I understand that my initial consultation is complimentary and is used to determine whether or not I am a candidate for care. The first step is an informational meeting about the care offered. The second step is a one-on-one consultation with the doctor of chiropractic to:

- **Review my case history to determine if the practice may be able to help me;**
- **Review my dietary and nutritional habits, nutritional supplements, herbs, minerals, botanicals, homeopathics, etc.; and**
- **Discuss my problems and answer questions.**

The only cost I will incur is the cost of any initial screening tests that I choose to undergo, which may include:

_____

_____

I am aware that after consultation, I may not be accepted as a patient or additional testing may be recommended. Whether or not I am accepted as a patient, I will receive a copy of any laboratory results.

I agree to fill out all paperwork completely to the best of my knowledge.

I am under the care of the following health care provider, who is licensed to prescribe medication:

Name: _____ **Phone:** _____

I understand that I am encouraged to communicate with my other health care providers about all of my health care, including care I receive at this office.

By signing below, I agree that I have read, understand, and accept the terms of the complimentary consultation:

_____ _____

Patient **Date**

New Patient Application and Case History (D)

Name _____ Age _____ Sex: M F DOB _____ Today's Date _____

Address _____ City_____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____ e-mail: _____

May we leave a voice mail? Y N Height _____ Weight: _____

How Did You Hear About Us? _____

Employer _____ Occupation _____ Length of Employment _____ SSN _____-_____-_____

Present Complaints

1. Main Problem(s):_____

_____

2. In spite of the fact that you are not a doctor, you are in fact the person who knows more about your condition than anyone else. In your own words and your own opinion what do you think the real problem is : _____

_____

3. When were you diagnosed with Type II diabetes: _____

What diagnostic tools were used to achieve your diagnosis:

_____

_____

4. What are the three things your condition has caused you to miss most:

_____

_____

_____

5. Symptoms(list all):

_____

_____

_____

_____

_____

6. Severity of problem (circle):

Minimal (annoying but causing no limitation)

Slight (tolerable but causing a little limitation)

Moderate (sometimes tolerable but definitely causing limitation)

Severe (causing significant limitation)

Extreme (causing near constant limitation (>80% of the time))

7. What relieves your symptoms or causes them to return:

_____

_____

8. Describe the first time you remember having symptoms:

_____

_____

9. If your symptoms include pain:

What is the quality (sharp, dull, stabbing, color, etc.): _____

Does the pain radiate: Y N where: _____

_____

10. Do your symptoms occur at a specific time, place, or environment: Y N

When and for how long do symptoms last each episode:

_____

_____

11. What types of treatment have you received:

Prescription/Drug therapy_____

Nutritional _____

Alternative/Holistic _____

12. List your health goals in order of Importance:

_____

_____

_____

Motivation to achieve these goals: 1 2 3 4 5 6 7 8 9 10

13. What are you hoping happens today as a result of your consultation:

_____

_____

14. How often are you aware of your main problem (circle one):

Occasionally (25% of the time) Frequently (75% of the time)

Intermittently (50% of the time) Constantly (100% of the time)

15. If you cannot find a solution to your problem what do you think will happen?

_____

_____

16. Due to your condition have you lost time from (describe how much time and what tasks have been limited)?

Work: Y N Describe: _____

Family: Y N Describe: _____

Leisure Activities Y N Describe: _____

Blood Sugar

HIGHEST your blood sugar gets WITHOUT medication _____

LOWEST your blood sugar gets WITHOUT medication _____

HIGHEST your blood sugar gets WITH medication _____

LOWEST your blood sugar gets WITH medication _____

Medications

(List all prescription, over-the-counter, **botanicals, homeopathic, and supplements**)

_____ _____

_____ _____

_____ _____

Medical and Social History

Surgeries/Hospitalizations Date

_____

_____

_____

Trauma Date

_____

_____

_____

Past/Recent Illness Date

_____

_____

Marital Status: S/ M/ W/Sep./D Spouse _____

Children / ages:

_____

Family History (mother, father, siblings, spouse, children) Date

_____

_____

Do you use: Alcohol Y N Tobacco Y N Caffeine Y N

___ drinks/week ___ pack/day ___ cups/day

Review of Systems: Past and Current

(Have you ever had the following (circle "P" for past and "C" for current - leave blank if you do not or have not experienced)

