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CONFIDENTIAL PATIENT INFORMATION

Personal Information

Full name:		Date:	
Address:			
Street	City	State	Zip
Home phone:		Work phone:	
Cell phone:		Email address:	
**Best place to contact you:		Can we leave a detailed message: Y/ N	
Date of birth:		Age:	
No. of children:		Pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Height:		Weight:	
Driver's license number:		SS#:	
Marital status: M S W D		Spouse/guardian name:	
Occupation:		Preferred Pharmacy Name & Phone #:	
Employer's name & address:			
Spouse's Occupation/Employer:			
Name of person responsible for account:		Emergency Contact:	
Do you have insurance that covers Chiropractic/Medical Care? Yes <input type="checkbox"/> No <input type="checkbox"/>		Do you have Medicare coverage? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Name of Insurance Company:			
Insurance Policy number:		Insurance Company phone number:	
Insurance Company address:			

***Who may we thank for referring you? _____

Addressing What Brought You Into This Office:

If you have no symptoms or complaints and are here for Chiropractic/Medical Wellness Services, please skip to the "General Health History".

Health Concerns

Please list your health concerns according to their severity	Rate of severity 1 = mild 10 = worst imaginable	When did this episode start?	If you had this condition before, when?	Did the problem begin with an injury?	% of the time pain is present
1.					
2.					
3.					
4.					

Is your pain dull? Or is your pain sharp? Does it radiate anywhere? If so, where?

Since the problem started is it: About the same? Getting better? Getting worse?

***What have you done for this condition? Was it of benefit? Did mainly temporary relief? Is that true so you haven't got to the underlying cause of the problem?

I do (do not) have a family history of this or similar symptoms (Please explain):

***Which activities aggravate your condition? (Affects persons life) tell me more about it

****Other doctors you have seen for this condition:

"Limited Scope" Chiropractor (focuses mainly on neck and back pain) Was experience + or -	<input type="checkbox"/>
"Wellness" Chiropractor (focuses on health and well being as well as underlying cause of pain and health concerns)	<input type="checkbox"/>
Medical Doctor	<input type="checkbox"/>
Dentist	<input type="checkbox"/>
Other (please describe)	<input type="checkbox"/>

Doctor's details:

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

Name:	Address:
When did you see them?	
What did they say was wrong?	
Did it help?	What did they do?

**** Have you been "forced" or "felt the need" to make any "positive" changes in your life due to this pain, illness, condition, etc?
(i.e., eat better, less alcohol or drugs, meditate or breathe more, less destructive sports, activities, etc.) If so, what?

****Is this condition interfering with any of the following?

Work <input type="checkbox"/>	Sleep <input type="checkbox"/>	Daily routine <input type="checkbox"/>	Sports/exercise <input type="checkbox"/>	Other <input type="checkbox"/> (please explain):
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What lesson(s) have you taken home from your healing process to date?

General Health History

Often times, accumulation of life's stress can lead to health problems and influence our ability to heal. Please pay close attention to this as it will help us help you!

Have you had any surgery? (Please include all surgery)

1. Type:	When?	Doctor
2. Type:	When?	Doctor
3. Type:	When?	Doctor
4. Type:	When?	Doctor

Have you had any accidents and/or injuries: auto, work-related, or other? (Especially those related to your present problems).

1. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Type:	When?	Hospitalized? Yes <input type="checkbox"/> No <input type="checkbox"/>

Have you ever had x-rays taken?

Area of body:	When?	Where?
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Do you wear orthotics or heel lifts? Yes No

Medication Allergies

Current Medicines and Supplements

Please list any medications/drugs you have taken in the past 6 months and why: (prescription and non-prescription)

Are you interested in knowing more about how your nutrition (food you eat) affects your overall health and well-being?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If dietary changes are indicated would you be willing to make changes in your diet?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
Would you take whole food supplements if indicated?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If specific exercises or stretching would help would you consider adding them to your program?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>
If reducing stress would help you would you like to know ways to reduce stress?	Yes <input type="checkbox"/> No <input type="checkbox"/> Maybe <input type="checkbox"/>

Patient Name: _____

*****Diet

Please circle any dietary selection that is appropriate for you, and grade according to the following scale:

D - Consume this daily | **FD** - Consume this a few times per day | **W** - Consume this weekly | **FW** - Consume this a few times per week
FM - Consume a few times per month (less than weekly) | **M** - Consume this monthly | **O** - Do not consume this

Alcohol	Eggs	Fasting	Artificial Sweetener
Tobacco	Fruit	Diet food	Weight Control Diet
Coffee	Beef	Refined Sugar	Raw Vegetables
Soda	Poultry	Fish	Whole Grains
Fried Foods	Organic foods	Seafood	Dairy
Cooked or canned vegetables			

The type of diet I usually follow is classified as: _____

Past Health History

Please mark the following conditions you may have had or have now (- have had + have now):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Allergy	<input type="checkbox"/> Anemia	<input type="checkbox"/> Arteriosclerosis	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Back Pain	<input type="checkbox"/> Cancer	<input type="checkbox"/> Cold Sores	<input type="checkbox"/> Constipation	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Depression
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Gall Bladder Problems
<input type="checkbox"/> Gout	<input type="checkbox"/> Headaches	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> HIV (Aids)
<input type="checkbox"/> Irregular Periods	<input type="checkbox"/> Low Blood Sugar	<input type="checkbox"/> Malaria	<input type="checkbox"/> Measles	<input type="checkbox"/> Menstrual Cramps	<input type="checkbox"/> Migraines
<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Nervousness	<input type="checkbox"/> Neuritis
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Polio	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Thyroid Problems	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Whooping Cough

Other (please explain) _____

****Stressors (Highlight) Helps Dr. Please Fill Out

Because accumulation of stress affects our health and ability to heal please list your top three stresses (you have ever had) in each category:

1. Physical stress (falls, accidents, work postures, etc.)

- a. _____
- b. _____
- c. _____

Patient Name: _____

2. Bio-chemical stress (smoke, unhealthy foods, missed meals, don't drink enough water, drugs/alcohol, etc.)

- a. _____
- b. _____
- c. _____

Psychological or mental/emotional stress (work, relationships, finances, self-esteem, etc.)

- d. _____
- e. _____
- f. _____

On a scale of 1-10 please grade your present levels of stress (including physical, bio-chemical and psychological or mental/emotional):

At work:	At home:	At play:
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On a scale of 1-10, (1 being very poor and 10 being excellent) please describe you're:

Eating habits:	Exercise habits:	Sleep:	General health:	Mind set:
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How do you grade your physical health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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How do you grade your emotional/mental health?

Excellent <input type="checkbox"/>	Good <input type="checkbox"/>	Fair <input type="checkbox"/>	Poor <input type="checkbox"/>	Getting better <input type="checkbox"/>	Getting worse <input type="checkbox"/>
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***Is there anything else which may help to better understand you which has not been discussed?

Why are you here at this point in time?

____ I consent to a professional and complete chiropractic/ medical examination and to any radiographic/diagnostic examination that the doctor deems necessary.

I understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

Print Patient Name: _____ Date: _____

Signature: _____

Print Patient Name: _____

Date: _____

Informed Consent for Medical / Chiropractic/ Acupuncture/NAET Treatment

Dear Patient,

We encourage and support a shared decision making process between us regarding your health needs. As a part of that process you have a right to be informed about your condition of your health and the recommended care and treatment to be provided to you so that you can make the decision whether or not to undergo such care with full knowledge of the known risks. The information is intended to make you better informed in order that you can knowingly give or withhold your consent.

Every type of health care is associated with some risk of a potential problem. This includes Medical/Chiropractic/Acupuncture/NAET care. We want you to be informed about potential problems associated with Medical /Chiropractic/Acupuncture/NAET care before consenting to treatment. This is called informed consent.

Chiropractic:

Chiropractic is based on the science which concerns itself with the relationship between structures (primarily the spine) and function (primarily the nervous system) and this relationship can affect the restoration and preservation of health.

