

CHIROPRACTIC • MASSAGE THERAPY • NATUROPATHIC MEDICINE

Nutrition Patient Questionnaire

Date:		_		
Name				Date of Birth
Address				City/State
be freely sha	ting your ema ared via emai		and Blume Hea	Zip Code reeing that health information for yourself can ling Center. While usually considered safe, ation.
Telephone:	Home			Work
Place of Em	ployment			Occupation
Married	Single	Divorced	Widow(er)_	# of Children
In case of e	mergency, w	ho should we cor	itact?	
Name		Phor	ne	Relationship
How did you	ı hear about	our office?		
you clearly i	understand t		ndered at Blume	rice. By signing below you are stating that e Healing Center are your responsibility and
Patient's Sig	gnature		Da	ate
According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment. I have read and understand the above.				
Patient's Sig	gnature		Da	ite

Insurance Billing

While we do not bill your insurance company for you for the nutrition services, you are welcome to submit a claim on your own seeking reimbursement. Before you do, please consider the following...

- 1. If you file a claim with your insurance company, all diagnosis codes and test results will go on file with your insurance company. This can be used to determine future premium costs for you and your family.
- 2. If your diagnosis includes a hereditary disease like high blood pressure, it will not only be seen on your health records, but also the records for your children and grandchildren and will be used to determine their coverage availability and premium costs.
- 3. Insurance companies are quick to raise premiums or drop coverage entirely when customers file too many claims, or just one of the wrong kind of claim (like nutritional treatment rather than the medical drug-fix it norm).
- 4. Your insurance carrier is responsible only for paying benefits covered under your policy and will deny anything they deem "medically unnecessary or experimental". Nutritional services frequently fall under this category and therefore are not covered which means you are supplying them with diagnosis codes, test results, etc (which they can use against you) yet you see no financial benefit.
- 5. Rescission if you have a serious illness, insurance companies will search your file to obtain medical records from the last several years and if they find any inconsistency in your application, your policy is rescinded so they can avoid paying for costly treatments or medication. Any information you share with them could be used against you.
- Preapproval if you call your insurance company to find out if certain services are covered, it is a warning sign to your provider that bills are coming which may spark a rescission search on your account.



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PATIENT SYMPTOM SURVEY

DATE PATIENT'S	NAME	AGE				
WEIGHT HEIGHT	BLOOD PRESSURE PUL	SEO ₂				
This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time						
Primary Complaints						
090 General Good Health	039 ☐ High Blood Pressure I10	063 ☐ Prostate Disorder N42.9				
091 ☐ Desires Nutritional &	040 □ Low Blood Pressure I95.9	069 ☐ Hyperthyroidism E05.90				
Metabolic Analysis	041 □ Tachycardia	070 Hypothyroidism E03.9				
001 Skin Disorder L25.9	(High Heart Rate) R00.0	071 ☐ Systemic Lupus M32.10				
002 □ Acne L70.8	042 ☐ Numbness R20.9	072 Infertility, female M97.9				
003 ☐ Psoriasis L40.8	043 ☐ Constipation K59.00	073 Interstitial Cystitis N30.11				
004 Urticaria (Hives) L50.9	044 ☐ Indigestion K30	074 Irregular Menstrual Cycle N92.6				
005 □ ADD/ADHD F90.1/F90.9	045 ☐ Ulcerative Colitis K51.90	075 Menopausal Symptoms N95.1				
006 ☐ Allergies, Unspecified J30.9	046 ☐ Depression F32.9	076 ☐ Hot Flashes N95.1				
007 ☐ Allergic Rhinitis from food J30.5	047 ☐ Diabetes Mellitus E11.9	077 Mental Disorder F99				
008 Sinusitis J01.90	030 ☐ Diabetes Type I E10.9	078 □ Insomnia G47.00				
009 Alzheimer's G30.9	031 Diabetes Type II E11.65	079 ☐ Mouth/Throat/Tongue				
010 Poor Concentration/Memory F07.8	029 □ Hyperglycemia	080 □ Canker Sores K12.0				
011 ☐ Parkinson's Disease G20	[high blood sugar] R73.09	081 ☐ Overweight E66.3				
012 Anemia D64.9	048 □ Hypoglycemia	082 ☐ Underweight R63.6				
013 Arthritic Disorder M12.9	[low blood sugar] E16.2	083 ☐ Sexual Disorder F66				
014 ☐ Osteoporosis M81.0	049 Dizziness/Balance Problem	084 □ Spinal Problems M53.9				
015 Asthma J45.909	R42	085 ☐ Obesity E66.9				
016 Emphysema J43.9	050 ☐ Ear Infection H65.90	086 □ GERD K21.9				
017 ☐ Cancer	051 ☐ Epstein Barr B27.90	087 □ HIV B20				
018 Breast C50.919female C50.929male	052 □ Eye Problems H57.13	088 Crohn's Disease K50.90				
019 □Prostate C61	053 ☐ Cataracts H26.9	089 ☐ Irritable Bowel Syndrome K58.9				
020 □Lung C34.90	054 ☐ Glaucoma H40.9	092 Normal Pregnancy Z33.1				
021 □Colon and Rectal C18.9	055 ☐Macular Degeneration H35.30	**only applicable if <i>currently</i> pregnant				
022 □Skin C44.90	056 □ Fever R50.9	093 ☐ Shingles B02.9				
023 Leukemia w/o remission C95.90	057 🗆 Fibromyalgia M79.7	140 □ Migraines G43.909				
Leukemia w/ remission C95.91	058 ☐ Gallbladder Disorder K82.9	141 ☐ Rheumatoid Arthritis M06.9				
024 Lymphoma, malignant C85.89	059 □ Gout M10.9	142 ☐ Non-Systemic Lupus L93.0				
025 □ Brain Tumor, malignant C71.9	060 ☐ Headaches R51	143 ☐ Multiple Sclerosis G35				
027 Anxiety Disorder F41.9	061 ☐ Hearing Loss H91.90	144 □ ALS (Lou Gehrig's) G12.21				
028 — Autism F84.0	062 ☐ Infertility, male N46.9	145 ☐ Polymyalgia Rheumatica мз5.3				
033 Edema R60.9	064 ☐ Liver Disease K76.9	146 □ Scleroderma M34.9				
034 Eczema L25.9	065 ☐ Hepatitis K71.6	171 ☐ Goiter E04.9				
035 Chronic Fatigue R53.82	066 ☐ Hepatitis B B16.9	178 □ Raynaud's Syndrome I73.00				
036 Circulatory Disorder 199.9	067 ☐ Hepatitis C B17.10	179 — Hemochromatosis E83.119				
037 — Heart Disease I51.9	068 ☐ Kidney Disorder N28.9 or	180 □ Thalassemia D56.8				
038 ☐ High Cholesterol E78.0	Bladder Disorder N32.9	181 ☐ Brain aneurysm I61.9				

