Patient Name: _____ Date: _____

Adult Questionnaire

Welcome to our office! Thanks for your trust in Samsel Integrative Health, LLC.

To insure that your visit is a pleasant one, here is an outline of the procedures you can expect at our office. Please ask if you have any questions, as there is someone here to assist you.

Step 1: Please take the time to fill out the health history questionnaire in its **entirety** to help us better serve you. Because of our ability to look at you in a more holistic manner, there are very specific reasons as to why we ask **all** of the questions that we do. **Please do not leave any blanks**.

Step 2: While the doctor is reviewing your information, you will see a short video to acquaint you with our office and explain part of how we help our patients regain and optimize their health. There are many other videos and other educational materials to help explain everything that we do on our website as well. We pride ourselves on patient education and encourage you to ask questions. The more a patient knows about their condition, the quicker they can get well and stay well.

Step 3: You will then meet with the doctor for a personal consultation to review your health history information. An appropriate physical, orthopedic, neurological, Chiropractic, and kinesiology examination will then be performed to determine the state of your health, and see if our methods of health care are appropriate for your condition(s). You will be advised as to the necessity of additional procedures such as laboratory work or X-rays, testing for nutrition, allergies, and/or emotional stress, or a referral to another healthcare professional.

Step 4: When you return for your second visit – the Report of Findings -- the doctor will inform you as to the results of your exam and recommendations for your care. We invite your spouse or those involved in your health care decisions to join you. If you are comfortable with the findings, treatment will begin at this time. To ensure that we are on track with your goals, a progress examination will be scheduled in advance to appropriately assess your progress. We recommend bringing your calendar with you to schedule multiple appointments that will be the most convenient for you.

Step 5: Financial arrangements, insurance coverage, and office policies will be covered with you at this time by one of the staff members.

Patient Name: _____ Date: _____

NEW PATIENT QUESTIONNAIRE

Please answer the following questions:

1. Are you willing to follow a treatment program designed to help you return to health for at least three months? (Treating the root causes)
   A. Yes B. No

2. Are you willing to take nutritional supplements, if needed, for your particular case?
   A. Yes B. No

3. Are you willing to make dietary changes, if needed, for your particular case?
   A. Yes B. No

4. Are you willing to start a moderate exercise program, if needed, for your particular case?
   A. Yes B. No

5. Please rate on scale how serious you are about staying healthy after your initial intensive care.

   _____

   0 1 2 3 4 5 6 7 8 9 10

   Not Serious Very Serious

6. Please check the following that you are familiar with:

   - ☐ Chiropractic | If you have had chiropractic care in the past, when were you last adjusted? _____
   - ☐ Applied Kinesiology / Muscle Response Testing
   - ☐ Holistic Healthcare / Functional Medicine

7. Concerning Chiropractic care, what have you experienced or heard, whether good or bad?

_____

_____

TREATMENT: What type of treatment are you looking for?

- ☐ I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.
- ☐ I am looking to resolve my symptoms and then go on to "fix the cause" of my problem so that it doesn't return.
- ☐ I am looking to take care of the cause of my problem and then go on to "achieve optimal health and wellness."

Please note the following treatments that you are interested in at this time:

- ☐ Chiropractic Care
- ☐ Diet/Nutrition and Lifestyle Coaching
- ☐ Allergy Testing/Treatments
- ☐ Neuro-Emotional Technique (Stress Reduction)
- ☐ Customized Nutritional Supplement Program
- ☐ Sports Medicine/Sports Performance
- ☐ Detoxification/ Fasting/Cleansing
- ☐ Hair Analysis Heavy Metal Testing
- ☐ Physical Therapy/Rehab
- ☐ Applied Kinesiology/Muscle Response Testing
- ☐ Saliva Hormone Testing
- ☐ Functional Medicine Blood Work and Lab Testing
- ☐ Massage Therapy
- ☐ Please evaluate me and recommend what I need

