# *Welcome to Weber Chiropractic & Nutritional Healing*

## *Patient Information*

Thank you for choosing Weber Chiropractic & Nutritional Healing for your chiropractic needs. Please complete this form in ink. If you have any questions or concerns, please do not hesitate to ask for assistance. We are happy to help.

*(please print clearly)*

Name: _____ SS/HIC/Patient ID #: _____
First Middle Initial Last

Address: _____ City: _____ State: _____ Zip Code: _____

Sex: ❑ Female ❑ Male Birthdate: _____ E-mail: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____ Work Phone: (_____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No Preference

❑ Married ❑ Widowed ❑ Single ❑ Minor ❑ Separated ❑ Divorced ❑ Partnered for ____ years

Patient Employer/School: _____ Occupation: _____

Employer/School Address: _____ City: _____ State: _____ Zip Code: _____

Spouse or parent's name: _____ Employer: _____ Work Phone: (_____)_____

Whom may we thank for referring you to us? _____

Person to contact in case of emergency: _____ Phone: (_____)_____

## *Responsible Party*

Name of person responsible for this account: _____

Relationship to patient: _____ Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Name of employer: _____ Work Phone: (_____)_____

## *Insurance Information*

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.:_____ Phone: (_____)_____ Group #:_____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

**Do you have additional insurance?** ❑ Yes ❑ No **If Yes, please complete the following:**

Name of insured: _____ Relationship to patient: _____

Birthdate: _____ Social Security#:: _____ Date employed: _____

Name of employer: _____ Work Phone: (_____)_____

Address: _____ City: _____ State: _____ Zip Code: _____

Insurance Co.:_____ Phone: (_____)_____ Group #:_____ Employer #: _____

Insurance Co. address: _____ City: _____ State: _____ Zip Code: _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit? _____

## *Symptoms*

Reason for visit: _____ When did you first notice the symptoms? _____

Is the condition getting progressively worse? _____ Where specifically is the problem(s) located? _____

Which activities are difficult to perform? ❑ Sitting ❑ Standing ❑ Walking ❑ Bending ❑ Lying down ❑ Other

Type of pain: ❑ Sharp ❑ Dull ❑ Throbbing ❑ Numbness ❑ Aching ❑ Shooting
❑ Burning ❑ Tingling ❑ Cramps ❑ Stiffness ❑ Swelling ❑ Other

Rate the severity of your pain. (1 = mild pain or discomfort, to 10 = severe pain) 1 2 3 4 5 6 7 8 9 10

Is the pain constant or does it come and go? _____

What treatment have you received for your condition?

❑ Medication ❑ Surgery ❑ Physical Therapy ❑ Other _____

Name and address of other doctor(s) who have treated you for your condition:

_____

## *Health History* *Check only those conditions which are applicable:*

| | | | | |
|---|---|---|---|---|
| ❑ AIDS/HIV | ❑ Cataracts | ❑ Hepatitis | ❑ Osteoporosis | ❑ Suicide Attempt |
| ❑ Alcoholism | ❑ Chemical Dependency | ❑ Hernia | ❑ Pacemaker | ❑ Thyroid Problems |
| ❑ Allergy Shots | ❑ Chicken Pox | ❑ Herniated Disc | ❑ Parkinson's Disease | ❑ Tonsillitis |
| ❑ Anemia | ❑ Depression | ❑ Herpes | ❑ Pinched Nerve | ❑ Tuberculosis |
| ❑ Anorexia | ❑ Diabetes | ❑ High Cholesterol | ❑ Pneumonia | ❑ Tumors, Growths |
| ❑ Appendicitis | ❑ Emphysema | ❑ Kidney Disease | ❑ Polio | ❑ Typhoid Fever |
| ❑ Arthritis | ❑ Epilepsy | ❑ Liver Disease | ❑ Prostrate Problems | ❑ Ulcers |
| ❑ Asthma | ❑ Fractures | ❑ Measles | ❑ Prosthesis | ❑ Vaginal Infections |
| ❑ Bleeding Disorders | ❑ Glaucoma | ❑ Migraine Headaches | ❑ Psychiatric Care | ❑ Venereal Disease |
| ❑ Breast Lump | ❑ Goiter | ❑ Miscarriage | ❑ Rheumatoid Arthritis | ❑ Whooping Cough |
| ❑ Bronchitis | ❑ Gonorrhea | ❑ Mononucleosis | ❑ Rheumatic Fever | ❑ Other _____ |
| ❑ Bulimia | ❑ Gout | ❑ Multiple Sclerosis | ❑ Scarlet Fever | _____ |
| ❑ Cancer | ❑ Heart Disease | ❑ Mumps | ❑ Stroke | _____ |