CONSTITUTIONAL

P C Fatigue
P C Recent weight change
P C Fever

EYES

P C Blurred/double vision
P C Glasses/contacts
P C Eye disease or injury

EAR/NOSE/MOUTH/THROAT

P C Swollen glands in neck
P C Hearing loss or ringing
P C Earaches or drainage
P C Chronic sinus problems or rhinitis
P C Nose bleeds
P C Mouth sores / Bleeding gums
P C Bad breath / bad taste
P C Sore throat or voice change

CARDIOVASCULAR

P C High or Low Blood Pressure
P C Shortness of breath walking/lying
P C Heart disease
P C Chest pain or angina pectoris
P C Palpitation
P C Mitral Valve Prolapse
P C Feet or ankle swelling
P C Shortness of breath
P C Spitting up blood

PSYCHIATRIC

P C Insomnia
P C Memory loss or confusion
P C Nervousness
P C Depression

GENITOURINARY

P C Frequent urination
P C Burning or painful urination
P C Blood in urine
P C Change in force or strain urinating
P C Kidney stones
P C Sexual difficulty
P C Male : testicle pain
P C Female: pain / irregular periods
P C Female: pregnant
P C Bladder Infections
P C Kidney Disease
P C Hemorrhoids

GASTROINTESTINAL

P C Abdominal pain
P C Nausea or Vomiting
P C Rectal bleeding/blood in stool
P C Painful bm / constipation
P C Ulcer
P C Change in bowel movement
P C Frequent diarrhea
P C Loss of appetite

RESPIRATORY

P C Chronic or frequent cough
P C Spitting up blood
P C Pneumonia / Bronchitis
P C Shortness of breath
P C Wheezing
P C Asthma

ENDOCRINE

P C Glandular or hormone problem
P C Excessive thirst or urination
P C Heat or cold intolerance
P C Skin becoming dryer
P C Change in hat or glove size
P C Diabetes
P C Thyroid Disease

MUSCUOSKELETAL

P C Back pain
P C Joint pain
P C Joint stiffness and swelling
P C Muscle pain or cramps
P C Muscle or joint weakness
P C Difficulty walking
P C Cold extremities

INTEGUMENTARY (skin, breast)

P C Change in skin color
P C Change in Hair or Nails
P C Varicose veins
P C Breast pain / discharge
P C Breast lump
P C Hives or Eczema
P C Rash or itching

NEUROLOG ICAL

P C Freq./ recurring headaches
P C Migraine headache
P C Convulsions or seizures
P C Numbness or tingling
P C Tremors
P C Paralysis
P C Head injury
P C Light headed or dizzy
P C Stroke

HEMATOLOGIC/LYMPHATIC/OTHER

P C Slow to heal after cuts
P C Easy bleeding or bruising
P C Anemia
P C Phlebitis
P C Past transfusion
P C Enlarged glands
P C Blood or Plasma Transfusions
P C Hepatitis
P C Cancer
P C Infectious Mono
P C AIDS or HIV+
P C Venereal
P C Chicken pox

ALLERGIES / OTHER (drugs, food, or environmental)_____

_____

_____

RECENT TESTS (lab work, x-rays, CT, MRI) _____

_____

_____

OTHER PROVIDERS

_____

_____

Reviewing Doctor:_____

JOSEPH AND HISHON INTEGRATED HEALTH CARE
5001 N. UNIVERSITY AVE, SUITE A
PEORIA, IL 61614

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGEMENT

This notice describes how your health information may be used and disclosed. Please Review it carefully.

YOUR RIGHTS

You have certain rights with respect to your health information, subject to legal limitations, including:

- Obtaining an electronic or paper copy of your record. We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Asking us to correct incorrect or incomplete information. We may say "no," but if we do, we'll tell you why in writing within 60 days.
- Requesting confidential communications or asking us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Asking us to limit what we use or share for treatment, payment, or our operation. We are not required to agree to your request, and we may say "no." If, however, you pay for a services or item out-of-pocket in full, you can request that we not share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Obtaining a list (accounting) of those with whom we've shared your information for six years prior to the date you ask, who we shared it with, and why. The list will not include disclosures for treatment, payment, and health care operations, and certain other disclosures (e.g. made at your request). We'll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for additional accountings.
- Obtaining a paper copy of this notice at any time, even if you agreed to receive the notice electronically.
- Designating someone to act for you. If you have a medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act on your behalf before we take any action.
- Filing a complaint if you feel we have violated your rights by contacting: U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Ave, S.W., Washington, D.C. 20201, 1-877-696-6775, www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against anyone for filing a complaint.