Chiropractic adjustments/ joint mobilizations are performed by Chiropractors. It is the moving of bones to correct or reduce spinal and extremity joint subluxations with the doctor's hands or with the use of a mechanical device, following palpation and/or other examination procedures. A Vertebral Subluxation is a disturbance to the nervous system and is a condition where one or more vertebra in the spine is misaligned and /or does not move properly causing interference and /or irritation to the nervous system. The primary goal of Chiropractic Care is the removal and/or reduction of the nerve interference caused by vertebral subluxation. A Chiropractic examination will be performed which may include spinal and physical examination, orthopedic and neurological testing, palpation, specialized instrumentation, x-rays and laboratory testing. Frequently with spinal or joint adjustments techniques create a "pop" or "click" sound/sensation in the area being treated, such as the noise when a knuckle is "cracked", and you may feel movement of the joint. In addition some ancillary procedures, such as hot and cold packs, electric muscle stimulation, therapeutic ultrasound, massage therapy, paraffin wax, cervical traction, mechanical traction, therapeutic exercises, vibrational -proprioceptive rehab and acupuncture/acupressure, laser acupuncture may also be used. In this office, we use trained staff personal to assist the doctor(s) with portions of your consultation, examination, x-ray taking, physical therapy application, traction, massage therapy, exercise instruction, etc. Occasionally when your doctor is unavailable, another clinic doctor under the direction of the primary doctor will treat you on that day.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. A minority of patients may notice stiffness or soreness after the first few days of treatment.

Stroke: There are reported cases of stroke associated with visits to medical doctors and chiropractors. Research and scientific evidence does not establish a cause and effect relationship between chiropractic treatment and the occurrence of stroke: rather recent studies indicate that patients may be consulting medical doctors and chiropractors when they are in the early stages of a stroke. In essence, there is a stroke already in process. However, you are being informed of this report associated because a stroke may cause serious neurological impairment.

Disc Herniation: Disc herniations that create pressure on the spinal nerve or on the spinal cord are frequently successfully treated by Chiropractors and Chiropractic adjustments/joint mobilizations, traction, etc. This includes both in the neck and in the back. Yet, occasionally chiropractic treatment (adjustments/joint mobilizations, traction, etc.) may aggravate the problem and rarely surgery may become necessary for correction.

Rarely chiropractic adjustment/joint mobilizations may also cause a disc problem if the disc is in a weakened condition. These problems occur so rarely that there are no available statistics to quantify their probability.

Soft Tissue Injury: Soft tissues primarily refer to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely chiropractic adjustments/joint mobilizations, traction, massage therapy, etc., may tear some muscle or ligament fibers. The result is a temporary increase in pain and necessary treatments for resolution, but there are no long-term effects for the patient. These problems occur so rarely that there are no statistics to quantify their probability.

Rib Fractures: The ribs are found only in the thoracic spine or the middle back. They extend from your back to your front chest area. Rarely a chiropractic adjustment/joint mobilization will crack a rib bone, and this is referred to as a fracture.

This occurs only on patients that have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust/manipulate all patients very carefully, and especially those who have osteoporosis noted on their x-rays. These problems occur so rarely that there are no statistics to quantify their probability.

Physical Therapy Burns: Some of the machines we use generate heat. We also use both heat and ice, and recommend them for home care on occasion. Everyone's skin has different sensitivity to these modalities, and rarely, both heat and ice can burn or irritate the skin. The result is temporary increase in pain, and there may even be some blistering of the skin. These problems occur so rarely that there are no statistics to quantify their probability. Furthermore physiotherapy may include the proceeding as well as a allergic reaction to gels or lotions in some cases.

Soreness: It is common for chiropractic adjustments/joint mobilizations, traction, massage therapy, exercise, etc. to result in a temporary increase in the soreness in the region being treated. This is nearly always a temporary symptom that occurs while your body is undergoing therapeutic changes. It is not dangerous, but please tell your doctor about it.

Acupuncture: If using dry needling technique the following risks can occur: infection at site of insertion of needle, bruising, itching, redness, swelling, allergic response to needle.

NAET: Sweating when holding the substance, itching, fatigue after treatment, muscle weakness after treatment.

Probability of risks occurring: There may be other problems or complications that might arise from Chiropractic/Medical/Acupuncture/NAET other than those noted above. These other problems or complications occur so rarely that it is not possible to anticipate and / or explain them all in advance of treatment. The risks of complications due to chiropractic treatment have been described as 'rare', about as often as complications are seen from the taking of a single aspirin tablet. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options, which could be considered, may include the following:

- Over the counter analgesics. The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- Medical care, typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- Hospitalization in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- Surgery in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probably that delay of treatment will complicate the condition and make future rehabilitation more difficult. The same consequences can occur with patients suffering from allergies, chronic conditions and specific medical problems not listed here.

