



## Health and Wellness Questionnaire

*This questionnaire was developed to create a better understanding of your overall of health and wellness so that we can better serve you.*

1. How many days per week do you participate in cardiovascular activity? \_\_\_\_\_
2. How many days per week do you participate in strength training? \_\_\_\_\_
3. How many ounces of water do you drink in an average day? \_\_\_\_\_
4. How many ounces of tea, soda, coffee, and/or juice do you drink in an average day? \_\_\_\_\_
5. How many servings of fresh fruits & vegetables do you eat in an average day? \_\_\_\_\_
6. How often do you eat breakfast in the morning? \_\_\_\_\_
7. During the average week, how many meals do you eat at home? \_\_\_\_\_
8. During the average week, how many meals do you eat outside the home? \_\_\_\_\_
9. During the average week, how often do you take *over the counter medication*? \_\_\_\_\_
10. During the average week, how often do you take *prescription medication*? \_\_\_\_\_
11. How would you characterize your ability to concentrate and pay attention? \_\_\_\_\_
12. During the average week, how often do you practice meditation/relaxation techniques? \_\_\_\_\_
13. Do you feel your life has purpose?    Yes    No
14. Do you set *written* goals every year? Yes    No
15. How would you rate your current level of health?    Poor    Moderate    Excellent
16. Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Goal Weight: \_\_\_\_\_
17. What would you most like to change about your health?  
\_\_\_\_\_

## Personal Health & Fitness Goals



*As our office strives to help you optimize your health, it is critical that we understand what is important to you! Where are you currently on the above illustration...where would you like to be...and what needs to change to get you there?*

1. In terms of your **health**, please list 2-3 short-term goals and 2-3 long-term goals:

a. Short-Term:

- i.
- ii.
- iii.

b. Long-Term:

- i.
- ii.
- iii.

2. What are your **fitness** goals?

- a.
- b.

3. Is there anything you would like to do that your current condition prevents you from doing?

## Family History

Please indicate with a check (✓) family members who have had any of the following conditions:

|                        | Mom | Dad | Grandparent | Sibling | Child |
|------------------------|-----|-----|-------------|---------|-------|
| Allergies              |     |     |             |         |       |
| Anemia                 |     |     |             |         |       |
| Asthma/COPD            |     |     |             |         |       |
| Cancer                 |     |     |             |         |       |
| Depression/Suicide     |     |     |             |         |       |
| Diabetes               |     |     |             |         |       |
| Genetic Disorders      |     |     |             |         |       |
| Glaucoma               |     |     |             |         |       |
| Heart Disease          |     |     |             |         |       |
| High Blood Pressure    |     |     |             |         |       |
| Neurological Condition |     |     |             |         |       |
| Osteoarthritis         |     |     |             |         |       |
| Osteoporosis           |     |     |             |         |       |
| Rheumatoid Arthritis   |     |     |             |         |       |
| Stroke                 |     |     |             |         |       |
| Thyroid Disease        |     |     |             |         |       |
| Other:                 |     |     |             |         |       |



## Appointment Reminders and Health Care Information Authorization

At times our office may need to contact you with appointment reminders, information about treatment or other health related information. By signing below, you are giving us authorization to contact you with these reminders / information and understand that...

**I may be contacted by:** phone at home or work, mobile phone, e-mail, postal mail.

**Messages may be left:** on my answering machine / voicemail at home, work, and on my mobile phone.  
Or with individuals answering my phone at home, or work.

**Also:** I may be sent personalized cards (birthday/holiday/special events), office newsletters, special office announcements or appointment reminders, correspondence letters pertaining to my care. With my permission, my name and/or photograph may be used for office events / testimonials / bulletin board. If I was a previous patient of the month my name will appear in the newsletter of that quarter.

*Please place a line through any above method you REFUSE to, and place your initials there.*

Information that we use or disclose based on this authorization may be subject to re-disclosure by anyone that has access to the reminder or information and may no longer be protected by the federal privacy rules.

