FILE # _____
DATE: _____

NAME: _____
ADDRESS: _____
CITY: _____
STATE: _____ ZIP: _____
HOME PHONE: _____
CELL PHONE: _____
EMPLOYER: _____
CO. ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____

SEX: (circle one) MALE FEMALE
AGE: _____
DATE OF BIRTH: _____
SOCIAL SECURITY: _____
E-MAIL ADDRESS: _____
BUSINESS PHONE: _____
OCCUPATION: _____
STUDENT STATUS: (circle one) HS COLLEGE FT/PT
MARITAL STATUS: _____

HOW WERE YOU REFERRED TO THIS OFFICE?

FRIEND: _____
PHYSICIAN: _____
OTHER: _____

TV RADIO PHONE BOOK MAILER
ATTY: _____
NEWSPAPER: _____

HEALTH INSURANCE

INS. CO: _____
INSURED'S NAME: _____
RELATIONSHIP TO INSURED: _____
POLICY #: _____
GROUP #: _____

SPOUSE'S INSURANCE

INS. CO: _____
INSURED'S NAME: _____
POLICY #: _____
SPOUSE'S SS#: _____
D.O.B. _____

Is your injury due to an accident? _____

Are you eligible for Medicare? _____

Did it occur at work? _____
If yes have you reported it to your employer?
_____

AUTHORIZATION TO RELEASE INFORMATIONS:
I herby authorize this clinic to release any information acquired in the courses of my examination or treatment

AUTHORIZATION OF BENEFITS:
I herby assign and grant the benefits that I am eligible to receive for professional services rendered in this office to this office. I understand that I am financially responsible for these charges not paid by my insurance.

PATIENTS SIGNATURE: _____ (PARENT IF MINOR)

**** PLEASE PRESENT YOU INSURANCE CARD WHEN RETURNING THIS FORM**
**** PAYMENT IS EXPECTED IN FULL UPON FIRST VISIT**

Ratio Wellness & Chiropractic
FINANCIAL POLICY REGARDING FEES

PLEASE NOTE THAT REGARDLESS OF INSURANCE BENEFITS AVAILABLE TO YOU, ANY FEES THAT ARE DENIED WILL BE YOUR RESPONSIBILTY TO PAY.

PLEASE CHECK ONE AND SIGN BELOW

_____ **I will pay for services as they are rendered.**

Treatment may be paid by cash, personal check or credit card. An insurance receipt will be issued upon request when the balance is paid in full

_____ **Group Health/Medical Insurance. Please bill my group health insurance directly.**

Please present you insurance ID card to the front desk personnel. Specific information is required for us to bill your insurance directly. Please sign our Office Policy form.

ALSO: If it is determined that we cannot bill your insurance directly, you will be advised that payment is required at time of service.

_____ **Workmen's Compensation Claim. Please bill my employer directly.**

Please advise the front desk personnel that your services are work-related. Specific information is required in order for us to bill this type of claim. Please complete the Workmen's Compensation Information Sheets.

_____ **Automatic Accident Injury Claim. Please bill my auto insurance directly.**

Please advise the front des personnel that your services are related to an auto accident. Specific information is required in order for us to bell this type of claim. Please complete the Auto Accident Information sheets.

_____ **Medicare Patient**

Our office will file your claim with Medicare for you. Your 20% co-pay will be due at the end of each visit after your $150 deductible has been met.

I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services tendered to me will be immediately due and payable.

Patient Signature _____

PAST HISTORY:

MARK "**X**" IF YOU EVER HAD OR NOW HAVE THE FOLLOWING CONDITIONS.

CIRCLE ALL CURRENT PROBLEMS.

_____ ALLERGIES
_____ ANEMIA
_____ ARTHRITIS
_____COLITIS
_____ DIABETES
_____ HYPOGLYCEMIA
_____ EPILEPSY
_____ POLIO
_____ ULCERS
_____ INJURIES
_____ DIZZINESS
_____ FAINTING
_____ HEADACHES
_____ TREMORS
_____ WEAKNESS/ FATIGUE
_____ GALLBLADDER TROUBLE
_____ LIVER TROUBLE
_____ THYROID TROUBLE
_____ VENEREAL DISEASE
_____ PNEUMONIA
_____ NERVOUSNESS
_____ SKIN PROBLEMS
_____ SMOKING
_____ HOSPITALIZAION
_____ OTHER

_____ WEIGHT GAIN OR LOSS
_____ HEARING DIFFICULT
_____ EYE TROUBLE/ GLASSES
_____ PERSISTENT COUGH
_____ CHEST PAIN
_____ BREATHING DIFFICULTY
_____ HEART TROUBLE
_____ RAPID HEARTBEAT
_____ HYPERTENSION
_____ CHOLESTEROL
_____ ABDOMINAL PAIN
_____ SWOLLEN JOINTS
_____ POOR APPETITE
_____ CONSTIPATION/ DIARRHEA
_____ NAUSEA/ VOMITING
_____ DIFFICULTY URINATING
_____ PARALYSIS
_____ TUMOR OR LUMPS
_____ CANCER
_____ JOINT PAINS
_____RHEUMATIC FEVER
_____ BREAST SORENESS
_____ VAGINAL PROBLEMS
_____ OPERATIONS (**LIST THEM**)

