care Health Profile

Date: _____ Name of Guardian, if applicable: _____ Relationship: _____

Name: _____
First Middle Last Suffix (Jr, Sr, MD, JD, DC, PhD)

Address:_____

_____
City State Zip Country

By what name would you like to be addressed? _____

Gender: ☐ Female ☐ Male Date of Birth: _____ Age: _____ Place of Birth: _____

Home Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____
Area Code Area Code Area Code

Preferred daytime phone number: ☐ Home ☐ Work ☐ Cell

Preferred Email Address: _____

Preferred method of communication: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

Please send announcements, lecture schedules, and newsletters via: ☐ Email ☐ Regular mail ☐ Neither

Ethnicity: ☐ Caucasian ☐ Hispanic/Latino ☐ African American ☐ Asian or Pacific Islander ☐ Multiracial
☐ Native American ☐ Other: _____ ☐ Decline response

Marital status: ☐ Married ☐ Single ☐ Single and living with partner ☐ Divorced ☐ Separated ☐ Widowed

Emergency Contact: _____ Relationship: _____
First Name Last Name

Emergency Phone: (_____)_____ Alternate Phone: (_____)_____
Area Code Area Code

How were you referred to care? ☐ Friend ☐ Physician ☐ Colleague ☐ Relative ☐ Website

☐ Other:_____

Referring person's name: _____

EDUCATION

☐ High school ☐ College, degree not completed ☐ Bachelor's, Associate's, or professional degree

☐ Master's degree ☐ PhD ☐ MD ☐ DC ☐ JD ☐ DDS ☐ Other: _____

EMPLOYMENT

Are you employed? ☐ Yes ☐ No Employer: _____

Occupation: _____ Job Title: _____

Typical number of hours worked per week: _____

If currently a full-time homemaker, please list previous occupation: _____

Please indicate any occupational exposures: ☐ Pesticides ☐ Other chemicals ☐ Radiation ☐ Other: _____

Job description: ☐ Sedentary (desk job, etc.) ☐ Moderately active ☐ Requires significant physical exertion

PHYSICIANS

Primary Care Physician

Name_____
First Last Professional Title
Specialty _____
Address _____
City, State, Zip _____
Phone (_____) _____

Specialist

Name_____
First Last Professional Title
Specialty _____
Address _____
City, State, Zip_____
Phone (_____) _____

HEALTHCARE GOALS

What are your health priorities?

_____ Enhance cognitive function
_____ Improve attention span
_____ Increase energy level
_____ Improve sleep pattern
_____ Optimize nutritional status
_____ Increase longevity
_____ Initiate detoxification program
_____ Increase endurance
_____ Improve memory
_____ Decrease anxiety level
_____ Decrease allergy symptoms
_____ Optimize health prior to pregnancy
_____ Optimize health prior to surgery
_____ Minimize the need for medication
_____ Lower blood pressure
_____ Balance hormone levels
_____ Relieve arthritis pain
_____ Reduce frequency of headaches
_____ Reduce risk of cardiovascular disease
_____ Reduce risk of diabetes
_____ Reduce risk of osteoporosis
_____ Overcome depression
_____ Speed recovery from injury or surgery
_____ Initiate detoxification program
_____ Determine ideal diet and supplements
Other: _____

care Health Profile

What is your primary health concern?

_____

When did these symptoms first develop?

_____

When do you last remember feeling 100% well?

_____

Describe any known or suspected cause(s) of these concerns:

_____

What makes your symptoms worse?

_____

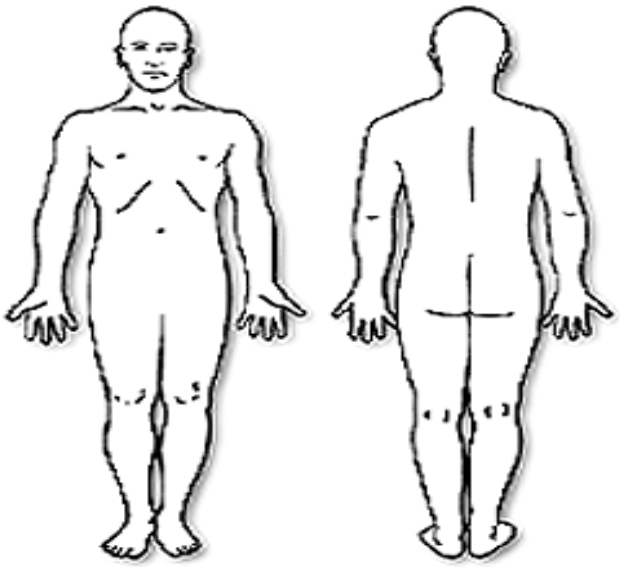
What alleviates or reduces your symptoms?