Dates of last exams: _____

(Woman) Are you pregnant? ❑Yes ❑No Nursing? ❑Yes ❑No Taking Birth Control Pills? ❑Yes ❑No

List any types of surgeries which you have had and the dates which they occurred: _____

_____

Please list all medications you are currently taking: _____

Allergies: _____

## *Daily Habits*

What type of exercise do you perform on a daily basis? ❑ None ❑ Moderate ❑ Heavy

What do your daily work habits include? _____

What vitamins do you currently take? _____ Nutritional supplements (if any)? _____

Do you smoke? ❑ Yes ❑ No How much per day? _____

How much liquor do you consume weekly? _____ How many caffeinated beverages do you consume daily? _____

## *Certification and Assignment*

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Weber Chiropractic & Nutritional Healing all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Weber Chiropractic & Nutritional Healing may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

WEBER CHIROPRACTIC & NUTRITIONAL HEALING

# Disability Questionnaire

Name:_____ Date:_____

Please circle the option that best applies:

Section 1: Pain Intensity

0 No pain
1 Mild pain
2 Moderate pain
3 Severe pain
4 Worst possible pain

Section 2: Sleeping

0 Perfect sleep
1 Mildly disturbed sleep
2 Moderately disturbed sleep
3 Greatly disturbed sleep
4 Totally disturbed sleep

Section 3: Personal Care (washing, dressing, etc.)

0 No pain; no restrictions
1 Mild pain; no restrictions
2 Moderate pain; need to go slowly
3 Moderate pain; need some assistance
4 Severe pain; need 100% assistance

Section 4: Travel (driving, passenger, etc.)

0 No pain on long trips
1 Mild pain on long trips
2 Moderate pain on long trips
3 Moderate pain on short trips
4 Severe pain; need 100% assistance

Section 5: Work

0 Can do usual work plus unlimited extra
1 Can do usual work; no extra work
2 Can do 50% of usual work
3 Can do 25% of usual work
4 Cannot work

Section 6: Recreation

0 Can do all activities
1 Can do most activities
2 Can do some activities
3 Can do few activities
4 Cannot do any activities

Section 7: Frequency of pain

0 No pain
1 Occasional pain; 25% of the day
2 Intermittent pain; 50% of the day
3 Frequent pain; 75% of the day
4 Constant pain; 100%

Section 8: Lifting

0 No pain with heavy weight
1 Increased pain with heavy weight
2 Increased pains with moderate weight
3 Increased pain with light weight
4 Increased pain with any weight

Section 9: Walking

0 No pain; any distance
1 Increased pain after 1 mile
2 Increased pain after ½ mile
3 Increased pain after ¼ mile
4 Increased pain with all walking

Section 10: Standing

0 No pain after several hours
1 Increased pain after several hours
2 Increased pain after 1 hour
3 Increased pain after ½ hour
4 Increased pain with any standing

WEBER CHIROPRACTIC & NUTRITIONAL HEALING

# Fragrance-Free Environment

Due to the sensitivities of our patients and employees, we ask that you do not wear any scented lotions, perfumes, after shave lotions, colognes or body sprays to our office. It is our goal to ensure that we have an environment that is conducive to health and wellness. Many people respond to these products in a negative way, causing reactions such as headaches, coughing, scratchy throat or nausea to name a few. If you choose to do so, it may be necessary to reschedule your appointment.

Thank You in advance,

Weber Chiropractic and Nutritional Healing

Patient Signature: _____ Date:_____

WEBER CHIROPRACTIC & NUTRITIONAL HEALING

# INFORMED CONSENT

Dear Patient,

Every type of health care is associated with some risk of potential problem. This includes chiropractic health care. We wish you to be informed about the possibility of any potential problems associated with chiropractic health care before consenting to treatment. This is called informed consent.

## Consent to Treatment

The following points have been explained to me to my satisfaction and I have had the opportunity to discuss them with the doctor and/or other clinic personnel.

