Chiropractic Bio-Tune Ups - Lloyd Katz, DC DABCO

www.ChiropracticBioTuneUps.com
3 Pheasant Lane Ithaca, NY 14850
Telephone / Fax# 607-319-0813

Welcome to Chiropractic Bio-Tune Ups!

Please fill out this confidential health history form (for **ADULTS**) as completely as you can. The more information you provide us, the better we will be able to help you. If you have any questions or need any assistance in filling out these forms, do not hesitate to ask for help. Please skip over any area that does not apply.

Today's Date: _____/_____/_____

Personal Information

Last Name:_____ First Name:_____ MI:_____

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

Home Phone:_____ Work Phone:_____ Mobile Phone:_____

Email Address:_____

Preferred Method of Contact: ❑Home Phone ❑Work Phone ❑Mobile Phone ❑Email

Would you like to be added to our emailing list? (This gives you updates to the practice, days we will be closed, newsletters and promotional sales) ❑Yes ❑No

Birth Date:_____ /_____ /_____ Current Age:_____ Gender: ❑Male ❑Female

Marital Status: ❑Married ❑Single ❑Divorced ❑Widowed ❑Other:_____

Employer:_____ Occupation:_____

Emergency Contact:_____ **Phone Number:**_____

Relationship:_____

Have you ever seen a Chiropractor before? ❑Yes ❑No If Yes, When?:_____

What made you consider this alternative medical treatment?:

❑Insufficient response to conventional medical therapy ❑Side effects from conventional medical treatment

❑Other:_____

Who can we thank for referring you?: ❑Friend ❑Family Member ❑A Physician ❑Another Healthcare Practitioner

Name:_____

If you were not referred by someone you know, how did you find out about us?

_____

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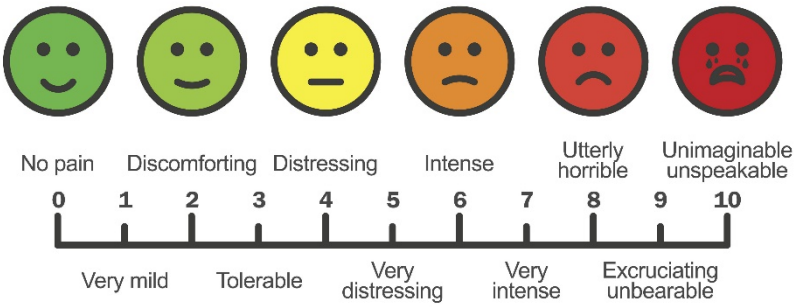
Primary Health Complaint

Primary Health Complaint(s): _____ _____	
Please write a brief history of how it started: _____ _____	
How long have you had this problem? _____ ❑Days ❑Weeks ❑Months ❑Years	Have you had this or a similar problem before? ❑Yes ❑No
Recently the problem has: ❑Improved ❑Gotten worse	Comments:
Is there anything that makes it better?	
Is there anything that makes it worse?	
Have you previously received treatment for this problem? ❑Yes ❑No	If yes, when?
Where and by whom?	What was the diagnosis?
What type(s) of treatment were/are being given?	Results of treatment
When this problem is at its worst, how does it make you feel?	
When this problem is at its worst, how does it interfere with your: Work?_____ Family Life?_____ Recreation/Hobbies?_____	
What effect is this problem having on other people in your life?	
What effect is this problem having on your level of stress?	
Before you began to suffer with this problem, was there and earlier accident, injury or other condition that could have brought this about or be related to it? ❑Yes ❑ No	
If yes was it: ❑Job related ❑Auto Accident_____/_____/_____ ❑ Other:_____ (if yes, list date of accident) _____	
If work related, has the accident been reported to your employer? ❑Yes ❑ No	