_____

Have your symptoms been getting worse over time?
☐ Yes ☐ No

Please provide any additional details if you believe they may be important: _____
_____
_____
_____

Please use this diagram to mark any areas of pain, numbness, or tingling.



Rate your average symptoms (primary complaint):

0 1 2 3 4 5 6 7 8 9 10
No Symptoms Severe

Rate your symptoms at their worst:

0 1 2 3 4 5 6 7 8 9 10
No Symptoms Severe

DIET AND LIFESTYLE

Please indicate any of the following that accurately describe your diet:

☐ Gluten free ☐ Dairy free ☐ Corn free ☐ Soy free ☐ Sugar free ☐ High protein ☐ Low carbohydrate
☐ Low fat ☐ High fat ☐ Ketogenic ☐ Low salt ☐ Reduced calorie ☐ Vegetarian ☐ High carbohydrate
☐ No restrictions ☐ Organic ☐ Other_____

How many times per week do you eat tuna, tilefish, swordfish, shark, or mackerel? _____

How many times per day do you eat fresh fruit or vegetables? _____

Do you eat primarily organic produce? ☐ Yes ☐ No

How many times per day do you eat bread, pasta or pastries? _____

How many times per week do you eat fast food? _____

How many glasses of water do you drink per day? _____ Do you drink primarily filtered water? ☐ Yes ☐ No

Do you drink coffee? ☐ Yes ☐ No If yes, how many cups do you drink per day? _____

Do you drink soda?

☐ Yes ☐ No If yes, what brand and how many ounces do you drink per day? _____

Do you drink energy drinks?

☐ Yes ☐ No If yes, how many per week? _____

Do you drink alcohol?

☐ Yes ☐ No If yes, what type and how often? _____

Have you ever smoked cigarettes, cigars, or a pipe?

☐ Yes ☐ No If yes, how many years did you smoke? _____

Which of the following did you smoke? ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Other: _____

If you are currently a smoker, how much do you smoke?

☐ Less than 1 pack per day ☐ 1 pack per day ☐ More than 1 pack per day

☐ Daily pipe smoking ☐ Occasional pipe smoking

☐ Daily cigar smoking ☐ Occasional cigar smoking

☐ Recreational marijuana ☐ Medical marijuana

Do you chew tobacco?

☐ Yes, daily ☐ Yes, occasionally ☐ No ☐ I quit chewing tobacco ____ years ago.

How often do you exercise?

☐ Daily ☐ 3 or more times per week ☐ Weekly ☐ Sporadically ☐ Rarely ☐ Never

What type of exercise do you prefer? _____

Do you use pesticides in your home? ☐ Yes ☐ No

Do you use pesticides in your yard? ☐ Yes ☐ No

How many mercury (silver) fillings do you currently have? _____

How many mercury (silver) fillings have you had removed? _____

How would you rate your present level of stress? ☐ Low ☐ Moderate ☐ High

How would you rate your present enjoyment of your job? ☐ Low ☐ Moderate ☐ High

How many hours of sleep do you usually get per night? _____

How many nights per week is your sleep interrupted? _____

FAMILY MEDICAL HISTORY

Please indicate if anyone in your family has had any of the following conditions: Use "D" if deceased due to this condition.