Chiropractic/ Medical/ Acupuncture/ NAET is a system of health care delivery, and therefore, as with any health care delivery system we cannot promise a cure for any symptoms, disease, or condition as a result of treatment in this center. We will always give you our best care, and if results are not acceptable, we will refer you to another provider whom we feel will assist your situation.

If you have any questions on the above, please ask your doctor. When you have a full understanding, please sign and date below.

1. I, _____, authorize the performance upon myself of the following procedure(s): Examination/ X-rays(gowned if needed) Ultrasound, sinusoidal current, interferential currents, traction, hydrocollator, electrical muscle stimulation, ice therapy, acupuncture, contact reflex analysis with nutritional supplementation, N.A.E.T, and chiropractic manipulative/joint mobilization techniques to be performed by or under the direction of the Doctors and staff of Integrated Medical Center, Inc. d.b.a./Quantum Wellness Center
2. I also consent to the performance of other diagnostic and / or therapeutic procedures in addition to or different from those stated above, whether or not arising from presently unforeseen conditions, that the doctors, associates and / or assistants, may consider necessary or advisable in the course of my health care or treatment.
3. I acknowledge that no guarantee or assurance as to the results that may be obtained from the procedure(s) has been given by the doctors, their associates or assistants.

4. I have read the explanation above of medical / chiropractic/ acupuncture / NAET treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment.

I, _____ of my own free will choose to become a patient of Drs. Popkin/Grundstein/Jomsky/Jimenez. I understand that some of the techniques and products used in this clinic are neither FDA (Food and Drug Association) approved or considered a "main stream" traditional medicine.

Drs. Popkin/Grundstein/Jomsky/Jimenez can not guarantee the results of these treatments or products.

I am aware that I am free to seek other medical opinions or other care at any time. I am also aware that Drs. Popkin/Grundstein/Jomsky/Jimenez meet the requirements by Florida law.

I hereby exercise my freedom of choice in medicine/chiropractic to follow Drs. Popkin/Grundstein's/Jomsky/Jimenez recommendations or not as I choose.

Signed _____ **Witness** _____ **Date** _____

Metabolic Detoxification Questionnaire

Part 1: Symptoms

Name: _____ Date: _____

Rate each of the following symptoms based on the last week using the point scale below:

0 Never or rarely have the symptom

1 Occasionally have it, effect is not severe

2 Occasionally have it, effect is severe

3 Frequently have it, effect is not severe

4 Frequently have it, effect is severe

Digestive Tract

Nausea, vomiting 0 1 2 3 4

Diarrhea 0 1 2 3 4

Constipation 0 1 2 3 4

Bloated feeling 0 1 2 3 4

Heartburn 0 1 2 3 4

Intestinal, stomach pain 0 1 2 3 4

Digestive Total:

Joints / Muscles

Pain or aches in joints 0 1 2 3 4

Arthritis, joint swelling 0 1 2 3 4

Stiff or limitation of movement 0 1 2 3 4

Pain or aches in muscles 0 1 2 3 4

Feeling of weakness or tired 0 1 2 3 4

Joints / Muscles Total:

Emotional

Mood swings 0 1 2 3 4

Anxiety, fear, nervousness 0 1 2 3 4

Anger, irritability, aggression 0 1 2 3 4

Depression 0 1 2 3 4

Emotional Total:

Weight / Food

Binge eating, drinking 0 1 2 3 4

Craving certain foods 0 1 2 3 4

Excessive weight 0 1 2 3 4

Compulsive eating, food addictions 0 1 2 3 4

Water retention 0 1 2 3 4

Underweight 0 1 2 3 4

Weight / Food Total:

Energy / Sleep

Fatigue, sluggishness 0 1 2 3 4

Apathy, lethargy 0 1 2 3 4

Hyperactivity 0 1 2 3 4

Restlessness, achiness 0 1 2 3 4

Sleep disturbances 0 1 2 3 4

Energy / Sleep Total:

Skin

Acne 0 1 2 3 4

Hives, rashes, dry skin, redness 0 1 2 3 4

Hair loss 0 1 2 3 4

Flushing, hot flashes 0 1 2 3 4

Excessive sweating 0 1 2 3 4

Skin Total:

