did you have?
_____

What did you have in between meals?
_____
_____

How many per day?
Pats of butter _____
Pats of margarine _____
White bread _____
Wheat bread _____
Rye bread _____
Corn bread _____
Other breads? _____
Sweet rolls _____

Glasses of water _____
Alcoholic beverages _____
Cups of coffee _____
Cups of Decaf _____
Cups of Tea _____
Cream in coffee, tea, etc. **Yes** **No**
How much sugar do you add to coffee or tea?_____
Do you use salt?
Sparingly_____
Freely _____
Moderately_____
Do you use vinegar?_____
Is this your average diet for the past three or four years? **Yes** **No**
What foods, if any, disagree with you?_____

Do you get indigestion? **Yes** **No**

Fond of fats? **Yes** **No**

Fond of sweets? **Yes** **No**

Fond of vegetables? **Yes** **No**

Fond of fruits? **Yes** **No**

Fond of bread? **Yes** **No**

Fond of butter? **Yes** **No**

Fond of cereal? **Yes** **No**

_____
Signature