Medical Condition	Relationship												
						Mother's Side				Father's Side			
	Child	Mother	Father	Bro	Sis	Aunt	Uncle	GF	GM	Aunt	Uncle	GF	GM
Alcoholism													
Anxiety Disorder/Panic Attacks													
Asthma													
Autism / PDD NOS													
Asperger's Syndrome													
ADD / ADHD													
Alzheimer's													
Anorexia / Bulimia													
Bipolar Disorder													
Birth defect													
Depression													
Down Syndrome													
Dyslexia													
Eczema													
Epilepsy / Seizures													
Gout													
Language Delay													
Heart Disease													
High Blood pressure													
High Cholesterol Level													
Kidney Stones													
Mental Retardation													
Migraines													
Obsessive Compulsive Disorder													
Parkinson's Disease													
Rett's Disorder													
Schizophrenia													
Spina Bifida													
Stuttering													
Stroke													
Suicide or suicide attempt													
Tourette's Syndrome													
Tremor													
Vertigo / Meniere's Disease													
Gastrointestinal:													
Celiac Disease													
Crohn's Disease													
Irritable Bowel Syndrome													
Pancreatitis													
Peptic Ulcer Disease													
Reflux Esophagitis / GERD													
Ulcerative Colitis													
Autoimmune:													
Ankylosing Spondylitis													
Chronic Fatigue Syndrome													
Diabetes													
Fibromyalgia													
Lupus (SLE or discoid)													
Multiple Sclerosis													
Psoriatic Arthritis													
Rheumatoid Arthritis													
Thyroid Disease													
Vitiligo													
Other													

CANCER

If anyone in your family has had cancer, please specify and indicate the relationship of this family member to you:

☐ Brain: _____ ☐ Breast: _____ ☐ Cervical: _____ ☐ Colon/rectal: _____

☐ Kidney: _____ ☐ Leukemia: _____ ☐ Lung: _____ ☐ Lymphoma: _____

☐ Stomach: _____ ☐ Oral (mouth, tongue): _____ ☐ Ovarian: _____ ☐ Pancreatic: _____

☐ Prostate: _____ ☐ Skin: _____ ☐ Stomach: _____ ☐ Testicular: _____

☐ Thyroid: _____ ☐ Uterine: _____ ☐ Other: _____

If you have had or currently have any of the following cancers, please specify:

☐ Breast ☐ Cervical ☐ Colon/rectum ☐ Kidney ☐ Leukemia ☐ Lung ☐ Lymphoma ☐ Oral (mouth, tongue)

☐ Ovarian ☐ Pancreas ☐ Prostate ☐ Skin ☐ Stomach ☐ Uterine ☐ Other:_____

If you have had cancer, please indicate any treatments you have had:

☐ Surgery ☐ Radiation ☐ Chemotherapy ☐ None ☐ Other: _____

ALLERGIES

Please indicate any drugs to which you are allergic:

☐ Penicillin ☐ Sulfa drugs (e.g., Bactrim, Septra) ☐ No known drug allergies ☐ Other _____

Please describe the nature of this allergic reaction:

☐ Diarrhea ☐ Fever ☐ Hives ☐ Irregular heart rate ☐ Loss of consciousness ☐ Rash ☐ Shortness of breath
☐ Swelling of the mouth, tongue, or throat ☐ Other _____

Please indicate any food allergies or sensitivities:

☐ Corn ☐ Eggs ☐ Gluten or wheat ☐ Milk, casein, or dairy ☐ Peanuts ☐ Shellfish ☐ Soy ☐ Tree nuts
☐ I have no known food allergies ☐ Other _____

What reactions do you have to these foods?

☐ Diarrhea ☐ Fever ☐ Hives ☐ Irregular hear rate ☐ Loss of consciousness ☐ Rash ☐ Shortness of breath
☐ Swelling of the mouth, tongue, or throat ☐ Other _____

Please indicate any environmental sensitivities you currently have:

☐ Cigarette smoke ☐ Grass ☐ Chlorine ☐ Mold ☐ Nickel or other metals ☐ Pet dander ☐ Pollen
☐ Radiology contrast dye ☐ Trees ☐ I have no environmental allergies
☐ Other _____

What reactions do you experience with exposure to these environmental allergens or toxins?

☐ Diarrhea ☐ Fever ☐ Hives ☐ Irregular hear rate ☐ Loss of consciousness ☐ Rash ☐ Shortness of breath
☐ Swelling of the mouth, tongue, or throat ☐ Other _____

MEDICATIONS AND SUPPLEMENTS

List all medications and supplements you are currently taking. Please be specific and include dosages.

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

_______________ **Dosage**__________ Date Started__________ Prescribed by ______________
- [ ] Daily - [ ] Twice a day - [ ] Three times a day - [ ] Other ______________ Taken ______ % of the time

HEIGHT AND WEIGHT

Height ____ feet ____ inches **Weight** _____ lbs

Please describe any problems you have had with your weight:

☐ Anorexia ☐ Binge eating ☐ Bulimia ☐ Loss of appetite ☐ Over ideal weight ☐ Under ideal weight

☐ Rapid/unexplained weight loss ☐ Unable to gain weight

At what weight do you feel most healthy? _____ lbs

How much has your weight changed over the past year?

