CONFIDENTIAL PEDIATRIC CASE HISTORY

Child's Name:____ Patient #_________

Mother's Name:____________________________Father's Name:_______________________________

Address:________________________________City:__________________ State:_______ Zip:______

Home Phone#:______________Mother's Work #:_________________Father's Work #:_______________

Cell Phone(s) #________________________________ Email address:____________________________

Referred
by:____

Birth Date:____ ____ ____ Age:_______ SS#________ - ________ - ________

Birth Weight:________ Birth Length:________ Current Weight:________ Current Length/Height:________

Type of Birth: Normal Vaginal_________ Forceps_________ Breech_________ Cesarean_________
Home_________ Birthing center_________ Hospital_________

Problems During Pregnancy:____
Pregnancy History:____
____
____
____
____
____
____

Problems During Labor/Delivery:____
Delivery/Birth History:____
____
____
____
____
____

Apgar Scores_______ ________ Was there presence at birth of:___________Jaundice (Yellow)
___________Cyanosis (Blue)

Congenital/Anomalies/Defects:____
____

Infant Feeding: Breast________________ Bottle________________ Formula________________

No. of hours sleep per night:__________ Quality of sleep: Good_________ Fair _________ Poor _________

Developmental History: At what age did the child:

___________________________Respond to sound ___________________________Crawl
___________________________Follow an object with his/her eyes ___________________________Stand
___________________________Hold head up ___________________________Walk alone
___________________________Sit alone

Obstetrician/Midwife:____

Pediatrician/Family MD:____

Date of last visit to MD: ___________________Purpose:____

Immunization History:____

Childhood Diseases: ___________Chicken Pox ___________Rubella ___________Mumps
___________Rubeola ___________Measles ___________Whooping Cough
Other: ____

Has Your Child Ever Suffered From:

☐ Dizziness	☐ Backaches	☐ Heart Trouble	☐ Chronic Earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Colds/Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Low Blood Sugar	☐ Behavioral Problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle Jerking
☐ Fainting	☐ Walking Problems	☐ Broken Bones	☐ Rupture/Hernias
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ "Growing Pains"
☐ Joint Problems	☐ Blood Disorders	☐ Stomach Aches	☐ Other __________

Present Complaints & History:____
____
____
____
____

Surgery:____
Medications:____
Accidents:____
Family History:____
____

Has your child ever been treated on an emergency basis? ____________________________________
Describe:____

Purpose of this appointment:____

Consent to Treatment of a Minor Child

I hereby authorize Don M. Weiss, D.C. and whomever he may designate as assistants to administer treatment as he deems necessary to my child.

Signed: ___________________________Witnessed:__________________________Date:____________

I realize that I am responsible for all fees charged by this office and that I will pay for services as they are performed to my child. I will be paying today by: ☐ Cash ☐ Check ☐ Visa ☐ Mastercard

Date:_____________ Signature: ____

BIOCHEMICAL SURVEY

Name____Date_________________________

Check first box for anything you are currently experiencing. Check second box for anything you have ever experienced.