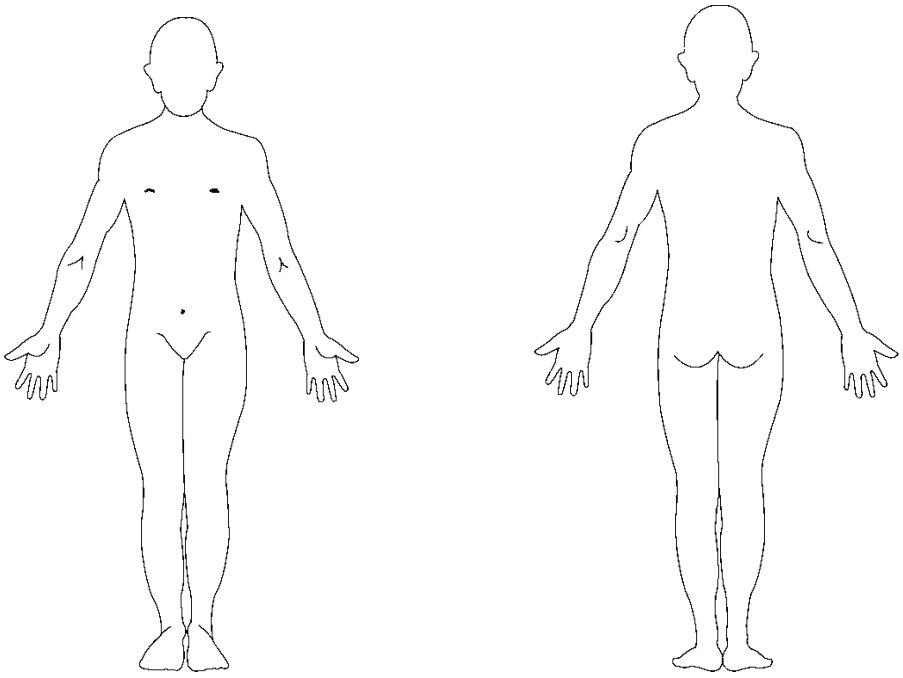
Pain Chart

Please mark on the pain scale the pain you feel with this condition, 10 being the worst pain you have felt.



Use the appropriate symbols. Mark areas of pain radiation. Include all affected areas.

Numbness	Pins & Needles	Burning	Aching	Stabbing
----------	oooooooooooooo	XXXXXXXXXX	^^^^^^^^^^^	///////////////



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Current Health History

List any medications you are currently taking (use separate sheet if needed):

Name	Dosage	How often	Taking since

Please list and describe allergic reactions you have had to food, drug, insect or environmental allergens:

Allergen	Reaction

Do you now or have you ever had a history of smoking cigarettes, cigars, vape or chew tobacco? ❑Yes ❑ No

If yes which method and how much?_____

Have you tried quitting? ❑Yes ❑ No If yes, what is the longest time period you quit?_____

Do you drink alcohol? ❑Yes ❑ No If yes, how much?_____

Significant Illnesses

Please check all conditions which you are currently experiencing or have experienced in the past:

❑Allergies
❑Anemia
❑Arthritis
❑Asthma
❑Autoimmune Disease
❑Cancer
❑Clotting Disorder
❑Connective Tissue Disorder
❑Diabetes
❑Eczema/Psoriasis
❑Epilepsy
❑Gallstones
❑Heart Disease
❑Hepatitis B or C
❑Herpes
❑High/Low Blood Pressure
❑HIV/AIDS
❑Influenza
❑Kidney Disease
❑Multiple Sclerosis
❑Mumps
❑Neurological Disease
❑Pleurisy
❑Pneumonia
❑Polio
❑Rheumatic Fever
❑Smallpox
❑Spinal injury/problems
❑Thyroid Disorder
❑Tuberculosis
❑Ulcers
❑Venereal Disease

❑Other:_____

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Current Symptom Profile

Please CHECK any of the following symptoms that you have had in the past 6 months:

Please CIRCLE the symptoms you are CURRENTLY experiencing:

Musculoskeletal
- ❑Back pain
- ❑Pain between the shoulders
- ❑Neck pain
- ❑Shoulder/ arm/ wrist pain
- ❑Hip/ knee/ ankle pain
- ❑Joint pain/ stiffness/ swelling
- ❑Difficulty walking
- ❑Jaw/ head pain
- ❑Muscle aches/ weakness
- ❑Broken bones

Nervous System
- ❑Pain or burning in extremities
- ❑Numbness/ loss of sensation
- ❑Dizziness
- ❑Vertigo
- ❑Headaches or Migraines
- ❑Poor balance
- ❑Memory problems
- ❑Seizures
- ❑Paralysis
- ❑Nervousness/ Stress

Cardiovascular
- ❑Chest pain or heaviness
- ❑Shortness of breath
- ❑High or low blood pressure
- ❑Irregular heartbeat
- ❑Stroke
- ❑Varicose veins
- ❑Foot/ ankle/ leg swelling

Respiratory
- ❑Blood in your sputum
- ❑Chest tightness or congestion
- ❑Dry cough
- ❑Cough with phlegm
- ❑Shortness of breath
- ❑Wheezing
- ❑Chest pain w/ inhalation or coughing

Gastrointestinal
- ❑Abdominal pain or cramps
- ❑Vomiting
- ❑Frequent nausea
- ❑Excessive thirst
- ❑Diarrhea
- ❑Constipation
- ❑Heartburn or indigestion
- ❑Blood in stool
- ❑Gas or bloating after meals
- ❑Gall bladder problems or stones
- ❑Hemorrhoids
- ❑Food intolerance
- ❑Colitis/ Crohn's/ IBS

Genitourinary
- ❑Painful or excessive urination
- ❑Discolored or blood in urine
- ❑Bladder infections
- ❑Kidney stones or infections
- ❑Urinary leakage or incontinence

Male Only
- ❑Prostate dysfunction
- ❑Loss of libido
- ❑Erection problems

Female Only
- ❑Breast pain
- ❑Lumps or masses
- ❑Nipple discharge
- ❑Loss of libido
- ❑Menstrual cramps
- ❑PMS
- ❑Irregular or absent periods
- ❑Vaginal pain or infection
- ❑Menopausal symptoms
- ❑Uterine/ ovarian fibroids
- ❑Date of last period

_____/ _____/ _____

Are you pregnant?

❑Yes ❑No ❑Not sure

Eyes
- ❑Vision problems
- ❑Poor night vision
- ❑Color blindness
- ❑Light sensitive
- ❑Eye pain or drainage
- ❑Dry/ irritated eyes
- ❑Eyelid(s) swollen
- ❑Eyelid(s) twitching

Ears
- ❑Ear pain or drainage
- ❑Hearing changes or loss
- ❑Earaches or infections
- ❑Ringing in ears

Nose
- ❑Frequent sinus infections
- ❑Nosebleeds
- ❑Loss of smell
- ❑Hayfever
- ❑Stuffy nose
- ❑Frequent sneezing
- ❑Frequent colds

Mouth and throat
- ❑Dental problems
- ❑Gum problems
- ❑Dry mouth
- ❑TMJ or grinding teeth
- ❑Sore throat
- ❑Lump in throat
- ❑Swallowing difficulty

❑Other health issues

_____
_____
_____
_____
_____
_____
_____

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Past Health History

Please list all surgical procedures you have had:

Procedure — Date

_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____
_____ _____/_____/_____

Major accidents or falls:

Incident — Date

_____ _____/_____/_____
_____ _____/_____/_____

Hospitalizations (other than above):

Hospitalization and Reason — Date

_____ _____/_____/_____
_____ _____/_____/_____

Family History

Has any blood relative had any of the following?