You may restrict the individuals or organizations to which your health care information is released, or revoke your authorization at any time; however the revocation must be in writing and mailed to us at our practice address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

You have the right to refuse any part of this authorization without affecting your treatment or the methods used to obtain reimbursement for your care. You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternatives, or other health related information at any time (§ 164.524).

I authorize the use or disclosure of my health information as described above. This notice is effective as of the date above and expires seven years from the date I last received services in this office.

|                      |                                 |
|----------------------|---------------------------------|
| _____                | _____                           |
| Patient Name Printed | Date                            |
| _____                | _____                           |
| Patient Signature    | Authorized Provider Rep. (NHCC) |
| _____                | _____                           |
| Personal Rep Printed | Personal Rep Signature          |

Description of personal representative's authority to act for the patient:



## PRIVACY NOTICE ACKNOWLEDGEMENT

We are concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the uses and limitation of the disclosure of your health information and your rights as a patient. If you ever have any questions or concerns regarding the use or dissemination of your personal health information, we would be happy to address them.

**I acknowledge that I have received a copy of Natural Health Chiropractic Center, L.L.C.'s Notice of Privacy Practices for Protected Health Information.**

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Patient Name Printed

Date

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Patient Signature

Authorized Provider Rep. (NHCC)

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Personal Representative Printed

Personal Rep. Signature

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Description of personal representative's authority to act for the patient



## **Consent for Chiropractic Treatment & Acknowledgment of Receipt of Information**

To the patient: Every type of health care is associated with some risk of potential problem. Health care providers, including chiropractors, are required, by law, to tell you the nature of your condition, the general nature of treatment, the risks involved, and the reasonable therapeutic alternatives.

In keeping with the Louisiana law of informed consent, you are being asked to sign a confirmation that we have discussed all these matters. We have already discussed with you the common problems and risks. Please this carefully. Ask about anything you don't understand, and we will be pleased to explain it.

In general, chiropractic treatment includes examination, taking of x-rays, manipulation/adjustment, and application of physical therapy modalities. Although their occurrence is extremely remote, some risks are known to be associated with these procedures. These included:

- 1) Stroke: is the most serious problem associated with spinal manipulation. The results can be temporary or permanent dysfunction of the brain, with a very rare complication of death (1 in 20 million). Spinal manipulations have been associated with strokes that arise from the vertebral artery (located in the neck vertebrae). (This problem occurs so rarely that there is no conclusive data to quantify probability.)
- 2) Disc Herniations: that create pressure on the spinal nerve or spinal cord are frequently successfully treated by chiropractors. Rarely, treatment may aggravate the problem, resulting in increased low back pain, radicular pain and numbness of a transient nature, Residuals may last for a few days but seldom for longer periods of time.
- 3) Soft tissue injury: Soft tissue primarily refers to muscles and ligaments. Muscles move bones and ligaments limit joint movement. Rarely, treatment may injure some muscle and ligament fibers. The result is temporary increase in pain and necessary treatments for resolution, but there are no long term affects for the patient.
- 4) Rib fractures: The ribs are found only in the thoracic spine or middle back. Rarely, a manipulation will fracture a rib bone. This occurs only on patients who have weakened bones from such things as osteoporosis. Osteoporosis can be noted on your x-rays. We adjust all patients carefully, especially those who have indications of osteoporosis on their x-rays.

I hereby authorize and direct \_\_\_\_\_, together with associates and assistants of her choice, to provide chiropractic treatment including examination/diagnostics, spinal manipulation/adjustment, carious modes of physical therapy, x-rays and any additional procedures or services that may be deemed necessary or reasonable. This treatment has been explained to me, and alternatives methods of treatment (if any) have also been addressed. I have read and understand all information set forth in this document, including any attachments. I acknowledge that I have had the opportunity to ask any questions about the contemplated procedure and that my questions have been answered to my satisfaction. This authorization for and consent to chiropractic treatment is and shall remain valid until revoked.

**Patient's name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature of patient / guardian** \_\_\_\_\_ **Relationship to patient** \_\_\_\_\_

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