Heart

Irregular or skipped heartbeat 0 1 2 3 4

Rapid or pounding heartbeat 0 1 2 3 4

Chest pain 0 1 2 3 4

Heart Total:

Other

Frequent illness 0 1 2 3 4

Frequent or urgent urination 0 1 2 3 4

Genital itch or discharge 0 1 2 3 4

Other Total:

Respiratory

Chest congestion 0 1 2 3 4

Asthma, bronchitis 0 1 2 3 4

Shortness of breath 0 1 2 3 4

Difficulty breathing 0 1 2 3 4

Respiratory Total:

Eyes

Watery or itchy eyes 0 1 2 3 4

Swollen, red, or sticky eyelids 0 1 2 3 4

Bags or dark circles under eyes 0 1 2 3 4

Blurred or restricted vision 0 1 2 3 4

Eyes Total:

Nose

Stuffy nose 0 1 2 3 4

Sinus problems or dripping nose 0 1 2 3 4

Hay fever 0 1 2 3 4

Sneezing attacks 0 1 2 3 4

Excessive mucus 0 1 2 3 4

Nose Total:

Mouth / Throat

Frequent, consistent coughing 0 1 2 3 4

Gagging, need to clear throat 0 1 2 3 4

Sore throat, hoarse, loss of voice 0 1 2 3 4

Swollen or discolored tongue, gums, or lips 0 1 2 3 4

Canker sores, other mouth sores 0 1 2 3 4

Mouth / Throat Total:

Ears

Itchy ears 0 1 2 3 4

Earaches, ear infections 0 1 2 3 4

Drainage from ear, waxy buildup 0 1 2 3 4

Ringling in ears, hearing loss 0 1 2 3 4

Ears Total:

Head

Headaches 0 1 2 3 4

Faintness or lightheadedness 0 1 2 3 4

Dizziness 0 1 2 3 4

Head Total:

Cognitive

Poor memory, recall 0 1 2 3 4

Confusion, poor comprehension 0 1 2 3 4

Poor concentration 0 1 2 3 4

Poor physical coordination 0 1 2 3 4

Difficulty in making decisions 0 1 2 3 4

Stuttering, stammering 0 1 2 3 4

Slurred speech 0 1 2 3 4

Learning disabilities 0 1 2 3 4

Cognitive Total:

Grand Total _____

For Practitioner Use Only:

Urinary pH _____

Metabolic Detoxification Questionnaire

Part 2: Xenobiotic Tolerability Test (XTT)

1. Are you presently using prescription drugs?

- Yes (1 pt.) No (0 pt.)

If yes, how many are you currently taking? ____ (1 pt. each)

2. Are you presently taking one or more of the following over-the-counter drugs?

- Cimetidine (2 pts.) Acetaminophen (2 pts.) Estradiol (2 pts.)

3. If you have used or currently use prescription drugs, which of the following scenarios best represents your response to them:

- Experience side effects; drug(s) is (are) efficacious at lowered dose(s) (3 pts.)
 Experience side effects; drug(s) is (are) efficacious at usual dose(s) (2 pts.)
 Experience no side effects; drug(s) is (are) usually not efficacious (2 pts.)
 Experience no side effects; drug(s) is (are) usually efficacious (0 pt.)

4. Do you currently (within the last 6 months) or have you regularly used tobacco products?

- Yes (2 pts.) No (0 pt.)

5. Do you have strong negative reactions to caffeine or caffeine-containing products?

- Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

6. Do you commonly experience "brain fog," fatigue, or drowsiness?

- Yes (1 pt.) No (0 pt.)

7. Do you develop symptoms with exposure to fragrances, exhaust fumes, or strong odors?

- Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

8. Do you feel ill after you consume even small amounts of alcohol?

- Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

10. Do you have a personal history of:

- Environmental and/or chemical sensitivities (5 pts.)
 Chronic fatigue syndrome (5 pts.)
 Multiple chemical sensitivity (5 pts.)
 Fibromyalgia (3 pts.)
 Parkinson's type symptoms (3 pts.)
 Alcohol or chemical dependence (2 pts.)
 Asthma (1 pt.)

11. Do you have a history of significant exposure to harmful chemicals such as herbicides, insecticides, pesticides, or organic solvents?

- Yes (1 pt.) No (0 pt.)

12. Do you have an adverse or allergic reaction when you consume sulfite-containing foods such as wine, dried fruit, salad bar vegetables, etc.?