YOUR CHOICES

- You have the right and choice to have us share information with family, friends, or others involved in your care; share information in a disaster relief situation; or include your information in a hospital directory.
- We will not sell your information or share it for marketing unless you give us written permission.
- We will not share psychotherapy notes unless you give us written permission.

If you are not able to tell us your choice, we may share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

OUR USES AND DISCLOSURES

- We can use your health information and share it with others for treatment, payment, and health care operations. This includes sharing information with others who are treating you, to bill and get paid, and to run our practice and improve care.
- We are also allowed or required to share your information in other ways, such as:
- Providing you with information related to your health;
- Contacting you regarding appointments, treatment alternatives, or other health related services;
- Incidental uses or disclosures (*e.g.*, listing your name on a sign-in sheet, etc.);
- Compliance with all laws (including reports of adverse reactions, suspected abuse, neglect or violence);
- Providing information to law enforcement or correctional institutions;
- Providing information to a coroner, medical examiner, funeral director, or for organ procurement;
- Public health activities when requested by a public health authority or the FDA.
- Responding to health oversight agencies;

- Responding to court or administrative orders, subpoenas, discovery requests or lawful process;
- Research activities;
- When necessary to avert a serious threat to health or safety;
- Military affairs, veterans affairs, national security, intelligence, Department of State, or presidential protective service activities;
- Providing information regarding your location, general condition or death to disaster relief agencies;
- Providing information for workers' compensation claims; or
- Informing a family member, other relative, or close personal friend when:
  - Information is relevant to the individual's involvement with your care;
  - Notification of your location, general condition or death;
  - To assist in your health care (pick-up prescriptions or documents, follow-up care instructions, etc.).

- Our practice will make other uses and disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice, you may revoke your authorization at any time by notifying us in writing.

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information and to let you know promptly if a breach occurs that may compromise the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us in writing that we can. If you tell us we can, you may change your mind at any time, but please let us know in writing if you change your mind.

CHANGES TO THE TERMS OF THIS NOTICE

We reserve the right to change the terms of this notice. The newly effective notice will be posted in our office, on our website, and will be available upon request. This Notice is effective September 23, 2013.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

PATIENT ACKNOWLEDGEMENT

I acknowledge receiving a copy of this notice regarding the use and disclosure of my health information.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Print Patient Name (required) Print Legal Guardian Name (if necessary)

INTERNAL PRACTICE USE ONLY: _____ refused to sign.

_____ _____

Signature of Practice Representative Date

Metabolic Assessment Form

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

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

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

Please circle the appropriate number "0 - 3" 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 relief 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 of "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

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 movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

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 from antacids, food, milk, 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 IV

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
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 V

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 VI

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded 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 VII

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

Category VIII

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

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Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only.

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts 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 X

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 gain 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 falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI

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 XII

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 XIII

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

Category XIV (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 evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in 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
Decrease in 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 XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No
Shortened menses, less than every 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 breakouts	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal? _____

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

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 a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

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

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

Do you smoke?_____ If yes, how many times a day: _____

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

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

_____

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

_____

Telehealth Informed Consent

I understand that my health and wellness providers Dr. Dan Joseph, DC & Amanda Gawelek, FNP-BC wishes me to have a telehealth consultation.

This means that through an interactive video connection, I will be able to consult with the above named provider about my health and wellness concerns.

I understand there are potential risks with this technology:

- The video connection may not work or it may stop working during the consultation.
- The video picture or information transmitted may not be clear enough to be useful for the consultation.

The benefits of a telehealth consultation are:

- I do not need to travel to the consult location.
- I have access to a specialist through this consultation

I also understand other individuals may need to use the Healthie telehealth platform and that they will take reasonable steps to maintain confidentiality of the information obtained. I have read this document and understand the risk and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby consent to participate in telehealth sessions under the conditions described in this document.

I,

_____ (print name)

have read, understand, and accept the information and conditions specified in this agreement.

_____(signature)

Date: _____