Alternative Health Management

Patient Information

Patient's Full Name:	Cell Phone # Work#
Email Address:	Date of Birth:
Address:	Gender: Male Female
City: St: Zip:	Marital Status: Single/Married/Divorced/Widowed
Emergency Contact:	Referral Source:
Reason for Visit (Major Complaint):	When Did Symptoms First Start?
Medications Currently Taking:	Supplements Currently Taking:
Allergies (Drug, Food, or Other)	Diagnosed Conditions (Current or Past)
Any Hospitalizations or Surgeries:	Any Family History of Health Conditions:
Any Additional Details you would like the Dr. to know:	

Alternative Health Management
952 Echo Ln. Ste 115
Houston, TX 77024
Phone 713-722-2580 Fax 713-722-0055
AlternativeHealthManagement@yahoo.com

Nutritional Assessment Questionnaire 1.5

Name: _____ Date: ____/____/____

Birth Date: _____ Gender: _____

Please list your five major health concerns in order of importance:

1. _____
2. _____
3. _____
4. _____
5. _____

Notes:

PART I Read the following questions and circle the number that applies:

KEY: 0 = Do not consume or use
1 = Consume or use 2 to 3 times monthly
2 = Consume or use weekly
3 = Consume or use daily

DIET

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1. 0 1 2 3 Alcohol
2. 0 1 2 3 Artificial sweeteners
3. 0 1 2 3 Candy, desserts, refined sugar
4. 0 1 2 3 Carbonated beverages
5. 0 1 2 3 Chewing tobacco
6. 0 1 2 3 Cigarettes
7. 0 1 2 3 Cigars/pipes
8. 0 1 2 3 Caffeinated beverages
9. 0 1 2 3 Fast foods
10. 0 1 2 3 Fried foods
11. 0 1 2 3 Luncheon meats
12. 0 1 2 3 Margarine
13. 0 1 2 3 Milk products
14. 0 1 Radiation exposure (0=no, 1=yes)
15. 0 1 2 3 Refined flour/baked goods
16. 0 1 2 3 Vitamins and minerals
17. 0 1 2 3 Water, distilled
18. 0 1 2 3 Water, tap
19. 0 1 2 3 Water, well
20. 0 1 2 3 Diet often for weight control

LIFESTYLE

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21. 0 1 2 3 Exercise per week (0 = 2 or more times a week, 1 = 1 time a week, 2 = 1 or 2 times a month, 3 = never, less than once a month)
22. 0 1 2 3 Changed jobs (0 = over 12 months ago, 1 = within last 12 months, 2 = within last 6 months, 3 = within last 2 months)
23. 0 1 2 3 Divorced (0 = never, over 2 years ago, 1 = within last 2 years, 2 = within last year, 3 = within last 6 months)
24. 0 1 2 3 Work over 60 hours/week (0 = never, 1 = occasionally, 2 = usually, 3 = always)

MEDICATIONS Indicate any medications you're currently taking or have taken in the last month (0=no, 1=yes):

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25. 0 1 Antacids
26. 0 1 Antianxiety medications
27. 0 1 Antibiotics
28. 0 1 Anticonvulsants
29. 0 1 Antidepressants
30. 0 1 Antifungals
31. 0 1 Aspirin/Ibuprofen
32. 0 1 Asthma inhalers
33. 0 1 Beta blockers
34. 0 1 Birth control pills/implant contraceptives
35. 0 1 Chemotherapy
36. 0 1 Cholesterol lowering medications
37. 0 1 Cortisone/steroids
38. 0 1 Diabetic medications/insulin
39. 0 1 Diuretics
40. 0 1 Estrogen or progesterone (pharmaceutical, prescription)
41. 0 1 Estrogen or progesterone (natural)
42. 0 1 Heart medications
43. 0 1 High blood pressure medications
44. 0 1 Laxatives
45. 0 1 Recreational drugs
46. 0 1 Relaxants/Sleeping pills
47. 0 1 Testosterone (natural or prescription)
48. 0 1 Thyroid medication
49. 0 1 Acetaminophen (Tylenol)
50. 0 1 Ulcer medications
51. 0 1 Sildenafal citrate (Viagra)

PART II (See key at bottom of page)