- Yes (1 pt.) No (0 pt.) Don't know (0 pt.)

Total _____

Part 3: Alkalinizing Assessment

1. Do you have a history of or currently have kidney dysfunction?

- Yes (1 pt.) No (0 pt.)

2. Have you ever been diagnosed with hyperkalemia?

- Yes (1 pt.) No (0 pt.)

3. Are you currently taking diuretics or blood pressure medication?

- Yes (1 pt.) No (0 pt.)

Total _____

Overall Score Tabulation

For Practitioner Use Only:

Part 1: Symptoms Grand Total _____ (High >50; moderate 15-49; low <14)

Part 2: XTT Total _____ (High >10; moderate 5-9; low <4)

Part 3: Alkalinizing Assessment Total _____ (High ≥1)

Urinary pH _____

Notes:

- Patients with high symptoms but low XTT may be exhibiting reactions that are not related to toxic load. Other mechanisms should be considered, such as inflammation/immune/allergy, gastrointestinal dysfunction, oxidative stress, hormonal/neurotransmitter dysfunction, nutritional depletion, and/or mind body. Individualize support with specific medical foods, diet, and/or nutraceuticals.
- Recommend non-alkalinizing nutrients if patient answers "yes" to any questions in the Alkalinizing Assessment.

Disclaimer: This questionnaire is for informational purposes only. It is not meant to diagnose or treat any condition or illness. All medical symptoms should be addressed by a qualified medical professional.

REVIEW OF SYSTEMS

Patient's Name: _____
 Treating Physician: _____

Date: _____
 D.O.B. _____

Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please identify if this is a problem that you currently have.

	YES	NO	CURRENT	EXPLAIN
CONSTITUTION: Sudden weight loss or gain?	_____	_____	_____	_____
EYES: Changes in vision?	_____	_____	_____	_____
Watering?	_____	_____	_____	_____
Pain or pressure?	_____	_____	_____	_____
EARS, Changes in hearing?	_____	_____	_____	_____
NOSE, Bloody nose?	_____	_____	_____	_____
MOUTH, Blisters in mouth?	_____	_____	_____	_____
THROAT: Throat pain?	_____	_____	_____	_____
CARDIO- Chest pain?	_____	_____	_____	_____
VASCULAR: Palpitations?	_____	_____	_____	_____
Ankle swelling?	_____	_____	_____	_____
RESPIRATORY: Difficulty breathing?	_____	_____	_____	_____
Coughing?	_____	_____	_____	_____
GASTRO- Abdominal pain?	_____	_____	_____	_____
INTESTINAL: Blood in stool?	_____	_____	_____	_____
GENITO- Frequent urination?	_____	_____	_____	_____
URINARY: Blood in urine?	_____	_____	_____	_____
Painful urination?	_____	_____	_____	_____
MUSCULO- Joint pain?	_____	_____	_____	_____
SKELETAL: Muscle pain?	_____	_____	_____	_____
NEUROLOGIC: Headaches?	_____	_____	_____	_____
Numbness, Tingling?	_____	_____	_____	_____
HEMATOLOGIC/ Swollen glands?	_____	_____	_____	_____
LYMPHATIC: Bleeding Problems?	_____	_____	_____	_____
ENDOCRINE: Increase thirst?	_____	_____	_____	_____
Changes in temperature?	_____	_____	_____	_____
SKIN: Rashes?	_____	_____	_____	_____
Itching?	_____	_____	_____	_____
ALLERGIC/ Allergies?	_____	_____	_____	_____
IMMUNOLOGIC: Immune disorders?	_____	_____	_____	_____

PAST, FAMILY, SOCIAL HISTORY

Patient's Name _____

Date _____

Treating Physician _____

PAST MEDICAL HISTORY

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page.)