(Please label with **P** for Paternal and **M** for Maternal - ex P Grandmother or M Uncle)

Condition	Yes	No	Relationship
Breast Cancer			
Colon Cancer			
Lung Cancer			
Ovarian Cancer			
Prostate Cancer			
Uterine Cancer			
Other Cancer (type):			

Condition	Yes	No	Relationship
High Blood Pressure			
Heart Disease			
Heart attack before age 55			
Cholesterol or blood fat disorder			
Stroke or DVT			
Clotting or bleeding disorder			

Condition	Yes	No	Relationship
Diabetes			
Glaucoma			
Kidney Disease			
Osteoporosis			
Thyroid Disease			
Genetic Disorder (type):			

Condition	Yes	No	Relationship
Alcohol / drug problems			
Depression / Anxiety			
Psychiatric Illness (type):			
Suicide			
Other:			

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Sensitive Health Information

The following items have been listed as sensitive health information and, therefore will never be copied or released. Even though they are sensitive, they are still vital to the effective management of your case. Please complete as accurately as possible.

THIS SECTION IS NOT AUTHORIZED TO BE COPIED UNDER ANY CIRCUMSTANCES

Do you now or have you ever had a history of alcohol abuse? ❑Yes ❑ No

Have you ever experienced a blackout or loss of consciousness due to alcohol intake? ❑Yes ❑ No

Have you ever needed a drink to stop shaking, sweating or becoming irritated? ❑Yes ❑ No

Have you tried to quit? ❑Yes ❑ No If yes, when and for how long?_____

Do you use drugs for recreational purposes? ❑Yes ❑ No

If yes, check all that apply: ❑Amphetamines ❑Cocaine ❑Marijuana ❑Heroin ❑Inhalants ❑LSD ❑RX_____

Method of delivery ❑Ingestion ❑Injection ❑Inhalation Frequency of use_____

Have you ever needed a drink to stop shaking, sweating or becoming irritated? ❑Yes ❑ No

Have you tried to quit? ❑Yes ❑ No If yes, when and for how long?_____

Are you sexually active? ❑Yes ❑ No

If so, do you practice safe sex or use birth control? ❑Yes ❑ No If no, are you in a monogamous relationship? ❑Yes ❑ No

If yes, check all that apply: ❑Condoms ❑Diaphragm ❑IUD ❑Birth Control Pills, patches or implants

Have you ever been tested for the HIV virus? ❑Yes ❑ No

Have you ever been diagnosed with HIV or an HIV related illness? ❑Yes ❑ No

If yes, what type of treatment are you under? _____

Have you been diagnosed with a mental illness? ❑Yes ❑ No

Diagnosis?_____ When?_____

Treatment?_____

_____

In the last 6 months have you experienced any of the following symptoms?

Anxiety without clear explanation	❑Yes	❑ No	Thoughts of hurting yourself	❑Yes	❑ No
Sadness lasting days or weeks	❑Yes	❑ No	Thoughts of hurting others	❑Yes	❑ No
Hearing voices	❑Yes	❑ No	Fear of people places or things	❑Yes	❑ No

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Emotional Health History

Scientific studies are now showing that emotional stress has a great deal to do with an individual's health. Please answer the following questions as accurately and completely as possible:

Please rate the following areas of potential stress on a scale of 1-10, with 10 being the highest stress you could imagine and 1 being relatively no stress.

	Low									**High**
Financial/Money matters	1	2	3	4	5	6	7	8	9	10
Relationship/Family	1	2	3	4	5	6	7	8	9	10
Job/Career/Education	1	2	3	4	5	6	7	8	9	10
Current level of health	1	2	3	4	5	6	7	8	9	10
Spiritual/Religious/Ethical	1	2	3	4	5	6	7	8	9	10
Overall level of life stress	1	2	3	4	5	6	7	8	9	10

Please check the following life events that you currently (or previously) experience stress with:

❑Birth of siblings
❑ Toilet training
❑Babysitters
❑Death of a pet
❑First year of school
❑Teachers
❑Peer relationships
❑Onset of puberty
❑Fights
❑Romance/dating
❑Illness/operations
❑Parental conflict / separation
❑Divorce / separation
❑Prom
❑College
❑Abortion / miscarriages
❑Any betrayal
❑Marriage
❑Moving
❑Accidents
❑Loss of job / layoff
❑Financial disruptions
❑Illness of a loved one
❑Diagnosis of a fatal condition
❑Death of a loved one
❑Other: _____

I would generally describe myself as (check all that apply):

❑Happy
❑Easy going
❑Restless
❑Irritable
❑Indecisive
❑Angry
❑Cry easily
❑In a hurry
❑Depressed
❑Stressed out
❑Difficulty expressing emotion
❑Short attention span
❑Other_____
_____
_____

Dr. Lloyd Katz is a specialist in NET (Neuro-emotional technique). Dr. Katz determines through this method if stress is affecting your present condition and overall health. He will discuss this with you in your consultation. If Dr. Katz can show you how your health can improve and your level of stress can be dramatically reduced, would you be interested in learning more about this technique? ❑ Yes ❑ No

Chiropractic Bio-Tune Ups

Diet / Nutritional Health History

What you eat has a direct effect on your health. Please help us help you by providing us with the following information.

Meals

Meal	Do you eat this meal on most days?	Approximate time	A list of foods you commonly eat at this meal
Breakfast			
Lunch			
Dinner			

Snacks

Approximate time	Types of foods commonly eaten

Foods

Food type	How often?
Soda (including diet sodas)	❑Every day ❑Most days ❑Occasionally ❑Never
Fried foods	❑Every day ❑Most days ❑Occasionally ❑Never
Multiple cups of coffee a day	❑Every day ❑Most days ❑Occasionally ❑Never
Sweets, donuts, ice cream, cookies etc	❑Every day ❑Most days ❑Occasionally ❑Never
Milk and cheese	❑Every day ❑Most days ❑Occasionally ❑Never
Meat (beef, chicken, pork – not fish)	❑Every day ❑Most days ❑Occasionally ❑Never
Shellfish (shrimp, crab, lobster etc.)	❑Every day ❑Most days ❑Occasionally ❑Never
Deep ocean fish (salmon, tuna, sea bass etc.)	❑Every day ❑Most days ❑Occasionally ❑Never
White sugar or artificial sweeteners	❑Every day ❑Most days ❑Occasionally ❑Never
Spicy foods	❑Every day ❑Most days ❑Occasionally ❑Never

Appetite and cravings

Please check all that apply:

❑Appetite up and down
❑Poor appetite
❑Good appetite

❑Hungry a lot
❑Loss of taste

❑Recent weight loss or gain
If recent loss or gain, how much? _____
Since when? _____

Cravings_____

Do you regularly take nutritional supplements or vitamins? ❑Yes ❑No If yes, please list them:

_____

_____

_____

Dr. Katz will be making specific dietary recommendations and prescribing an individual supplementation program just for you. Please rate, on a scale of 1 – 10 (with 10 being the highest), your willingness to follow the recommended dietary and nutritional supplementation program. _____

Chiropractic Bio-Tune Ups

Ergonomic Health History

How you treat and support your body daily has a direct impact on your health. Please help us help you by providing us with the following information:

Exercise Habits

Do you currently exercise? ❑Never ❑A little(1-2 days/ wk) ❑Moderate(3-5 days/ wk) ❑ Heavy (6-7 days/ wk)

Type(s) of exercise: _____

Do you wear orthotics/foot inserts? ❑Yes ❑No

Dr. Katz may recommend a cardiovascular, strength training, and/or stretching program. Please rate, on a scale of 1- 10 (with 10 being the highest), your willingness to incorporate the prescribed exercise into your health care program. _____