	lf	necessary	please	state '	vour	most	significant	concern
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Hysterectomy, partial 712	703 Thyroid	710 □ Spinal surgery	717 Hemorroidectomy
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405 □ Glands often swell 413 □ Tongue burns 419 □ Has had root canal(s)		_	
		_	. ,
	406 Frequent canker sores	. J	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2

Endocrine		
	☐ Frequently feels cold	253 Unusually jumpy or nervous
	☐ Frequently feels hot	254 Unusually tired most of the time
	☐ Gets lightheaded when standing	•
	☐ Heals slowly	
	·	
Cardiovascular		
190 □ Cold feet		198 ☐ Pain in leg/hips when walking
191 □ Cold hands		199 Frequent swollen ankles
192 ☐ Experiences shortness o	f breath while sitting still	200 ☐ Pains in the heart or chest
193 ☐ Heart skips beats	i breath write sitting still	201 ☐ Spells of rapid heart rate
194 ☐ Tendency of High blood	pressure	202 ☐ Troubled with blood clots
195 ☐ Leg cramps during bedtir		203 Unusually slow pulse rate
196 ☐ Leg cramps during daytir		204 □ Varicose veins
197 □ Low blood pressure at tin		205 ☐ Heart palpitations
Claire		
Skin		
520 □ Bruises easily	526 🗆 Itchy skin	529 Skin eruptions
521 ☐ Excessive perspiration	527 Problems with Eczema	
522 Frequent goose bumps	528 Has moles which are ch	
523 Has acne	and/or color	533 Troubled with boils
524 ☐ Has Psoriasis	530 □ Skin is rough, especiall	y on 534 \square Dry skin
525 ☐ Hives	the back of the arms	
Ears		
220 ☐ Discharge from ears	222 Punctured ear drum	224 Ringing or noises in the ears
221 Hard of hearing	223 Recurrent ear infection	on 225 Tinnitus
Eyes		
320 ☐ Bloodshot eyes	325 ☐ Eyes watery	329 ☐ Mild Macular degeneration
321 □ Blurred vision	326 ☐ Mild Glaucoma	330 ☐ Itchy eyes
322 □ Cross eyes	327 □ Far sighted	331 ☐ Near sighted
323 □ Eye pain	328 Developing cataracts	332 □ Dry Eyes
324 □ Eyes feel gritty	, 0	
Foot		
Feet		
350 □ Corns	353 Painful feet	355 ☐ Swelling in the feet and/or ankles
351 ☐ Frequent foot cramps	354 □ Plantar warts	356 ☐ Plantar fasciitis
352 ☐ Heel spurs		357 □ Fungal Infection
Neuromuscular		
440 ☐ Bites nails	449 Has motion sick	ness 457 Low back pain
441 ☐ Frequent muscle sorenes		·
442 Muscle spasms	451 Has Rheumatisn	•
443 Muscle weakness	452 ☐ Rheumatoid Arth	
444 ☐ Tremors	453 ☐ Joint stiffness in	•
445 ☐ Frequent headaches	morning	462 □ Sleep walks
446 □ Often dizzy	454 □ Swollen joints	463 Stutters or stammers
447 Frequently feels faint	455 □ Leg pain at rest	464 □ Nerve pain
448 □ Has Epilepsy	456 Spinal curvature	