	Yes	No	Explain
1. Any history of heart, lung, bowel or urinary problems?	_____	_____	_____
2. Any history of diabetes?	_____	_____	_____
3. Any history of high blood pressure?	_____	_____	_____
4. Any history of accidents?	_____	_____	_____
5. Any history of surgery or operations?	_____	_____	_____
6. Are you taking any medication?	_____	_____	_____
7. Any history of cancer?	_____	_____	_____
8. Have you ever been hospitalized?	_____	_____	_____

SOCIAL HISTORY

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page)

1. Have you ever smoked?	_____	_____	_____
2. Do you smoke now?	_____	_____	_____
3. Do you drink alcohol?	_____	_____	_____
4. Are you working?	_____	_____	_____
5. Are you working part time?	_____	_____	_____
6. Are you working full time?	_____	_____	_____
7. Are you married or do you have a significant other?	_____	_____	_____

FAMILY HISTORY

Section One

(Please check the appropriate "yes" or "no" responses to the following questions. If the answer is "yes", please explain in the space provided. If more space is required, please use opposite side of page.)

1. Any history of diabetes in your family?	_____	_____	_____
2. Any history of heart disease in your family?	_____	_____	_____
3. Any history of cancer in your family?	_____	_____	_____
4. Any history of arthritis in you family?	_____	_____	_____

Section Two

(Please describe the health status of each of the following family members. If deceased, please list the age and cause of death)

Mother _____

Father _____

Siblings _____

Children _____

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be use rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patients' diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Quantum Wellness Center

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____, have read and understand the above statement on _____ (date).

Witnessed by _____ Date: _____

*Integrated Medical
Centers, Inc/DBA/ Quantum Wellness Center
1261 South Pine Island Road Plantation, FL 33324
954-370-1900 (Office) 954-476-6281 (Fax)*

HEALTH CARE AUTHORIZATION FORM

I have been provided with a copy of the Notice of Privacy Practices for Protected Health Information. The Notice of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) that will occur in my treatment, payment of my bills or in the performance of health care operations of this chiropractic office. A copy of our notice is attached and we encourage you to read it and request your own copy if you would like one.

This Notice of Privacy Practices also describes my rights and duties of the Chiropractor with respect to my protected health information. I hereby give permission to _____ Family Chiropractic Center to use and/or disclose Protected Health Information in accordance with the following:

SPECIFIC AUTHORIZATIONS:

- I give permission to _____ to use my address, phone number and clinical records to contact me with appointment reminders, missed appointment notification, birthday cards, holiday related cards, newsletters, information about treatment alternatives or other health related information.
- If _____ contacts me by phone, I give them permission to leave a phone message on my answering machine or voice mail.
- I give permission to _____ to use my name on a welcome board, referral board, and birthday board.
- I give permission to _____ to use my photograph on their patient picture bulletin board and other marketing materials such as their brochure, website and ads in print media.
- I give permission to _____ to use any testimonial written by me for marketing purposes such as, sharing with other patients or potential patients, in their brochure, on their website or in ads in print media.
- I give _____ permission to treat me in an open room where other patients are also being treated. I am aware that other persons in the office may overhear some of my protected health information during the course of care. Should I need to speak with doctor at any time in private, the doctor will provide a room for these conversations.
- By signing this form you are giving _____ permission to use and disclose your protected health information in accordance with the directives listed above.

The use of this format is intended to make your experience with our office more efficient and productive as well as to enhance your access to quality health care and health information. This authorization will remain in effect for the duration of my care at _____ Family Chiropractic Center plus 7 years or until revoked by me.

(over)

RIGHT TO REVOKE AUTHORIZATION:

You have the right to revoke this AUTHORIZATION, in writing, at any time. However, your written request to revoke this AUTHORIZATION is not effective to the extent that we have provided services or taken action in reliance on your authorization.

You may revoke this AUTHORIZATION by mailing or hand delivering a written notice to the Privacy Official of _____. The written notice must contain the following information:

- Your name, Social Security number and date of birth;
- A clear statement of your intent to revoke this AUTHORIZATION;
- The date of your request; and
- Your signature.

The revocation is not effective until it is received by the Privacy Official.

This AUTHORIZATION is requested by ____ for its own use/disclosure of PHI. (*Minimum necessary standards apply.*)

I have the right to refuse to sign this AUTHORIZATION. If I refuse to sign this AUTHORIZATION, ____ will not refuse to provide treatment however, it will not be possible for ____ to file third party billing on my behalf and I will be responsible for 1)payment in full at the time services are provided to me 2) scheduling my own appointments since ____ will be unable to contact me 3) all contact with ____ regarding my care. *Additionally, any collection activity as permitted by law is not waived by refusal to sign the authorization.*

I have the right to inspect or copy, within boundaries, the protected health information to be used/disclosed. A reasonable fee for copying will apply. A copy of the signed authorization will be provided to me.