☐ ☐ Abnormal hair growth
☐ ☐ Acid foods upset
☐ ☐ Acne
☐ ☐ Attention Deficit Disorder
☐ ☐ Addiction - Smoke
☐ ☐ Addiction - Sugar
☐ ☐ Addiction - alcohol
☐ ☐ Addiction - drugs
☐ ☐ Allergy to drugs
☐ ☐ Allergies
☐ ☐ Amnesia - temporary
☐ ☐ Anemia
☐ ☐ Appetite - excess
☐ ☐ Appetite - poor
☐ ☐ Arthritis
☐ ☐ Asthma
☐ ☐ Bad breath
☐ ☐ Belching
☐ ☐ Bowel disorders
☐ ☐ Brain fog
☐ ☐ Bronchitis
☐ ☐ Brown spots
☐ ☐ Bruise easily
☐ ☐ Burning/itching anus
☐ ☐ Burning feet
☐ ☐ Coated tongue
☐ ☐ Cold hands
☐ ☐ Cold feet
☐ ☐ Cold sweats often
☐ ☐ Colds/flu frequently
☐ ☐ Colitis
☐ ☐ Constipation
☐ ☐ Cough
☐ ☐ Crave spices
☐ ☐ Crave salts
☐ ☐ Crave sour
☐ ☐ Crave onions/beans
☐ ☐ Crave bitters
☐ ☐ Crave sweets
☐ ☐ Cuts heal slowly
☐ ☐ Dandruff
☐ ☐ Depression
☐ ☐ Diabetes
☐ ☐ Diarrhea
☐ ☐ Difficulty swallowing
☐ ☐ Diverticulitis
☐ ☐ Dry nose
☐ ☐ Dry eyes
☐ ☐ Dry mouth
☐ ☐ Dyslexia
☐ ☐ Earaches
☐ ☐ Ear infection
☐ ☐ Eating disorder
☐ ☐ Eczema
☐ ☐ Edema (fluid retention)
☐ ☐ Excess thirst
☐ ☐ Eyelids puffy
☐ ☐ Eyes watery
☐ ☐ Eyes itch
☐ ☐ Fainting spells
☐ ☐ Fatigue
☐ ☐ Feel cold often
☐ ☐ Fever
☐ ☐ Frequent rashes
☐ ☐ Fungus
☐ ☐ Gallstones
☐ ☐ Gas
☐ ☐ General itching
☐ ☐ Greasy foods upset
☐ ☐ Hair loss
☐ ☐ Hay fever
☐ ☐ Headache/sinus
☐ ☐ Headache/morning
☐ ☐ Headache/afternoon
☐ ☐ Headache/migraine
☐ ☐ Hearing decreased
☐ ☐ Heartburn
☐ ☐ Heart irregularities
☐ ☐ Hemorrhoids
☐ ☐ Herpes
☐ ☐ High altitude problems
☐ ☐ High blood pressure
☐ ☐ Hives
☐ ☐ Hoarseness
☐ ☐ Hot flashes
☐ ☐ Humidity discomfort
☐ ☐ Hungry between meals
☐ ☐ Hyperactivity
☐ ☐ Ileocaecal Valve Syndrome
☐ ☐ Impotency Syndrome
☐ ☐ Indigestion
☐ ☐ Infections (Frequent)
☐ ☐ Insomnia
☐ ☐ Internal trembling
☐ ☐ Irritable Bowel Syndrome
☐ ☐ Irritable/restless
☐ ☐ Labored breathing
☐ ☐ Loss of taste
☐ ☐ Low blood pressure
☐ ☐ Lump in the throat
☐ ☐ Menses, scanty
☐ ☐ Menses, irregular
☐ ☐ Menses, excess
☐ ☐ Menses, painful
☐ ☐ Metallic taste
☐ ☐ Migrating pains
☐ ☐ Milk causes discomfort
☐ ☐ Mucous production
☐ ☐ Muscle cramps at night
☐ ☐ Nasal polyps
☐ ☐ Nausea
☐ ☐ Nervous stomach
☐ ☐ Night sweats
☐ ☐ Nose bleeds
☐ ☐ Ovarian cysts
☐ ☐ Pain – unexplained
☐ ☐ Perspiration excess
☐ ☐ PMS
☐ ☐ Poor Memory
☐ ☐ Post nasal drip
☐ ☐ Premature graying
☐ ☐ Psoriasis
☐ ☐ Red eyes
☐ ☐ Ring worm
☐ ☐ Seizures
☐ ☐ Sensitive to cold
☐ ☐ Sinusitis
☐ ☐ Skin problems
☐ ☐ Skin peels
☐ ☐ Sleepy during day
☐ ☐ Slow pulse
☐ ☐ Smell decreased
☐ ☐ Sneezing attacks
☐ ☐ Sore throat
☐ ☐ Startles easily
☐ ☐ Strong light irritates
☐ ☐ Swollen ankles/feet
☐ ☐ Thickening skin
☐ ☐ Thinning skin
☐ ☐ Throat constriction
☐ ☐ Tingling sensation
☐ ☐ Tires easily
☐ ☐ Urinary tract disorders
☐ ☐ Urine amount increased
☐ ☐ Urine amount decreased
☐ ☐ Varicose veins
☐ ☐ Warts
☐ ☐ Weight loss
☐ ☐ ____________________
☐ ☐ ____________________
☐ ☐ ____________________
☐ ☐ ____________________
☐ ☐ ____________________

WEISS HOLISTIC HEALTH CENTER
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Weiss Holistic Health Center (WHHC) is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment
On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with WHHC.

It is our policy to provide a substitute health care provider, authorized by WHHC to provide assessment and/or treatment to our patients, without advanced notice, in the event of Dr. Weiss's absence due to vacation, sickness, or other emergency situation.

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law-enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes. It is our practice to participate in charitable events to raise awareness, food or toy donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of WHHC sponsored fund-raising events.

Appointment Confirmation.
On occasion, we may call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

Change of Ownership.
In the event that WHHC is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that WHHC is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that WHHC amend your protected health information. Please be advised, however, that WHHC is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s)and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by WHHC.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
WHHC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, WHHC is required by law to comply with this Notice. WHHC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Privacy Officer by calling this office at 215-887-7100. If the Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how WHHC has handled your health information should be directed to the Privacy Officer by calling this office at 215-887-7100. If the Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W., Room 509F HHH Building, Washington, DC 20201

This notice is effective as of ____/____/___. I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide WHHC with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

____
Patient's Name (print)

____ ____________
Patient's Signature Date

____ ____________
Authorized Facility Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

WEISS HOLISTIC HEALTH CENTER

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of **Weiss Holistic Health Center's** "NOTICE OF PRIVACY PRACTICES," revision date April 14, 2003.