Section 1

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52. 0 1 2 3 Belching or gas within one hour after eating
53. 0 1 2 3 Heartburn or acid reflux
54. 0 1 2 3 Bloating within one hour after eating
55. 0 1 Vegan diet (no dairy, meat, fish or eggs) (0=no, 1=yes)
56. 0 1 2 3 Bad breath (halitosis)
57. 0 1 2 3 Loss of taste for meat
58. 0 1 2 3 Sweat has a strong odor
59. 0 1 2 3 Stomach upset by taking vitamins
60. 0 1 2 3 Sense of excess fullness after meals
61. 0 1 2 3 Feel like skipping breakfast
62. 0 1 2 3 Feel better if you don't eat
63. 0 1 2 3 Sleepy after meals
64. 0 1 2 3 Fingernails chip, peel or break easily
65. 0 1 2 3 Anemia unresponsive to iron
66. 0 1 2 3 Stomach pains or cramps
67. 0 1 2 3 Diarrhea, chronic
68. 0 1 2 3 Diarrhea shortly after meals
69. 0 1 2 3 Black or tarry colored stools
70. 0 1 2 3 Undigested food in stool

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 2

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71. 0 1 2 3 Pain between shoulder blades
72. 0 1 2 3 Stomach upset by greasy foods
73. 0 1 2 3 Greasy or shiny stools
74. 0 1 2 3 Nausea
75. 0 1 2 3 Sea, car, airplane or motion sickness
76. 0 1 History of morning sickness (0 = no, 1 = yes)
77. 0 1 2 3 Light or clay colored stools
78. 0 1 2 3 Dry skin, itchy feet or skin peels on feet
79. 0 1 2 3 Headache over eyes
80. 0 1 2 3 Gallbladder attacks (0=never, 1=years ago, 2=within last year, 3=within past 3 months)
81. 0 1 Gallbladder removed (0=no, 1=yes)
82. 0 1 2 3 Bitter taste in mouth, especially after meals
83. 0 1 Become sick if you were to drink wine (0=no, 1=yes)
84. 0 1 Easily intoxicated if you were to drink wine (0=no, 1=yes)
85. 0 1 Easily hung over if you were to drink wine (0=no, 1=yes)
86. 0 1 2 3 Alcohol per week (0=<3, 1=<7, 2 =<14, 3=>14)
87. 0 1 Recovering alcoholic (0=no, 1=yes)
88. 0 1 History of drug or alcohol abuse (0=no, 1=yes)
89. 0 1 History of hepatitis (0=no, 1=yes)
90. 0 1 Long term use of prescription/recreational drugs (0=no, 1=yes)
91. 0 1 2 3 Sensitive to chemicals (perfume, cleaning agents, etc.)
92. 0 1 2 3 Sensitive to tobacco smoke
93. 0 1 2 3 Exposure to diesel fumes
94. 0 1 2 3 Pain under right side of rib cage
95. 0 1 2 3 Hemorrhoids or varicose veins
96. 0 1 2 3 Nutrasweet (aspartame) consumption
97. 0 1 2 3 Sensitive to Nutrasweet (aspartame)
98. 0 1 2 3 Chronic fatigue or Fibromyalgia

Section 3

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99. 0 1 2 3 Food allergies
100. 0 1 2 3 Abdominal bloating 1 to 2 hours after eating
101. 0 1 Specific foods make you tired or bloated (0=no, 1=yes)
102. 0 1 2 3 Pulse speeds after eating
103. 0 1 2 3 Airborne allergies
104. 0 1 2 3 Experience hives
105. 0 1 2 3 Sinus congestion, "stuffy head"
106. 0 1 2 3 Crave bread or noodles
107. 0 1 2 3 Alternating constipation and diarrhea
108. 0 1 2 3 Crohn's disease (0 =no, 1=yes in the past, 2=currently mild condition, 3=severe)
109. 0 1 2 3 Wheat or grain sensitivity
110. 0 1 2 3 Dairy sensitivity
111. 0 1 Are there foods you could not give up (0=no, 1=yes)
112. 0 1 2 3 Asthma, sinus infections, stuffy nose
113. 0 1 2 3 Bizarre vivid dreams, nightmares
114. 0 1 2 3 Use over-the-counter pain medications
115. 0 1 2 3 Feel spacey or unreal