1. I understand that the chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, and there may be an audible “pop” or “click” as a result of joint movement.
2. The practice of health care is not an exact science, but relies upon information related by the patient, information gathered during the examination (and the doctor’s interpretation thereof,) as well as the doctor’s judgment and expertise. Chiropractic health care is no different.
3. It is not reasonable to expect my doctor to be able to anticipate or explain all possible risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise professional judgment during the course of any procedures which s/he feels at the time to be in my best interest.
4. Though infrequent, as with any health procedure, there are certain complications which may arise during chiropractic health care. These complications include soreness, sprains/strains dislocations, factures, disc injuries, cerebral-vascular accidents, physiotherapy burns, or soft tissue injuries. These complications are extremely rare occurrences.
5. Chiropractic is a system of health care delivery; therefore, as with any other health care delivery system, we cannot promise a cure for any symptom, disease, or condition as a result of treatment in this clinic. We will give you our best care.
6. I understand that there are other forms of treatment, including drugs and surgery, which could be treatment options for my condition, but at this time, I choose chiropractic care.

I have read the above consent, or it has been read to me, have had the opportunity to ask questions and receive answers, am comfortable with the information provided, and consent to chiropractic treatment and management on that basis. In signing this document, I in no way compromise my protection against negligence.

Patient Signature_____ Date _____

Witness Signature_____ Date _____

# Symptom Survey

## *What to fill out*

**Instructions**

- Please circle any of the symptoms you've had within the last 6 months Circle
  - 1. Mild
  - 2. Mediocre
  - 3. Severe
- When you complete this form, you will talk ***privately with the Doctor*** to discuss your health problems and any concerns you may have
- An appropriate care plan will be discussed and may require further testing, necessary to determine the precise cause of your health problems.
- You will be ***scheduled*** for a ***follow up call or visit,*** to go over the results of this information along with any recommendations for treatment and any other consultations.

**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: _____

# Diet Diary

## *What to fill out*

### Instructions

- Write down everything and anything you have eaten within the last 5-7 days
  - Please list anything that you put in your mouth, i.e. gum, candies, etc
- When you complete this form, you will talk ***privately with the Doctor*** to discuss your health problems and any concerns you may have
- An appropriate care plan will be discussed and may require further testing, necessary to determine the precise cause of your health problems.
- You will be ***scheduled*** for a ***follow up call or visit,*** to go over the results of this information along with any recommendations for treatment and any other consultations.

## *Daily Record of Food Intake* | *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.

*Name:*

### *Day 1 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** (good) 1 2 3 4 5 (poor) |

### *Day 2 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** (good) 1 2 3 4 5 (poor) |

### *Day 3 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** (good) 1 2 3 4 5 (poor) |

Notes:

*Day 4 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** **(good) 1 2 3 4 5 (poor)** |

*Day 5 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** **(good) 1 2 3 4 5 (poor)** |

*Day 6 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** **(good) 1 2 3 4 5 (poor)** |

*Day 7 - Date:*

| ***BREAKFAST*** *Time:* | ***LUNCH*** *Time:* | ***DINNER*** *Time:* |
|---|---|---|
| Meat & Dairy: | | |
| Vegetables & Fruits: | | |
| Breads, Cereals, & Grains: | | |
| Fats (butter, margarine, oils, etc.): | | |
| Candy, Sweets, & Junk Food: | | |
| Water Intake (fl. oz.): | | |
| Other Drinks: | | |
| ***MID-MORNING SNACK*** *Time:* | ***MID-DAY SNACK*** *Time:* | ***NIGHTTIME SNACK*** *Time:* |
| Snack: | | |
| ***Bowel Movements****(# and consistency):* | ***Hours of Sleep:*** | ***Quality of Sleep:*** **(good) 1 2 3 4 5 (poor)** |

WEBER CHIROPRACTIC & NUTRITIONAL HEALING
3802 TIETON DRIVE · YAKIMA WA 98902

**Please take the time to review the fee scales listed below. It is important that we have open communication with our patients regarding our fees. If you have any questions feel free to ask!**

**NEW PATIENT (NP)**

| **OUR FEES** | **NORMAL FEES** | **PCD PROGRAM FEES** |
|---|---|---|
| NP Chiropractic Exam | $85.00 to $145.00 | $95.00 |
| X-rays per area | $65.00 to $125.00 | $25.00 |
| NP Exam and X-rays Combo | | $165.00 |

**ESTABLISHED PATIENT (EP)**

| | | |
|---|---|---|
| EP Progress Exam | $85.00 | $50.00 |
| Office Visit/ Adjustment | $65.00 | $50.00 |
| Extremity Adjustment (In addition to above) e.g. wrist, shoulder, knee, etc. | $28.00 | $15.00 |
| Spinalator Traction Table per 15 minutes (In addition to above) | $28.00 | $15.00 |
| Vibracussor Massage (In addition to above) | $15.00 | $11.25 |
| Laser Therapy | $45.00 | $45.00 |
| Ice Pack | $15.00 | $11.25 |
| After Hours Office Visit Evenings & Weekends (In addition to above) | $60.00 | $60.00 |

## Insurance Policies

**Insurance assignment: If you have insurance which covers chiropractic services, we will bill your insurance company for you if they allow you to assign benefits to our office. If your insurance has been verified and your deductible has not been fully met, on your first visit we require payment for the remainder of your deductible and any co-payments that you are responsible for. If your deductible has been met, we require that the co-pays are paid on the day of service. _____ (Initial)**

If you do not understand these arrangements or this is a Workman's Compensation or Personal Injury Case, please consult with a member of our staff. Our main concern is your health and well-being and we will do our best to help and serve you.