Patient Name: _____ Date: _____

Office Use Only:
□Entered into A8
□Scanned

Date of Birth: _____

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

Email: _____

Home Phone: _____ Work Phone: _____ **Cell Phone**: _____

Social Security #: _____ Age: _____ □ Male □ Female

Race /Ethnicity (circle one): White Hispanic Black Asian Native American Other:_____

Marital Status: □ Married □ Single □ Divorced □ Separated □ Other _____

Name of Spouse/ Nearest Relative: _____Phone: _____

Do you have any children? _____ If so, how many and what ages? _____

Patient's Occupation: _____ Patient's Employer: _____

Spouse's Occupation: _____ Spouse's Employer: _____

Who can we thank for referring you? _____

Payment for Services will be by: □ Cash/Check/CreditCard □Health Insurance □Auto Ins. □ WorkComp

Primary Care Doctor: _____ Phone: _____

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

Insurance Company: _____ ID #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Are you the primary policy holder? □Yes □No If not, who is: _____

Insured's Address: _____City: _____State:_____Zip:_____

Insured's Employer: _____Employer's Phone #: _____

Are you covered by more than one insurance company? □Yes □No

Name: _____

For Medicare, please list your secondary insurance: _____

HEALTH CONCERNS/GOALS: Please list your top health concerns/goals in order of priority

1) _____

2) _____

3) _____

Have You Ever Been Given A Name Or Diagnosis For Your Condition? □ Yes □No If Yes Please Explain:

_____

Patient Name: _____ Date: _____

MEDICAL / FAMILY HISTORY: S = Self M = Mother F = Father
(Please indicate which conditions have been experienced by the above by marking appropriate boxes).

S	M	F		S	M	F		S	M	F	
☐	☐	☐	AIDS	☐	☐	☐	epilepsy	☐	☐	☐	migraines
☐	☐	☐	anemia	☐	☐	☐	German measles	☐	☐	☐	neck pain
☐	☐	☐	arthritis	☐	☐	☐	headaches	☐	☐	☐	nervousness
☐	☐	☐	asthma	☐	☐	☐	heart trouble	☐	☐	☐	numbness
☐	☐	☐	back pain	☐	☐	☐	hepatitis	☐	☐	☐	polio
☐	☐	☐	bladder trouble	☐	☐	☐	high blood pressure	☐	☐	☐	poor circulation
☐	☐	☐	bone fracture	☐	☐	☐	HIV/ARC	☐	☐	☐	rheumatic fever
☐	☐	☐	bowel control loss	☐	☐	☐	indigestion	☐	☐	☐	rheumatism
☐	☐	☐	cancer	☐	☐	☐	kidney disorder	☐	☐	☐	serious injury
☐	☐	☐	chest pain	☐	☐	☐	reproductive disorders	☐	☐	☐	sinus trouble
☐	☐	☐	concussion	☐	☐	☐	menstrual cramps	☐	☐	☐	stroke
☐	☐	☐	convulsions	☐	☐	☐	mental illness	☐	☐	☐	thyroid disease
☐	☐	☐	diabetes	☐	☐	☐	multiple sclerosis	☐	☐	☐	tuberculosis
☐	☐	☐	dislocated joints	☐	☐	☐	muscular dystrophy	☐	☐	☐	venereal disease

Please **list** your **symptoms** below and the relative pain intensity
(0 – 10) <u>for each</u> symptom.

No Pain Mild Moderate Severe Unbearable
0 1 2 3 4 5 6 7 8 9 10

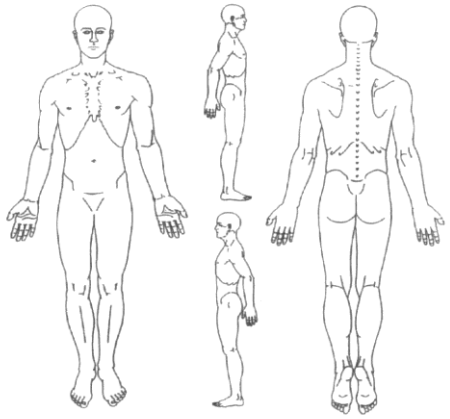
Symptoms: (*<u>Example: Low back pain – 4</u>*)

a) _____ b) _____

c) _____ d) _____

e) _____ f) _____

Please **mark** on the diagram to the right the following symbols as they relate to your symptoms:
SS= spasms ST= stiffness DP= dull pain SP= sharp pain
SH= shooting pain TI= tingling NU= numbness O= other