Section 4

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116. 0 1 2 3 Anus itches
117. 0 1 2 3 Coated tongue
118. 0 1 2 3 Feel worse in moldy or musty place
119. 0 1 2 3 Taken antibiotic for a total accumulated time of (0=never, 1= <1 month, 2= <3 months, 3= >3 months)
120. 0 1 2 3 Fungus or yeast infections
121. 0 1 2 3 Ring worm, "jock itch", "athletes foot", nail fungus
122. 0 1 2 3 Yeast symptoms increase with sugar, starch or alcohol
123. 0 1 2 3 Stools hard or difficult to pass
124. 0 1 History of parasites (0=no, 1=yes)
125. 0 1 2 3 Less than one bowel movement per day
126. 0 1 2 3 Stools have corners or edges, are flat or ribbon shaped
127. 0 1 2 3 Stools are not well formed (loose)
128. 0 1 2 3 Irritable bowel or mucus colitis
129. 0 1 2 3 Blood in stool
130. 0 1 2 3 Mucus in stool
131. 0 1 2 3 Excessive foul smelling lower bowel gas
132. 0 1 2 3 Bad breath or strong body odors
133. 0 1 2 3 Painful to press along outer sides of thighs (Iliotibial Band)
134. 0 1 2 3 Cramping in lower abdominal region
135. 0 1 2 3 Dark circles under eyes

Section 5

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136. 0 1 History of carpal tunnel syndrome (0=no, 1=yes)
137. 0 1 History of lower right abdominal pains or ileocecal valve problems (0=no, 1=yes)
138. 0 1 History of stress fracture (0=no, 1=yes)
139. 0 1 2 3 Bone loss (reduced density on bone scan)
140. 0 1 Are you shorter than you used to be? (0=no, 1=yes)
141. 0 1 2 3 Calf, foot or toe cramps at rest
142. 0 1 2 3 Cold sores, fever blisters or herpes lesions
143. 0 1 2 3 Frequent fevers
144. 0 1 2 3 Frequent skin rashes and/or hives
145. 0 1 Herniated disc (0=no, 1=yes)
146. 0 1 2 3 Excessively flexible joints, "double jointed"
147. 0 1 2 3 Joints pop or click
148. 0 1 2 3 Pain or swelling in joints
149. 0 1 2 3 Bursitis or tendonitis
150. 0 1 History of bone spurs (0=no, 1=yes)
151. 0 1 2 3 Morning stiffness
152. 0 1 2 3 Nausea with vomiting
153. 0 1 2 3 Crave chocolate
154. 0 1 2 3 Feet have a strong odor
155. 0 1 2 3 History of anemia
156. 0 1 2 3 Whites of eyes (sclera) blue tinted
157. 0 1 2 3 Hoarseness
158. 0 1 2 3 Difficulty swallowing
159. 0 1 2 3 Lump in throat
160. 0 1 2 3 Dry mouth, eyes and/or nose
161. 0 1 2 3 Gag easily
162. 0 1 2 3 White spots on fingernails
163. 0 1 2 3 Cuts heal slowly and/or scar easily
164. 0 1 2 3 Decreased sense of taste or smell

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 6

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165. 0 1 Experience pain relief with aspirin (0=no, 1=yes)
166. 0 1 2 3 Crave fatty or greasy foods
167. 0 1 2 3 Low- or reduced-fat diet (0=never, 1=years ago, 2=within past year, 3=currently)
168. 0 1 2 3 Tension headaches at base of skull
169. 0 1 2 3 Headaches when out in the hot sun
170. 0 1 2 3 Sunburn easily or suffer sun poisoning
171. 0 1 2 3 Muscles easily fatigued
172. 0 1 2 3 Dry flaky skin or dandruff

Section 7

39

173. 0 1 2 3 Awaken a few hours after falling asleep, hard to get back to sleep
174. 0 1 2 3 Crave sweets
175. 0 1 2 3 Binge or uncontrolled eating
176. 0 1 2 3 Excessive appetite
177. 0 1 2 3 Crave coffee or sugar in the afternoon
178. 0 1 2 3 Sleepy in afternoon
179. 0 1 2 3 Fatigue that is relieved by eating
180. 0 1 2 3 Headache if meals are skipped or delayed
181. 0 1 2 3 Irritable before meals
182. 0 1 2 3 Shaky if meals delayed
183. 0 1 2 3 Family members with diabetes (0=none, 1=1 or 2, 2=3 or 4, 3=more than 4)
184. 0 1 2 3 Frequent thirst
185. 0 1 2 3 Frequent urination