Sleep Habits

What is your most common sleep position? ❑Back ❑Side ❑ Stomach

What type of pillow do you use? ❑Soft ❑Medium ❑Firm ❑Cervical (neck) ❑None

What type of mattress do you sleep on? ❑Soft ❑Medium ❑Firm ❑Other_____

How old is it? _____

Average bed time _____ Average waketime _____

How many hours of sleep do you average per night? _____

Falling asleep ❑Easy ❑Average ❑Difficult **Staying asleep** ❑Easy ❑Average ❑Difficult

Waking up ❑Easy ❑Average ❑Difficult

Sleep quality (check all that apply): ❑Restless ❑Lots of dreams ❑Easily awakened ❑Nightmares ❑Difficulty falling back to sleep

Work Habits

How many hours per day are you:

Sitting:_____ Standing:_____ Crouching or bending over: _____

Lifting:_____ Walking:_____ Working at a computer: _____

Electronic Radiation Exposure

Do you use any of the following daily? Check all that apply.

❑Blow dryer/curling iron ❑Microwave ❑Sleep within 3 feet of an electrical outlet

❑Cell phone/cordless phone ❑Electric razor/toothbrush ❑Spend more than 1 hour/day in the car

Scientific studies are now showing that repeated exposure to the above items can be extremely hazardous to your health. Dr. Katz will discuss ways to reduce your exposure to these harmful elements.

Chiropractic Bio-Tune Ups

Goals for Your Care

We would like to thank you for choosing our office for your chiropractic and healthcare needs. It is our primary goal to provide the highest level of health care available. At Chiropractic Bio Tune-Ups, we know that people see chiropractors for a variety of reasons. Some go just for pain relief; some go further by wanting to correct the CAUSE of their pain/ symptoms as well; and others go even further by choosing complete health and wellness by correcting all means of bodily dysfunction even before any symptoms are present.

Please check the type of care desired so that we can best serve your needs.

❑Relief Care: Pain/Symptom relief only

❑Corrective Care: Correction of the CAUSE of the pain/symptoms as well as relief of pain/symptoms

❑Comprehensive Care: Bring all areas of the body that are malfunctioning to the highest state of health possible, while correcting the cause and providing pain/symptom relief to the areas of complaint

❑I want the doctor to select the type of care appropriate for my health and condition

Informed Consent for Chiropractic Care

Chiropractic examination procedures include, but are not limited to, health history, posture and range of motion evaluation, orthopedic and neurological testing, palpitation of various body structures, spinal extremity mobilization, manual or mechanical muscle testing and palpitation and referral for specialized testing. Chiropractic therapeutic procedures include, but are not limited to, spinal and extremity manipulation/mobilization, manual or mechanical muscle therapy, exercise demonstration and prescription, physiotherapy, applications such as heat, ultrasound, nutritional recommendations and advice on posture and homebased self-care.

The most common adverse effects of chiropractic treatment are short-term soreness and/or a temporary increase in pain. The likelihood of initial soreness or increased pain has been found to be similar to that of starting an exercise program. Chiropractic adjustments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. Dr. Katz, of course, will not give any treatment or health care if he is aware that such care may be contradicted.

Upon signing this form, I hereby authorize Dr. Lloyd Katz, and whomever he may designate as his assistant, to provide me with a consultation and examination in order to determine if my case can be helped by chiropractic and other care provided here. I understand that other exams and tests such as X-Rays, lab tests etc. may be necessary to gain more information regarding my health. I understand if I am accepted as a patient here at Chiropractic Bio-Tune Ups, Dr. Katz will discuss with me which course of care would be best for my case. I also understand that there is no guarantee or warranty for a specific cure or result.

_____ _____

Printed name of Patient Date

_____

Signature of Patient

Chiropractic Bio-Tune Ups

Confidentiality Agreement

We at Chiropractic Bio-Tune Ups have always made your privacy one of our top priorities. We would like to inform you of the measures our office has taken to ensure your rights of patient privacy (in accordance with HIPPA).

