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: ________________

These forms are provided as a service to subscribers to HIPAAps, and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in you locale.

Date__________________ Referred by ____

Cell phone _____________________

Name _______________________________________Home phone ___________________

Last *First* *Middle* Email__________________________

Address ____________________________ City/ State/ Zip _________________________

DOB _________________Sex _____ SS# ____________ Marital Status M S D W

Contact Friend/ Relative ___________________________ Phone ____________________

Address ____________________________ City/ State/ Zip _________________________

Name of Employer ____

Address ___________________________ City/ State/ Zip __________________________

Phone ____________________________ Position ________________________________

Spouse's Name _________________________________ Phone ______________________

Name of Employer ____

Address __________________________ City/ State/ Zip ___________________________

Phone ____________________________ DOB ___________________________________

Primary Care Provider _______________________ Phone __________________________

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*

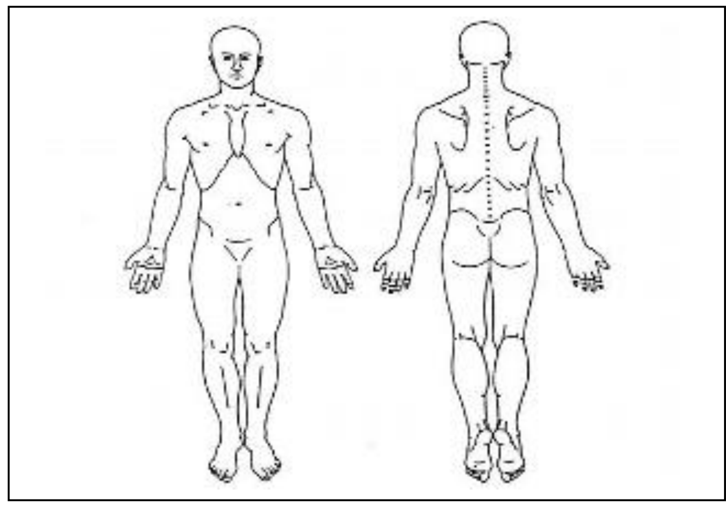
NAME____DATE__________________

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 ________

Highland Wellness Center
www.truhealers.com

PERSONAL HISTORY

Mark the box with an X if it applies to you & circle the appropriate symptom. Explain all YES answers with dates (month & year).

Has any blood relative ever had:

- [ ] Diabetes
- [ ] Thyroid Problems
- [ ] Tuberculosis (TB)
- [ ] Kidney Problems
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Heart Problems
- [ ] Cancer
- [ ] Hypoglycemia

Have you ever had problems with:

- [ ] Weight Change, gained or lost in past 5 years
- [ ] Fever, chills, sweats
- [ ] Allergy, Aslhma
- [ ] Anemia, Bleeding or bruising
- [ ] Thyroid Problems, Heat or cold intolerance
- [ ] Diabetes
- [ ] Eye problems (glasses, glaucoma etc.)
- [ ] Ear problems (ringing, deafness, ear infections)
- [ ] Nose/Throat problems (sinis, 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?

- [ ] Tarry black stool or blood in stool
- [ ] Hernia
- [ ] Hemorrhoids
- [ ] Liver or Gall Bladder problems
- [ ] Pancreas
- [ ] Do you drink alcohol?

How much?

- [ ] Shortness of breath, wheezing
- [ ] Lung problems (coughing, phlegm blood, infection, pneumonia) Tuberculosis?
- [ ] Do you smoke? How many years? How many packs?
- [ ] Occupational or Environmental Inhalation
- [ ] Heart problems
- [ ] Chest pain
- [ ] Palpitations in the heart
- [ ] High Blood Pressure
- [ ] Rheumatic fever

NAME ______________________ Date __________

- [ ] Urinary problems (Frequent, painful, or dribbling urination)
- [ ] Blood in Urine
- [ ] Bladder or Kidney problems
- [ ] Sexually transmitted diseases
- [ ] Testicle mass or pain
- [ ] Breast lump, pain or nipplc discharge

FOR FEMALES:

- [ ] Menstral problems
- [ ] Pelvic pain, vaginal discharge
- [ ] Ovarian cyst
- [ ] Menopause , At what age?

Menstrual flow: How many days? How many days between periods?
Date of last period
Date of last PAP?

- [ ] 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
- [ ] Car accidents, falls or injuries
- [ ] Drug abuse
- [ ] Pyschiatric problems, anxiety, depression
- [ ] Shoe lift or insert
- [ ] Poor sleep quality. How many hours per night?

List all hospitalizations, surgeries, diseases with date:

List current medications & 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. We are participating providers for most insurance companies including Cigna, Aetna, Emerald, Medical Mutual, United Healthcare, Humana, PHCS and Medicare, we are not participating in any HMOs. Most insurance companies cover chiropractic, however deductibles and co-pays do vary.

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_____________

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

SYMPTOM SURVEY FORM

(Restricted to Professional Use)

PATIENT____________________________ DOCTOR _________________________ DATE _______________________

AGE_______ PHONE (________)___________________ VEGETARIAN ____ Yes ____ No

INSTRUCTIONS: Circle the number that applies to you. **If symptom doesn't apply, leave blank.** Use **(1)** for **MILD** symptoms (occurs once or twice a month), **(2)** for **MODERATE** symptoms (occurs several times a month), and **(3)** for **SEVERE** symptoms (you are aware of it 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 seems 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 sle ep
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 hor ses"
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 ½ - 1 hour after eating; may be up to 3 – 4 hrs.
104 - 1 2 3 Mucous colitis or "irritable bowel"
105 - 1 2 3 Gas shortly after eating
106 - 1 2 3 Stomach "bloating" after eating

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 rending" 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 Apprehension
174 - 1 2 3 Irritability
175 - 1 2 3 Morbid fears
176 - 1 2 3 Never seems to get well
177 - 1 2 3 Forgetfulness
178 - 1 2 3 Indigestion
179 - 1 2 3 Poor appetite
180 - 1 2 3 Craving for sweets
181 - 1 2 3 Muscular soreness
182 - 1 2 3 Depression; feelings of dread
183 - 1 2 3 Noise sensitivity
184 - 1 2 3 Acoustic hallucinations
185 - 1 2 3 Tendency to cry without reason
186 - 1 2 3 Hair is coarse and/or thinning
187 - 1 2 3 Weakness
188 - 1 2 3 Fatigue
189 - 1 2 3 Skin sensitive to touch
190 - 1 2 3 Tendency toward hives
191 - 1 2 3 Nervousness
192 - 1 2 3 Headache
193 - 1 2 3 Insomnia
194 - 1 2 3 Anxiety
195 - 1 2 3 Anorexia
196 - 1 2 3 Inability to concentrate; confusion
197 - 1 2 3 Frequent stuffy nose; sinus infections
198 - 1 2 3 Allergy to some foods
199 - 1 2 3 Loose joints

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
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 and or health 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: __________

BP SIT__________ BP STAND__________
PULSE SIT__________ PULSE STAND__________
SALIVA PH__________ BLOOD TYPE__________