Section 8

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186. 0 1 2 3 Muscles become easily fatigued
187. 0 1 2 3 Feel exhausted or sore after moderate exercise
188. 0 1 2 3 Vulnerable to insect bites
189. 0 1 2 3 Loss of muscle tone, heaviness in arms/legs
190. 0 1 2 3 Enlarged heart or congestive heart failure
191. 0 1 2 3 Pulse below 65 per minute (0=no, 1=yes)
192. 0 1 2 3 Ringing in the ears (Tinnitus)
193. 0 1 2 3 Numbness, tingling or itching in hands and feet
194. 0 1 2 3 Depressed
195. 0 1 2 3 Fear of impending doom
196. 0 1 2 3 Worrier, apprehensive, anxious
197. 0 1 2 3 Nervous or agitated
198. 0 1 2 3 Feelings of insecurity
199. 0 1 2 3 Heart races
200. 0 1 2 3 Can hear heart beat on pillow at night
201. 0 1 2 3 Whole body or limb jerk as falling asleep
202. 0 1 2 3 Night sweats
203. 0 1 2 3 Restless leg syndrome
204. 0 1 2 3 Cracks at corner of mouth (Cheilosis)
205. 0 1 2 3 Fragile skin, easily chaffed, as in shaving
206. 0 1 2 3 Polyps or warts
207. 0 1 2 3 MSG sensitivity
208. 0 1 2 3 Wake up without remembering dreams
209. 0 1 2 3 Small bumps on back of arms
210. 0 1 2 3 Strong light at night irritates eyes
211. 0 1 2 3 Nose bleeds and/or tend to bruise easily
212. 0 1 2 3 Bleeding gums especially when brushing teeth

Section 9

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213. 0 1 2 3 Tend to be a "night person"
214. 0 1 2 3 Difficulty falling asleep
215. 0 1 2 3 Slow starter in the morning
216. 0 1 2 3 Tend to be keyed up, trouble calming down
217. 0 1 2 3 Blood pressure above 120/80
218. 0 1 2 3 Headache after exercising
219. 0 1 2 3 Feeling wired or jittery after drinking coffee
220. 0 1 2 3 Clench or grind teeth
221. 0 1 2 3 Calm on the outside, troubled on the inside
222. 0 1 2 3 Chronic low back pain, worse with fatigue
223. 0 1 2 3 Become dizzy when standing up suddenly
224. 0 1 2 3 Difficulty maintaining manipulative correction
225. 0 1 2 3 Pain after manipulative correction
226. 0 1 2 3 Arthritic tendencies
227. 0 1 2 3 Crave salty foods
228. 0 1 2 3 Salt foods before tasting
229. 0 1 2 3 Perspire easily
230. 0 1 2 3 Chronic fatigue, or get drowsy often
231. 0 1 2 3 Afternoon yawning
232. 0 1 2 3 Afternoon headache
233. 0 1 2 3 Asthma, wheezing or difficulty breathing
234. 0 1 2 3 Pain on the medial or inner side of the knee
235. 0 1 2 3 Tendency to sprain ankles or "shin splints"
236. 0 1 2 3 Tendency to need sunglasses
237. 0 1 2 3 Allergies and/or hives
238. 0 1 2 3 Weakness, dizziness

Section 10

29

239. 0 1 Height over 6' 6" (0=no, 1=yes)
240. 0 1 Early sexual development (before age 10) (0=no, 1=yes)
241. 0 1 2 3 Increased libido
242. 0 1 2 3 Splitting type headache
243. 0 1 2 3 Memory failing
244. 0 1 Tolerate sugar, feel fine when eating sugar (0=no, 1=yes)
245. 0 1 Height under 4' 10" (0=no, 1=yes)
246. 0 1 2 3 Decreased libido
247. 0 1 2 3 Excessive thirst
248. 0 1 2 3 Weight gain around hips or waist
249. 0 1 2 3 Menstrual disorders
250. 0 1 Delayed sexual development (after age 13) (0=no, 1=yes)
251. 0 1 2 3 Tendency to ulcers or colitis

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

Section 11

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252. 0 1 2 3 Sensitive/allergic to iodine
253. 0 1 2 3 Difficulty gaining weight, even with large appetite
254. 0 1 2 3 Nervous, emotional, can't work under pressure
255. 0 1 2 3 Inward trembling
256. 0 1 2 3 Flush easily
257. 0 1 2 3 Fast pulse at rest
258. 0 1 2 3 Intolerance to high temperatures
259. 0 1 2 3 Difficulty losing weight
260. 0 1 2 3 Mentally sluggish, reduced initiative
261. 0 1 2 3 Easily fatigued, sleepy during the day
262. 0 1 2 3 Sensitive to cold, poor circulation (cold hands and feet)
263. 0 1 2 3 Constipation, chronic
264. 0 1 2 3 Excessive hair loss and/or coarse hair
265. 0 1 2 3 Morning headaches, wear off during the day
266. 0 1 2 3 Loss of lateral 1/3 of eyebrow
267. 0 1 2 3 Seasonal sadness