The following have been incorporated to secure your private patient information:

1. Locks on the office doors and on file cabinets where your patient records are stored with the only keys belonging to the doctor and the office manager.
2. All employees in the office have signed a strict confidentiality agreement that requires them to keep all patient information in the office, confidential, both written and verbal.
3. All areas where mail and/or patient correspondence may be found is restricted to employees only.
4. All computers with patient data are locked in a secure location. Access to the computers is restricted to the doctor and office manager, and requires a security log in, with a password, each time the computer is accessed.
5. Patients are NOT allowed behind the front desk at any time.
6. In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI).

Acknowledgement of Privacy Policy

I understand that I have the right to review the Notice of Privacy Practices prior to signing this document. A copy of this notice has been offered to me for my review.

The notice of Privacy Practices (Notice) describes the types of uses and disclosures of my "protected health information (PHI)" that will occur in my treatment, payment of bills, or in the performance of healthcare operations of this practice. My PHI means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this practice or employees. PHI is information that relates to my past, present or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me. The notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI.

By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Practices and acknowledge receipt of the Notice.

Please Note: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will NEVER be discussed, verbally or in writing, with anyone but you or your spouse. We will only disclose information to others (i.e. family members, other physicians etc.) Once we have obtained your express written permission. If you wish to keep your information private from your spouse as well, please indicate below.

_____ **I wish to keep my PHI private from my spouse.**

The information described above may be disclosed to:

_____ _____

Name of person or organization Name of person or organization

I have read, or have had read to me, the above policies. I have had an opportunity to ask questions and by signing below I agree to the above.

_____ _____

Name of Patient (Print) Date

_____

Signature

Chiropractic Bio-Tune Ups

Office Policies

In order to maintain the quality of care at Chiropractic Bio-Tune Ups, we have instituted a number of polices which are outlined below. Before becoming a new patient at the practice, please initial each point and sign at the bottom.

Chiropractic Bio-Tune Ups does not discriminate based upon age, gender, race, religion, sexual orientation, health status or the ability to pay.

_____ Late Arrival: As a courtesy to other patients, we regret that late arrivals will not receive an extension of the scheduled appointment time, thus your treatment will be shortened. We ask that if you are running more than 10 minutes late for your scheduled appointment that you take a moment to call the office and let us know. We will be happy to help resolve any scheduling issues that arise and do have some flexibility. However, in some instances, out of respect for other patients scheduled after you, you may need to re-schedule.

_____ Cancellations or Missed Appointments: All appointment cancellations must be made by 6pm the business day prior to your scheduled appointment. Failure to do so or a failure to show (no show) will result in a $30 fee.

_____ Payment Policy: I understand that payment in full is due at time of visit. This office accepts cash, credit cards or checks.

_____ Insurance: Our office is NOT affiliated with any medical insurance companies, but we will be happy to provide you with an invoice with specific medical codes for reimbursement that you can submit to your health insurance provider. Our office is NOT in a position to know what your specific insurance will cover. Patients who carry any form of health insurance should know that all services rendered by this office are charged directly to the patient.

_____ Medicare and Medicaid: We do not have the infrastructure to accommodate the requirements for Medicare and Medicaid. Due to the small part time nature of this practice, Dr. Katz cannot do spinal adjustments for submission to these insurances. The requirements for those systems are too extensive for this small practice to achieve.

_____ Returned Checks: There will be a $35 charge on all returned checks.

_____ Nutritional Supplements and Health Supplies: Nutritional supplements and other health supplies must be paid for at time of visit. Dr. Katz does not offer Barters or Sliding Scale Discounts for these items.

Please ask any questions you have regarding our polices before signing below. We welcome questions at any time.

I have read, or have had read to me, the above office policies. I have had an opportunity to ask questions and by signing below I agree to the above.

_____ _____

Patient Name (Print) Date

_____

Signature