HEALTHCARE AUTHORIZATION

I have read and understand this Healthcare Authorization Form and acknowledge receipt of The Notice of Privacy Practices for Protected Health Information. My signature below represents agreement with these practices.

SSN: _____ DOB: _____

Patient's name (please print): _____

Patient's Signature: _____

Today's Date: _____

Name of Personal Representative (if someone is designated to act on your behalf/or for a minor)

Parent or Personal Representative name (please print): _____

Signature: _____

Description of Representative's Authority to Act on Patient's Behalf: _____

**Integrated Medical Centers, Inc./dba/Quantum Wellness Center
1261 South Pine Island Road Plantation, Florida 33324**

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

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.

Our Legal Duty

We are required by law to maintain the privacy of protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of this Notice while it is in effect. However, we reserve the right to change the terms of this Notice and to make the new notice provisions effective for all of the protected health information that we maintain. If we make a change in the terms of this Notice, we will notify you in writing and provide you with a paper copy of the new Notice, upon request.

Uses and Disclosures

There are a number of **situations in which we may use or disclose** to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations requires you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstance, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment. *Example:* We may use your health information within our office to provide health care services to you or we may disclose your health information to another provider if it is necessary to refer you to them for services.

Payment. *Example:* We may disclose your health information to a third party such as an insurance carrier, an HMO, a PPO, or your employer, in order to obtain payment for services provided to you.

Health Care Operations. *Example:* We may use your health information to conduct internal quality assessment and improvement activities and for business management and general administrative activities.

Appointment Reminders. *Example:* Your name, address and phone number and health care records may be used to contact you regarding appointment reminders (such as voicemail messages, postcards or letters), information about alternatives to your present care, or other health related information that may be of interest to you.

In the following cases we never share your information unless you give us written permission: Marketing purposes, sale of your information, most sharing of psychotherapy notes. In the case of fundraising: We may contact you for fundraising efforts, but you can tell us not to contact you again.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization:**

Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. You should be aware that we utilize an "open adjusting room" in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may

use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

EXCEPT AS INDICATED ABOVE, YOUR HEALTH INFORMATION WILL NOT BE USED OR DISCLOSED TO ANY OTHER PERSON OR ENTITY WITHOUT YOUR SPECIFIC AUTHORIZATION, WHICH MAY BE REVOKED AT ANY TIME. In particular, except to the extent disclosure has been made to governmental entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

Patient Rights

Right to Request Restrictions. You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction. Your request must be made in writing to our Privacy Official. If you pay for a service or health care item out-of-pocket in full, you can ask us not to 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.

Right to Receive Confidential Communications. You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled. Your request to receive confidential communications must be made in writing to our Privacy Official.

Right to Inspect and/or Copy. You have the right to inspect, copy and request amendments to your health records including electronic health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to inspect and/or copy your health information must be made in writing to our Privacy Official.

Right to Amend. You have the right to request that we amend certain health information for as long as that information remains in your record. Your request to amend your health information must be made in writing to our Privacy Official and you must provide a reason to support the requested amendment.

Right to Receive an Accounting. You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceeding to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information. Your request to receive an accounting must be made in writing to our Privacy Official.

Right to Receive Notice. You have the right to receive a paper copy of this Notice, upon request. We are obligated to notify you if there is a breach of your PHI unless there is a low probability of PHI compromise.

Complaints

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S. Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint.

All questions concerning this Notice or requests made pursuant to it should be addressed to:

Privacy Officer, *Integrated Medical Centers, Inc./dba/Quantum Wellness Center*
1261 South Pine Island Road Plantation, Florida 33324

I do hereby acknowledge receipt of a copy of the Notice of Privacy Practices, Policies, and Procedures.

_____	_____	
Patient Name	Patient Signature	Date

_____	_____	_____
Name of Personal Representative	Signature of Personal Representative	Date

Legal Authority of Personal Representative _____

**ACKNOWLEDGMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

Patient Name (please print)

Date

Parent, Guardian or Patient's legal representative

Signature

THIS FORM WILL BE PLACED IN THE PATIENT'S CHART AND MAINTAINED FOR SIX YEARS.

List below the names and relationship of people to whom you authorize the Practice to release PHI.

_____	_____
_____	_____
_____	_____