As required by the Privacy Regulations,______________________________from **Weiss Holistic Health Center** has explained the "NOTICE OF PRIVACY PRACTICES" to my satisfaction.
Name of Staff Member

As required by the Privacy Regulations, I am aware that **Weiss Holistic Health Center** has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

Requests:

☐ I wish to file a "Request for Restriction" of my Protected Health Information.

☐ I wish to file a "Request for Alternative Communications" of my Protected Health information.

☐ I wish to object to the following in the "Notice of Privacy Practices:"

____
____

I understand that this office is not required to honor any changes to the "Notice of Privacy Practices."

______________________________________ ________________________
Signature Date

____
Print Name

(OFFICE USE ONLY)

Signed form received by: ______________________________ Date: _________

Good faith effort to obtain receipt:
(Describe)____

____

____

____

Dr. Don M. Weiss

Informed Consent Agreement

NMT- The Feinberg Technique Treatment Consent Form

NeuroModulation Technique ("NMT") is intended to determine the patient's perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary soreness in muscles of the arms tested, or a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches.

I understand that NMT- *The Feinberg Technique* is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient's perception of conditions contributing to illness. I understand that Muscle Response Testing, ("MRT") employed in NMT, like any medical testing procedure, is not 100% accurate.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT- The Feinberg Technique.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT- The Feinberg Technique does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

NMT- The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider administering NMT. I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my screening and treatment.

I also understand that clinical data is presently being collected on the technique that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this ___ day of ____________, 20___.

___________________________________	________________________________
Patient's Signature	*Patient's Printed Name*
___________________________________	________________________________
If minor, signature of parent or guardian	*Parent or Guardian's Printed Name*
___________________________________	________________________________
Practitioner	*Witness*

Informed Consent Agreement

NMT- The Feinberg Technique Remote Treatment Consent Form

Neuro Modulation Technique ("NMT") is intended to determine the patient's perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment. In this case, I am seeking NMT screening and treatment via telephone as I am unable to physically visit the physicians clinic.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches. I understand that if any unexpected exacerbation of my symptoms should occur, I am solely responsible for obtaining appropriate medical care to address those symptoms or conditions.

I understand that NMT: The Feinberg Technique is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient's perception of conditions contributing to illness. I understand that Muscle Response Testing, ("MRT") employed in NMT, like any medical testing procedure, is not 100% accurate. Since I have chosen to undergo screening and treatment via telephone, I understand that my treatment will be based upon surrogate muscle response testing as an indicator of response to semantic queries and statements the practitioner verbally delivers to me. I understand that the efficacy of such treatment has been both established and refuted in published scientific literature.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, or any health condition for which I have been prescribed medications to control dangerous symptoms, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT: The Feinberg Technique.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT: The Feinberg Technique does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

Please initial after reading this page. ______________________________

NMT: The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer, or any other health care condition. I understand that I am not being asked to discontinue any concurrent medical care. Moreover, I understand that it is recommended that I do not discontinue any care prescribed by my doctors.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from my other health care practitioners, and communicating progress and any possible side effects or new symptoms that may or may not be related to my NMT treatment to the health care provide administering NMT.

I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them. I also understand that improvement in my health resulting from the NMT treatment I am requesting, may result in a change in my requirement for medications other providers have prescribed for me, and will consult that medical provider to see if a change in medication or medication dosage is necessary.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my screening and treatment. I understand that if I terminate treatment without the recommendation of my NMT practitioner, that this may adversely influence the degree or durability of improvement from my treatment. I agree that if I am being treated for allergies causing dangerous symptoms such as anaphylactic response, or for any condition that is aggravated by certain activities or exposures, that I will not expose myself to such risk of aggravation except as advised by my NMT practitioner under controlled and defined circumstances. I understand that if I expose myself to such aggravating factors prematurely, this may pose a risk to my health.

I understand that any services that are being provided on a remote basis are my sole financial responsibility, and that no aspect of such services may be billed to insurance companies for the purposes of reimbursement. I understand and authorize all charges for this service to be billed to the credit card account I have provided.

I further agree to be interviewed during this teleconference, and that this interview and my voice may be audio taped. I understand that these recorded audiotapes may be used for telephone consultation evaluation, research and NMT encounter purposes only, at both the transmitting and receiving facilities, and that my identity will not be disclosed except where medically necessary. I understand that without prior written consent, said recorded tapes will not be broadcast or otherwise played outside the health care or educational setting.

Please initial after reading this page. ______________________________

I also understand that clinical data is presently being collected on NMT that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this ___ day of _____________, 20___.

________________________________ ______________________________

Patient's Signature Patient's Printed Name

________________________________ ______________________________

If minor, signature of parent or guardian Parent or Guardian's Printed Name

________________________________ ______________________________

Practitioner Witness