Please be advised that benefits quoted from your insurance company to us are not a guarantee of payment. Determination of benefits are not made until claims are received and processed by your insurance carrier. It is important to understand that your contract is between you and your insurance company and not us. We are not responsible for any benefits that are incorrectly quoted by the insurance. It has been our experience that insurance companies usually pay less than expected in some if not most cases. Any conflict concerning your benefits or payments from your insurance company should be addressed by you to your insurance company. _____ (Initial)

***Please be advised that if your insurance company does not pay in a timely fashion (usually 30 days) then you will be required to pay your bill in full in order to keep your account current. It has been our experience that insurance companies come up with many "excuses" for not paying the bills in a timely fashion for whatever self serving reason. If this is the case, then we will not continue to rebill your insurance company and you will be responsible for immediate payment of your account. It is your responsibility to work out any problems with your insurance company on payment issues after the initial billing. We have found this to be necessary in order to keep our costs and our fees affordable. _____ (Initial)***

**A monthly service charge of 1% or 12% per annum will be added to any unpaid balance after 30 days.**

**Any unpaid balanced for services rendered in our office after 30 days will require all future services to be paid in full at the time of service regardless of insurance coverage_____ (Initial)**

## Prepay Plans, Chiropractic, Laser

If you have limited or no insurance coverage for chiropractic care, are enrolled in an HMO that does not cover chiropractic care, your deductible is exceptionally high, or your insurance coverage runs out before your care program is complete, we have prepaid plans. These are very affordable programs you can join independently that allows you to purchase our services at reduced rates listed on the front of this page. Please consult with a member of our staff for more information.

We accept cash, check, MasterCard and Visa for our prepaid plans. For these prepay plans we will not do any paperwork at all for any kind of insurance reimbursement. If you acquire insurance benefits that cover chiropractic care or are in an automobile accident or work related injury and your care is covered, we will begin billing that insurance for your care at our normal rates under the same rules and requirements as stated above under the insurance policies.

I acknowledge financial responsibility for all services rendered to me or a minor in my charge and if necessary, any collection costs including attorney fees. I also understand that if I should terminate my care for any reason, any professional services rendered me will be immediately due and payable.

Patient's Signature: _____ Date: _____

WEBER CHIROPRACTIC
& NUTRITIONAL HEALING

# FORM: NOTICE OF PRIVACY PRACTICE SUMMARY

This summary discloses how health information about you may be used. A full notice of your privacy rights has also been provided to you.

Weber Chiropractic Clinic, Inc. P.S. uses health information about you for treatment, to obtain payment for treatment with your authorization as required (check your state laws,) for administrative purposes, and to evaluate the quality of care that you receive.

Weber Chiropractic Clinic, Inc. P.S., will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

Weber Chiropractic Clinic, Inc. P.S. may use your information to provide appointment reminders, information about treatment alternatives or other health related issues.

Weber Chiropractic Clinic, Inc., P.S. may disclose your information for public health activities, to funeral directors to enable them to carry out their activities, for organ and tissue donations, research, health and safety, governmental function in order to comply with workers compensation laws and regulations, a right to request restriction, report and retain a copy of your health record, request communication of your information by alternative means at alternative locations, revoke your authorization and request and accounting of your health records.

You may complain to the Privacy Officer Gene C. Weber and to the Department of Health and Human Services if you believe your privacy rights have been violated. You will not be retaliated against for filing a complaint.

Weber Chiropractic Clinic, Inc. P.S. must maintain the privacy of protected health information, provide you with notice of its legal duties and privacy practices with respect to your health information, abide by terms of the notice, notify you if it was unable to agree to the requested restriction on how your information is used or disclosed, accommodate reasonable requests you may make to communicate with health information by alternative means or by alternative locations and obtain your written authorization to use or disclose your health information for reason other than those listed above and permitted under law.

If you have any questions or complaints, please contact Gene C. Weber at (509)-965-7155.

Patient Signature: _____ Date: _____