Please describe your current problem

_____

_____

How long have you had this condition? _____

HAVE YOU EVER HAD CHIRPORACTIC CARE? _____ DOCTOR'S NAME_____

NAME OF YOUR MEDICAL PHYSICIAN: _____

DATE OF LAST PHYSICAL EXAM: _____

DATE OF LAST LABORATORY TESTS: _____ LIST THEM: _____

LIST MEDICATIONS: -

_____

_____

Please answer the following questions:

1) Why did you choose to come to this clinic?

_____

_____

_____

2) For you to feel your treatment successful, what do you want to take place over the course of your care here?

_____

_____

_____

3) How long do you feel this will take?

_____

_____

4) What are the areas of your lifestyle that you would like to improve: (Circle, than prioritize #1, 2, 3 etc.)

My level of anxiety	My pace of living
Not enough quiet time and rest	My diet and nutrition program
My exercise program	My energy level

5) What is you present level of commitment to address any underlying causes of your signs and symptoms that related to your lifestyle? (Rate from 1 to 10 being with 10 being 100% committed)

_____

_____

6) How confident are you that you will follow through on the healthy lifestyle changes (e.g. nutrition and exercise) that it will take to achieve your wellness goals? (Rate 1 to 10, where 1 is “not at all” and 10 is “100%” certainty”).

_____

_____

_____

Name

1. Please state your ***primary*** reason for attending this clinic. If it involves a specific health condition, please describe ***in detail***. In your own words, list the very first time that you noticed the condition and describe carefully any factors that you suspect may have played a role in its onset and perpetuation. (Please attach a sheet if more space is required). _____

2. Is your health currently getting better, worse, or staying the same? How do you know?

3. What are the most significant measures that you have taken to date to improve your state of health?

4. Please list the 5 most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life?

5. Are you currently working with a professional counselor, psychologist, social worker, pastor or therapist? (Y/N) Select One

6. Have you consulted a medical doctor regarding the aforementioned condition? Please explain his/her diagnosis, therapy and the result.

FAMILY HISTORY:

7. Please indicate whether there is any history of the following conditions in your immediate family (grandparents, parents, siblings) and give details below:

Heart Disease, Cancer, Diabetes, Osteoarthritis, Ankylosing Spondylitis, Rheumatoid Arthritis, Multiple Sclerosis, Muscular Dystrophy, Mental Illness, Autoimmune disorders, Asthma, Allergies, Psoriasis, Eczema, Alcoholism, Drug Abuse or any other conditions which may be pertinent to your present state of health (please attach sheet if additional space is required).

PERSONAL HISTORY:

8. Were you considered a "difficult child", with history of colic or GI distress?

9. Were you breastfed as child? If so, what was your mother's health at the time? When was the previous pregnancy? (Please look into it if possible).

_____

_____

10. Did you require any medical attention, hospitalization, or medication as an infant (before age 2)? Y/N ____. If yes, please explain in detail. _____

_____

_____

11. Briefly describe your childhood diet: (i.e. favorite foods, intake of fruits and vegetables, intake of fast or packaged foods, etc.)

_____

_____

12. Do any smells, aromas, or volatile chemicals adversely affect you?

_____

13. What is your level of physical activity? _____

14. What do you feel is your weakest organ system, and why? (i.e. heart, kidney, lungs, etc.)_____

_____

15. How many times each year do you have a cold, sinusitis, the flu, sore throat, or bronchitis? How long do they usually last, and are they severe?_____

_____

16. Have you ever fainted, blacked out or had a convulsion? (Y/N) _____. Please describe.

_____

_____

Name:

DYSBIOSIS QUESTIONNAIRE AND SCORE SHEET FOR CHILD

Circle the appropriate point score for questions you answer "yes". Total your score and record it in the box at the end of the questionnaire.

Note: Dysbiosis refers to the condition where the normal healthy population of beneficial bacteria in the intestines has been disrupted, leaving it open to the overgrowth of yeast, fungi, parasites, and potentially harmful strains of bacteria. This intestinal imbalance in turn adversely effects other important organ systems via toxic stress and interfering with nutrient absorption and utilization.