Date of Last Physical:_____ **Have You Been Treated By A Physician in the Last 12 Months?**: ☐ Yes ☐ No

Please check the doctors you have previously seen for this: **Blood Type: _____**
☐ DC ☐ MD ☐ PT ☐Acupuncturist ☐Psychologist

Are you pregnant? ☐No ☐Yes Date of last menstrual period: _____

<u>SCARS / SURGICAL PROCEDURES</u>: Have you had any surgical procedures? ☐Yes ☐No List on back, along with any scars:

Spine: ☐Cervical ☐Thoracic ☐Lumbar **Extremities:** ☐Shoulder / Elbow / Hand / Wrist ☐R ☐L ☐Hip / Knee / Ankle / Foot ☐R☐L

Abdominal / Chest: ☐Appendix ☐Colon ☐Gall Bladder ☐Heart ☐Lungs ☐Breast ☐Other: _____

DO YOU HAVE A MOTOR VEHICLE ACCIDENT HISTORY? ☐Yes ☐No If yes, please note and include dates.
_____
_____

Patient Name: _____ Date: _____

Symptoms developed from: □Job related injury □Auto accident □Other Accident □Illness
□Unknown cause □Gradual onset Other: _____ **Date occurred**: _____

Symptoms have persisted for # _____ Hour(s) _____ Day(s) _____ Week(s) _____ Month(s) _____ Year(s)

Describe the pain: □Sharp □Dull □Numbness □Tingling □Ache □Stiffness □Burning □Shooting □Spasm □Weakness
□Stabbing □ Throbbing □Other: _____

Have you ever had this before? □ Yes □ No

Symptoms/Complaints: □Come & go □Are constant □Nearly constant

Symptoms are WORSE in: □Morning □Afternoon □ Evening

Do your symptoms happen around at the same time every day? If yes, at what time? _____

Please check the following activities that AGGRAVATE your condition:
□Bending □Reaching □Straining while going to bathroom □Coughing □Sitting □Turning head □Lifting □Sneezing □Walking
□Lying down □Standing □Twisting □Weather changes □Other: _____

Please check the following activities that RELIEVE your condition:
□Bending □Sitting □Lifting □Standing □Lying down □Turning head □Reaching □Walking □Ice □Heat
□Pain relieving medications □Other: _____

Please check any ADDITIONAL SYMPTOMS you may be experiencing:
□blurred vision □buzzing in ears □cold feet □cold hands □cold sweats □concentration loss / confusion □ TMJ □constipation
□depression □diarrhea □dizziness □face flushed □fainting □fatigue □fever □head seems too heavy □headaches □insomnia
□light bothers eyes □loss of balance □loss of memory □loss of smell □loss of taste □low resistance to colds □muscle jerking
□numbness in fingers □numbness in toes □ low back pain □ neck pain □ skin issues □ poor digestion □pins & needles in arms
□pins & needles in legs □ringing in ears □shortness of breath □stiff neck □stomach upset

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	**Date Started**
□ Antacids		
□ Antibiotics		
□ Antidepressants		
□ Anti-Diabetics		
□ Anti-Inflammatory		
□ Blood Pressure Lowering Meds.		
□ Cholesterol Lowering Meds.		
□ Hormone Replacements (HRT)		
□ Oral Contraceptives		
□ OTC (over the counter) Other		
□ Vaccines		

Effects On Lifestyle:

Work:

□ Not as productive at work □ Can't work long hours

Home:

□ Interrupted Sleep □ Moody/Irritable □Trouble falling asleep

□Losing patience w/ spouse □ Losing patience w/ kids □ Hinders household activities

Patient Name: _____ Date: _____

Life In General:

□Uncomfortable/ Nervousness □ Hinders recreational activities

□Anxiety □Hinders decisions □Poor Attitude

□Other: _____

REVIEW OF SYSTEMS:		Y	N
General:	Recent weight loss or weight or gain	□	□
Skin:	Rashes, hives or lesions	□	□
HEENT:	Hay fever or post nasal discharge	□	□
Cardiovascular:	Chest pain or palpitations	□	□
Pulmonary:	Shortness of breath, wheezing or coughing	□	□
Gastrointestinal:	Nausea, vomiting, or diarrhea	□	□
Genitourinary:	Frequency or urgency	□	□
Lymphatic:	Lymphadenopathy or Polydypsia	□	□
Endocrine:	Polyuria or polydypsia	□	□
Neurological:	History of seizures or headache	□	□

SOCIAL HISTORY:

Tobacco usage: □ None □ Light □ Moderate □ Heavy
Alcohol usage: □ None □ Light □ Moderate □ Heavy
Drug usage: □ None □ Light □ Moderate □ Heavy

HABITS:	Heavy	Moderate	Light	None
Alcohol	□	□	□	□
Coffee	□	□	□	□
Soda / Diet Soda	□	□	□	□
Tobacco	□	□	□	□
Drugs	□	□	□	□
Chocolate	□	□	□	□

List hobbies/activities: _____
_____
_____

	5+	4	3	2
Meals / day	□	□	□	□

Exercise: □ Never □ Seldom/Occasional □ Regularly

If yes: What Type/ How Often?

□ Cardio/Aerobic: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk □ None
□ Weights/ Strength: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk □ None
□ Stretching/ Yoga: □ 5-7x/wk □ 3-5x/wk □ 1-3x/wk □ None

ALLERGIES/ SENSITIVITIES: Please check and list all allergies

□ Food: □Dairy □Wheat □Corn □Soy □Seafood □Gluten □Peanuts □Fruits □Other: _____
□ Medications: □Penicillin □Sulfa Drugs □Iodine □Insulin □Antibiotics □Other: _____
□ Seasonal: □Pollen □Dust □Hay □Mold □Chemical(s) □Smoke □Animals □Insects
□ Other: _____

Any Pets At Home? □ Yes □ No

PAST MEDICAL INJURIES: List all major injuries, accidents, fractures, hospitalizations, falls, _____
_____

Date of Last Lab / Blood Work: _____ Anything abnormal? _____

Date of most recent X-ray/MRI: _____ Anything abnormal? _____

NOTE: If you have any test results (blood, imaging, etc), please bring in your paper results, if possible.
If you have recent **x-rays**, please bring in your CD or film.

Patient Name: _____ Date: _____

64+ oz 32-64 oz 16-32 oz <8 oz

Stress Level: □ Low □ Medium □ High **Water Per Day** □ □ □ □

List any emotional / stress related issues: _____

_____

How do you sleep? □ On back □ On side □ On stomach

Number of bowel movements per day _____ Number of times you urinate per day _____

WORK ACTIVITY: □ Heavy Labor □ Light Labor □ Mostly Sitting □ Mostly Standing □ Walking / Moving □ Driving

How long has it been since you really felt good? □ Days □ Weeks □ Months □ Years □ >10 years

What was different then than now? _____

List any major dental work: _____

Do you currently wear heel lifts or orthotics? □ Yes □ No If yes, are they soft or hard? _____

Is there anything else you are concerned about or you feel the Doctor should know? _____

_____

Patient's Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

Patient Health Information Consent Form

We want you to know how your Patient Health Information (**PHI**) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (**PHI**) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment. The patient also agrees to allow this chiropractic office to send PHI to the patient's primary care physician and/or other health practitioners involved in the patient's healthcare.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is obligated to agree to those restrictions only to the extent they coincide with state and federal law.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. Our office may contact you periodically regarding appointments, treatments, products, services, or charitable work performed by our office. You may choose to opt-out of any marketing or fundraising communications at any time.
6. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
7. Patients have the right to file a formal complaint with our privacy official and the Secretary of HHS about any possible violations of these policies and procedures without retaliation by this office.
8. Our office reserves the right to make changes to this notice and to make the new notice provisions effective for all protected health information that it maintains. You will be provided with a new notice at your next visit following any change.
9. This notice is effective on the date stated below.
10. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

_____ _____

Patient Signature Date

For further information regarding this notice, please contact our office at 215-944-8424.