Behavior	
150 Afraid to eat anywhere except home	161 ☐ Often annoyed by people
151 ☐ Always needs someone to advise	162 □ Recurrent bad dreams
152 ☐ Cries often	163 ☐ Sometimes wishes to be dead or away from it all
153 Difficulty concentrating	164 ☐ Upset by criticism
154 Difficulty falling asleep	165 ☐ Poor memory
155 Difficulty staying asleep	166 □ Scared to be alone
156 □ Easily angered	167 ☐ Strange people or places cause fear
157 ☐ Feelings are easily hurt	168 ☐ Under considerable emotional stress
158 Frequently becomes scared for no reason	169 ☐ Unhappy when others are happy
159 ☐ Frequently miserable or blue	170 ☐ Brain fog
160 \square Has to be on guard even with friends	
Urinary	
555 ☐ Urinates more than 2 times per night	561 ☐ Troubled by urgent urination
556 ☐ Bed wetting	562 ☐ Incontinence when sneezing or laughing
557 ☐ Blood in the urine	563 ☐ Loses bladder control
558 Difficulty starting urination	564 Frequent bladder infections
559 Painful urination	565 Frequent kidney infections
560 ☐ Frequent urination	566 ☐ Kidney stones
NA	
Men	
585 Difficulty completing intercourse	591 ☐ Painful genitals
586 Difficulty getting or keeping an erection	592 — Prostate troubles
587 □ Discharge from the urethra	593 ☐ Sores on external genitalia
588 ☐ Had a vasectomy	594 — Herpes
589 Had difficulty fathering children	595 □ Sexual diseases
590 □ Lumps in the testicles	
Women	
610 Heavy hair growth on face or body	630 Lumps in the breasts
611 Cycles are every 27-29 days	631 Tender breasts
612 Abnormal cycle >29 days and/or <26 days	633 □ Vaginal discharge
613 — PMS	634 ☐ Bloody spotting discharge
614 Menstrual cramps	635 Yeast infections
615 Painful periods	636 ☐ Sores on external genitalia
616 Acne worse at menstruation	637 □ Herpes
617 ☐ Excessive menstrual flow	638 □ Sexual diseases
618 ☐ Retains fluid during periods	639 ☐ Endometriosis
619 ☐ Pre-menstrual depression	640 ☐ Breast reduction
620 Currently taking birth control medication	641 ☐ Breast augmentation
621 Has taken birth control medication more than 1 year	642 Abortion
622 \square Has taken birth control medication within the last year	643 □ D&C
623 Has had miscarriage	644 Tubal pregnancy
624 ☐ Hot flashes	645 Uterine fibroids
625 Takes hormone replacement medication	646 Ovarian fibroids
627 Diminished sexual desire	647 ☐ Breast fibroids
628 Painful intercourse	648 Currently Breastfeeding
629 Poor or infrequent orgasm	

Please list all d	rugs you are <u>currently</u>	taking on a <u>daily basis</u> .		
<u>DRUG</u>	<u>PRESCRIBED F</u>	<u>'OR:</u>	<u>HOW LONG</u>	
drugs, antibiot	ics, aspirin, inhalers, et	c.	as needed including over the o	counter
<u>DRUG</u>	<u>PRESCRIBED F</u>	<u>OR:</u>	<u>HOW LONG</u> — —	
Alleraine				
Allergies Please list any	known allergies (ex. fo	ods, medications, spice	s, environmental, etc.)	
□ Dairy □ Eggs □ Garlic	□Gluten □ Mold □ Peanut	□ Ragweed□ Shellfish□ Soy	☐ Sulfa drugs☐ Tree nuts☐ Wheat	
Other				
Suppleme	nts			
Please list all v <u>VITAMIN</u>	itamins/herbs/supplem <u>BRAND</u>	ents you are currently t	aking and dosages. <u>DOSAGE</u>	

HIPAA NOTICE OF PRIVACY PRACTICES FOR BLUME HEALING CENTER

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.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:

Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Patient Acknowledgement

I acknowledge that I have reviewed a copy of the Privacy Practices for Blume Healing Center. I acknowledge that any questions I have

regarding that book above.	nese policies have been answered to my satis	faction and that I acknowledge that I understand these policies as written
I hereby spe	ecifically authorize disclosure of my protected	health care information to the persons listed below.
☐ Spouse	☐ Any member of immediate family	☐ Other healthcare provider(s)
Signature o	f Patient (or Patient Representative)	Date
Name of P	atient (or Patient Representative)	