HISTORY AND SYMPTOMS	POINT SCORE
1. During the two years before your child was born, were you (**mother**) bothered by recurrent vaginitis, menstrual irregularities, premenstrual tension, fatigue, headache, depression, digestive disorders, or "feeling bad all over"?	☐30
2. Was your child bothered by thrush? (Score 10 if mild, Score 20 if severe or persistent)	☐10 ☐20
3. Was your child bothered by frequent diaper rashes in infancy? (Score 10 if mild, 20 if severe or persistent)	☐10 ☐20
4. During infancy, was your child bothered by colic and irritability lasting over 3 months (Score 10 if mild, 20 if moderate or severe)	☐10 ☐20
5. Is your child's symptoms worse on damp days or in moldy places?	☐20
6. Has your child been bothered by recurrent or persistent "athlete's foot" or chronic fungus infections of his/her skin or nails?	☐30
7. Has your child been bothered by recurrent hives, eczema, or other skin problems?	☐30
8. Has your child received: A. 4 or more courses of antibiotic drugs during the past year? Or has he/she received continuous "prophylactic"	

courses of antibiotic drugs? ☐ 60

B. 8 or more courses of "broad-spectrum" antibiotics (such as Amoxicillin, Keflex, Septra, Bactrim, or Ceclor) during the past three years? ☐ 30

9. Has your child experienced recurrent ear infections? ☐ 10

10. Has your child had tubes inserted in his/her ears? ☐ 10

11. Has your child been labeled "hyperactive"? (Score 10 if mild, 20 if moderate or severe) ☐ 10 ☐ 20

12. Is your child bothered by learning problems even though his/her early development history was normal? ☐ 10

13. Does your child have a short attention span? ☐ 10

14. Is your child persistently irritable, unhappy, and hard to please? ☐ 10

15. Has your child been bothered by persistent or recurrent digestive problems, including constipation, diarrhea, bloating or excessive gas? (Score 10 if mild, 20 if moderate, or 30 if severe) ☐ 10 ☐ 20 ☐ 30

16. Has he/she been bothered by persistent nasal congestion, cough, and/or wheezing? ☐ 10

17. Is your child unusually tired or unhappy or depressed? (Score 10 if mild, 20 if severe) ☐ 10 ☐ 20

18. Has your child been bothered by recurrent headaches, abdominal pain, or muscle aches? (Score 10 if mild, 20 if severe) ☐ 10 ☐ 20

19. Does your child crave sweets? ☐ 10

20. Does exposure to perfume, insecticides, gas, or other chemicals provoke moderate to severe symptoms? ☐ 10

21. Does tobacco smoke really bother your child? ☐ 10

22. Do you feel that your child isn't well, yet diagnostic tests and studies haven't revealed the cause? ☐ 10

TOTAL SCORE 0

WEEKLY SYMPTOM INVENTORY CHECKLIST FOR CHILDREN

Name_____ Date_____

Rate each of the following symptoms based on your child's current health profile

Point Scale

0 - *Never* or *almost never* has the symptom
1 - *Occasionally* has symptoms
2 - *Frequently* has symptoms

HEAD

_____ Headaches
_____ Difficulty falling asleep
_____ Wakes up during the night Total 0

EYES

_____ Watery or itchy eyes
_____ Dark circles under eyes
_____ Bags under eyes
_____ Swollen eyelids Total 0

EARS

_____ Reddening of ears
_____ Itchy ears
_____ Earaches/Ear infections (circle which apply)
_____ Drainage from ear
_____ Hearing loss
_____ Frequent pulling on ears Total 0

NOSE

_____ Runny nose
_____ Stuffy nose
_____ Sneezing
_____ "Allergic Salute" (rubs, itches, wipes nose frequently with hands) Total 0

MOUTH/THROAT

_____ Swollen or red lips
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or sore or discolored tongue
_____ Swollen or sore gums or lips
_____ Canker sores Total 0

SKIN

_____ Easy bruising
_____ Hives
_____ Rash
_____ Dry or flaky skin
_____ Flushing
_____ Cold hands or feet
_____ Eczema

Total 0 _____

LUNGS

_____ Coughing
_____ Sneezing
_____ Difficulty breathing
_____ Wheezing

Total 0 _____

DIGESTIVE TRACT

_____ Nausea
_____ Vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching
_____ Passing gas (flatulence)
_____ Heartburn
_____ Tummy ache
_____ Poor appetite
_____ Refusal to eat

Total 0 _____

JOINTS/MUSCLE

_____ Coordination problems
_____ Pain in muscles (e.g., leg ache)
_____ Pain in joints (e.g., knee ache)

Total 0 _____

ENERGY

_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ Sleeping problems

Total 0 _____

MIND/EMOTIONS

_____ Inattentiveness or poor concentration
_____ Mood swings
_____ Anxiety, nervousness
_____ Fear
_____ Anger
_____ Irritability
_____ Aggressiveness (e.g. hitting, kicking, biting)
_____ Crying or weepiness

_____ Tantrums
_____ Hyperactivity

Total 0

OTHER

_____ Frequent urination
_____ Itching of anus or genitals
_____ Bed wetting
_____ Wetting or soiling of clothes

Total 0

GRAND TOTAL

TOTAL 0