☐ 0-5 pound increase ☐ 6-10 pound increase ☐ 11-15 pound increase ☐ 16 or more pound increase
☐ 1-5 pound decrease ☐ 6-10 pound decrease ☐ 11-15 pound decrease ☐ 16 or more pound decrease

Please indicate any conditions you currently have or have experienced in the past:

BLOOD AND IMMUNE SYSTEM

☐ Anemia ☐ Factor V Leiden deficiency ☐ Frequent bruising ☐ Frequent infections ☐ Hemophilia

☐ High red blood cell count ☐ HIV/AIDS ☐ Idiopathic thrombocytopenia purpura (ITP)

☐ Low platelet count ☐ Low white blood cell count ☐ Protein C deficiency ☐ Protein S deficiency

☐ von Willebrand's Disease ☐ Other _____

EYES

Do you wear contacts or corrective lenses? ☐ Yes ☐ No Date of last eye exam:_____

Have you ever had eye surgery? ☐ Yes ☐ No If yes, please describe: _____

Do you have a history of any of the following?

☐ Blurred vision ☐ Cataracts ☐ Corneal laceration ☐ Detached retina ☐ Double vision ☐ Dry eyes

☐ Eye infection ☐ Glaucoma ☐ Increased tearing ☐ Loss of vision ☐ Spots in visual field ☐ Strabismus

☐ Other: _____

EARS

Do you have hearing loss? ☐ Left ear ☐ Right ear ☐ No

Do you wear a hearing aid? ☐ Left ear ☐ Right ear ☐ No

Please indicate any conditions you currently have or have experienced in the past:

☐ Auditory sensitivity ☐ Ringing in the ears ☐ Earaches ☐ Recurrent ear infections ☐ Ruptured ear drum

☐ Other: _____

NOSE

☐ Allergic rhinitis/nasal congestion ☐ Fracture ☐ Frequent nosebleeds ☐ Hay fever ☐ Loss of smell ☐ Polyps

☐ Sinus infections

☐ Other: _____

MOUTH AND THROAT

☐ Difficulty swallowing ☐ Frequent sore throats ☐ Gum infections/gingivitis ☐ Hoarseness ☐ Jaw pain/TMJ pain
☐ Loss of taste ☐ Mouth sores or ulcers ☐ Multiple cavities/fillings ☐ Swollen lymph nodes
☐ Other: _____

LUNGS

Do you experience shortness of breath during any of these activities?

☐ Walking ☐ Climbing one flight of stairs ☐ Sitting at rest

Please indicate any respiratory problems you currently have or have experienced in the past:

☐ Asthma ☐ Chronic cough ☐ Chronic Obstructive Pulmonary Disease (COPD) ☐ Coughing up blood
☐ Emphysema ☐ Pneumonia ☐ Shortness of breath ☐ Sleep apnea ☐ Tuberculosis ☐ Valley fever
☐ Other: _____

CARDIOVASCULAR

☐ Angina (chest pain) ☐ Blood clot ☐ Congestive heart failure ☐ Enlarged heart ☐ Fainting ☐ Heart attack
☐ Heart murmur ☐ Irregular heart beat ☐ Leg pain or cramping ☐ Pain in legs when walking ☐ Phlebitis
☐ Poor circulation ☐ Rapid heart beat ☐ Swelling in the legs or feet ☐ Slow heart beat ☐ Varicose veins
☐ Other: _____

Heart valve problems:

☐ Aortic regurgitation ☐ Aortic stenosis ☐ Mitral regurgitation ☐ Mitral stenosis ☐ Mitral valve prolapse

Please indicate any treatments or procedures you have had for heart disease:

☐ Angioplasty ☐ Angioplasty with stent placement ☐ Coronary artery bypass (CABG)
☐ Dietary changes ☐ Exercise ☐ Medication ☐ Other: _____