Patient Name: _____ Date: _____

Samsel Integrative Health Consent Form

At Samsel Integrative Health a licensed Chiropractor treats patients through manipulation of the spine, pelvis, extremities, and organs; and other supporting therapies as indicated. These "other supporting therapies" include but are not limited to:

- Percussion and massage therapy
- Cold laser therapy and kinesiotaping
- Diet, nutrition, and lifestyle coaching
- Pharmaceutical-grade nutritional, herbal, and homeopathic supplements
- Applied Kinesiology (AK) and Acupressure
- Rehab, electrical stimulation, ice, and traction therapies
- NET (Neuro-Emotional Technique) and other stress reduction techniques

Every treatment listed above is non-invasive; we do not inject any substances through the skin, prescribe or make recommendations or changes to any medications under any circumstances. Many of these therapies are not covered by insurance. All of the treatments listed above are used as an adjunct to the Chiropractic adjustment. They are designed to support the Chiropractic subluxation from reoccurring and help address the root causes of pain and dysfunction.

We use some additional methods to help us assess what will best help you with your treatment and lifestyle recommendations called muscle response testing or Applied Kinesiology (AK). These are always used in conjunction with all other appropriate testing such as detailed personal and family history; nutrition and lifestyle questionnaires; orthopedic, neurological, and chiropractic examinations; X-rays and MRI's, and other forms of diagnostic and laboratory testing. We never diagnose or assess any conditions or make any specific recommendations for your case, including nutritional supplements, based on AK or muscle response testing alone.

If you are currently under the care of a physician—please remain under that care. You should always consult with your family doctor or pediatrician considering any alternative treatments. If you are currently taking prescribed medication—please continue to take the medication unless your physician tells you to stop or wean off of them with their supervision. You must remain under the care of a family physician or a pediatrician while being treating at SIH. We cannot and do not act as your primary care physician or pediatrician under any circumstances.

If you receive Neuro-Emotional Technique (NET) or <u>any</u> other stress reduction technique it does not take the place of psychotherapy, counseling, or any psychiatric medications. This is not a substitution for any kind of therapy. If you are already receiving those therapies you must continue with those doctors or therapists until they release you. If you have any doubts as to whether you should be seeing someone please consult a licensed professional in those fields. If we think you should see someone, we will make that recommendation as well.

_____ Please initial that you read the first page and read the other side

If we perform testing or treatment for allergies, we are testing for and treating sensitivities of the body, not true allergies as per blood or scratch tests or other traditional medical testing. If you have or suspect true allergies, especially severe ones, you should be and remain under the care of a medical allergist.

Patient Name: _____ Date: _____

Please note that we do not diagnose, treat, or cure in any way infectious diseases, visceral or systemic diseases, pathology, or cancer. If you have or suspect you have any of the aforementioned, you must remain under the care of a medical physician for their primary diagnosis and treatment.

If we order blood tests or other lab tests like hair, saliva hormone, or stool tests, they are used as an adjunct to help guide us in your treatment, nutrition, and lifestyle recommendations. We do not perform any of them to diagnose disease or pathology. If disease or pathology is found, you should always consult your primary doctor or the appropriate medical physician.

Please read the following statement and sign if you agree:

I understand that Chiropractic care is not a substitute for the care of my physician or medical specialist; and I understand that I am not to reduce, change or stop any medications I am currently taking unless my physician tells me to. I have read and agree with all that is contained in this document. I consent to be treated with Chiropractic and any of the therapies listed above based on the doctor's assessment. I intend this consent to apply to all of my past, present, and future treatments at this clinic.

If you have questions about anything on this form, please ask us before signing or receiving any treatment.

_____ *Date:* _____

Patient signature (or parent/guardian of minor)