GASTROINTESTINAL

☐ Abdominal pain ☐ Alternating diarrhea and constipation ☐ Blood in stool ☐ Celiac disease ☐ Constipation
☐ Cirrhosis ☐ Clay colored stools ☐ Cramping ☐ Crohn's disease ☐ Diarrhea ☐ Difficulty swallowing
☐ Diverticulosis or diverticulitis ☐ Excessive belching ☐ Foul smelling stools ☐ Gallstones ☐ Gas/bloating
☐ Gluten sensitivity ☐ Heartburn/reflux ☐ Hemorrhoids ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Itching ☐ Jaundice ☐ Hiatal hernia ☐ Lactose intolerance ☐ Nausea ☐ Pancreatitis ☐ Peptic ulcer
☐ Polyps ☐ Ulcerative colitis ☐ Vomiting ☐ Vomiting blood ☐ Other: _____

KIDNEYS AND BLADDER

☐ Blood in urine ☐ Difficulty urinating ☐ Frequent urination ☐ Frequent bladder infections ☐ Incontinence
☐ Increased volume of urine ☐ Kidney infection ☐ Kidney stones ☐ Low urine output ☐ Painful urination
☐ Waking up frequently during night to urinate ☐ Sudden urge to urinate ☐ Other: _____

Code # _____

MUSCULOSKELETAL

☐ Back Pain ☐ Bone fracture ☐ Gout ☐ Jaw pain or clicking ☐ Joint dislocation ☐ Joint swelling
☐ Muscle spasms ☐ Muscle weakness ☐ Osteoarthritis ☐ Osteoporosis ☐ Psoriatic arthritis
☐ Rheumatoid arthritis ☐ Scoliosis ☐ Torticollis ☐ Other: _____

If you have arthritis, what joints are involved?

☐ Ankles ☐ Feet ☐ Hands ☐ Hips ☐ Knees ☐ Neck ☐ Wrists ☐ Spine

SKIN

☐ Acne ☐ Birthmark ☐ Eczema ☐ Hives ☐ Increase in size or change in color of mole ☐ Itching
☐ Psoriasis ☐ Rash ☐ Shingles ☐ Skin cancer ☐ Skin ulcer ☐ Vitiligo (loss of pigment in skin)
☐ Other: _____

NERVOUS SYSTEM

☐ Aneurysm ☐ Carpal tunnel syndrome ☐ Concussion ☐ Dizzy spells ☐ Headaches ☐ Head injury
☐ Insomnia ☐ Loss of consciousness ☐ Loss of sensation ☐ Memory loss ☐ Migraines
☐ Poor concentration ☐ Poor word retrieval ☐ Ringing in ears ☐ Sciatica ☐ Seizures ☐ Strabismus
☐ Stroke ☐ TIA (transient ischemic attack) ☐ Tic disorder or Tourette's ☐ Tingling in extremities
☐ Torticollis ☐ Tremor ☐ Vertigo ☐ Weakness ☐ Other: _____

ENDOCRINE

☐ Cushing's disease ☐ Cushing's syndrome ☐ Diabetes: ☐ Type 1 ☐ Type 2 ☐ Gestational diabetes
☐ Dry, brittle hair ☐ Edema/fluid retention ☐ Fatigue ☐ Frequent chills/cold intolerance ☐ Hair loss
☐ Hyperthyroidism ☐ Hypoglycemia ☐ Hypothyroidism ☐ Infertility ☐ Pancreatitis
☐ Pituitary tumor ☐ Rapid weight gain ☐ Rapid weight loss ☐ Thick, brittle nails
☐ Other: _____

MOOD AND BEHAVIOR

☐ Agitation ☐ Anxiety ☐ Attention deficit disorder ☐ Depression ☐ Mood swings ☐ Nervousness
☐ Panic Attacks ☐ Phobias/fears ☐ Suicidal thoughts ☐ Suicide attempt

Have you ever taken medication for anxiety, depression or attention? ☐ Yes ☐ No

MEN

☐ Benign prostatic hypertrophy ☐ Biopsy ☐ Prostate cancer ☐ Prostate infection ☐ Resection/TURP
☐ Decreased libido ☐ Discharge ☐ Herpes ☐ HPV (human papilloma virus) ☐ Pain ☐ Swelling
☐ Ulcers ☐ Warts ☐ Other_____

What form of contraception do you use?

☐ Condoms ☐ Vasectomy ☐ Partner uses contraception ☐ Natural family planning ☐ None

Code # _____

WOMEN

Age at first period: _____ **Date of last period:** _____

Average number of days of bleeding per cycle: _____ **Average cycle length:** _____ **days**

Are your cycles ever more than 35 days apart? ☐ Yes ☐ No

Please indicate any symptoms you have with your period:

☐ Bloating/weight gain ☐ Breast tenderness ☐ Diarrhea ☐ Fainting ☐ Fatigue

☐ Headaches/migraines ☐ Heavy bleeding ☐ Mood swings ☐ Nausea/vomiting ☐ Pain/cramping

Total number of pregnancies: ____

Number of full-term births: ____ Number of premature births: ____ Number of stillborns: ____

Number of miscarriages: ____ Number of abortions: ____ Number of living children: ____

Have you ever had infertility problems? ☐ Yes ☐ No ☐ I have not yet attempted to become pregnant

Have you ever taken fertility drugs? ☐ Yes ☐ No

Age of mother at menopause: _____ **Your age at menopause, if applicable:** _____

Date of last mammogram:

☐ <1 year ago ☐ >1 year ago ☐ No mammograms have been obtained

Mammogram results: ☐ Abnormal ☐ Normal ☐ Uncertain

Check any that have been necessary:

☐ Breast biopsy ☐ Repeat mammogram ☐ Surgery ☐ Ultrasound

Date of last Pap smear:

☐ Unknown ☐ <1 year ago ☐ >1 year ago ☐ I have never had a Pap smear

Results of Pap Smear**:** ☐ Abnormal ☐ Normal ☐ Uncertain

If you have had an abnormal Pap smear, what was the follow up:

☐ Conization ☐ Cryotherapy ☐ Laser ☐ LEEP ☐ Repeat Pap smear

☐ Other: _____

What form of contraception do you use?

☐ Contraceptive patches ☐ Depoprovera ☐ Hysterectomy ☐ Intrauterine device (IUD)

☐ Natural family planning ☐ None ☐ Oral contraceptive pills ☐ Partner uses condoms

☐ Partner had vasectomy ☐ Tubal ligation ☐ Other: _____

Please indicate any gynecologic problems you have had:

☐ Abnormal bleeding ☐ Decreased libido ☐ Ectopic pregnancy ☐ Endometriosis ☐ Herpes

☐ Human papilloma virus (HPV) ☐ Ovarian cysts ☐ Ovarian surgery ☐ Pain with intercourse

☐ Recurrent yeast infections ☐ Venereal warts ☐ Other: _____

Code # _____

SURGERY

Please indicate any surgeries you have had:

☐ Appendectomy ☐ Back / Spine ☐ CABG (coronary artery bypass graft) ☐ Cataracts
☐ Cosmetic surgery ☐ D and C ☐ Ear tubes ☐ Fracture repair ☐ Gallbladder ☐ Hernia
☐ Hysterectomy ☐ Joint replacement ☐ Laparoscopy ☐ Lumpectomy ☐ Mastectomy
☐ Orthopedic: _____ ☐ Prostatectomy ☐ Stomach ☐ Tonsillectomy
☐ Tubal ligation ☐ Vasectomy ☐ Other: _____

INJURIES AND ACCIDENTS

Please indicate any injuries you have sustained:

☐ Bicycle accident ☐ Bone fracture ☐ Car accident ☐ Fall ☐ Gunshot wound ☐ Head injury
☐ Laceration requiring sutures or surgery ☐ Motorcycle accident
☐ Other: _____

Guarantee of truthful and complete responses

I understood each of the items and questions in this questionnaire. I have answered every question to the best of my knowledge and did not falsely respond to any question. I understand that by providing misleading information on this questionnaire, I may be endangering myself and impairing the potential ability of my doctor to help me with my health concerns. I further guarantee that if any important issue regarding my health status was not covered in this questionnaire, I will bring this to the attention of my doctor at my first appointment.

SIGNED: _____ DATE: _____

Financial policies

Payment is due at the time of service. We accept VISA, MasterCard, American Express, checks or cash.

I agree to pay all costs of a collection agency if necessary to obtain an unpaid balance due for services rendered. I understand and agree that my entire unpaid bill will be subject to an interest charge equivalent to an annual rate of 25%, which will begin accruing immediately after CARE issues the first 'request for payment' notice to me.

SIGNED: _____ DATE: _____

Privacy Practices and your rights to patient confidentiality

I have received and signed CARE's notice of privacy practices for protected health information.

DATE: _____

SIGNED: _____