Section 12 – Men Only

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268. 0 1 2 3 Prostate problems
269. 0 1 2 3 Difficulty with urination, dribbling
270. 0 1 2 3 Difficult to start and stop urine stream
271. 0 1 2 3 Pain or burning with urination
272. 0 1 2 3 Waking to urinate at night
273. 0 1 2 3 Interruption of stream during urination
274. 0 1 2 3 Pain on inside of legs or heels
275. 0 1 2 3 Feeling of incomplete bowel evacuation
276. 0 1 2 3 Decreased sexual function

Section 13 – Women Only

60

277. 0 1 2 3 Depression during periods
278. 0 1 2 3 Mood swings associated with periods (PMS)
279. 0 1 2 3 Crave chocolate around periods
280. 0 1 2 3 Breast tenderness associated with cycle
281. 0 1 2 3 Excessive menstrual flow
282. 0 1 2 3 Scanty blood flow during periods
283. 0 1 2 3 Occasional skipped periods
284. 0 1 2 3 Variations in menstrual cycles
285. 0 1 2 3 Endometriosis
286. 0 1 2 3 Uterine fibroids
287. 0 1 2 3 Breast fibroids, benign masses
288. 0 1 2 3 Painful intercourse (dysparenia)
289. 0 1 2 3 Vaginal discharge
290. 0 1 2 3 Vaginal dryness
291. 0 1 2 3 Vaginal itchiness
292. 0 1 2 3 Gain weight around hips, thighs and buttocks
293. 0 1 2 3 Excess facial or body hair
294. 0 1 2 3 Hot flashes
295. 0 1 2 3 Night sweats (in menopausal females)
296. 0 1 2 3 Thinning skin

Section 14

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297. 0 1 2 3 Aware of heavy and/or irregular breathing
298. 0 1 2 3 Discomfort at high altitudes
299. 0 1 2 3 "Air hunger" or sigh frequently
300. 0 1 2 3 Compelled to open windows in a closed room
301. 0 1 2 3 Shortness of breath with moderate exertion
302. 0 1 2 3 Ankles swell, especially at end of day
303. 0 1 2 3 Cough at night
304. 0 1 2 3 Blush or face turns red for no reason
305. 0 1 2 3 Dull pain or tightness in chest and/or radiate into right arm, worse with exertion
306. 0 1 2 3 Muscle cramps with exertion

Section 15

13

307. 0 1 2 3 Pain in mid-back region
308. 0 1 2 3 Puffy around the eyes, dark circles under eyes
309. 0 1 History of kidney stones (0=no, 1=yes)
310. 0 1 2 3 Cloudy, bloody or darkened urine
311. 0 1 2 3 Urine has a strong odor

Section 16

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312. 0 1 2 3 Runny or drippy nose
313. 0 1 2 3 Catch colds at the beginning of winter
314. 0 1 2 3 Mucus producing cough
315. 0 1 2 3 Frequent colds or flu (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
316. 0 1 2 3 Other infections (sinus, ear, lung, skin, bladder, kidney, etc.) (0=1 or less per year, 1=2 to 3 times per year, 2=4 to 5 times per year, 3=6 or more times per year)
317. 0 1 2 3 Never get sick (0 = sick only 1 or 2 times in last 2 years, 1 = not sick in last 2 years, 2 = not sick in last 4 years, 3 = not sick in last 7 years)
318. 0 1 2 3 Acne (adult)
319. 0 1 2 3 Itchy skin (Dermatitis)
320. 0 1 2 3 Cysts, boils, rashes
321. 0 1 2 3 History of Epstein Bar, Mono, Herpes, Shingles, Chronic Fatigue Syndrome, Hepatitis or other chronic viral condition (0 = no, 1 = yes in the past, 2 = currently mild condition, 3 = severe)

KEY: 0=No, symptom does not occur
1=Yes, minor or mild symptom, rarely occurs (monthly)
2=Moderate symptom, occurs occasionally (weekly)
3=Severe symptom, occurs frequently (daily)

NUTRITION CONSULTING INFORMED CONSENT

I hereby request and consent to nutritional care/consulting on me (or on the client named below, for whom I am legally responsible) provided by the health practitioner and/or his/her staff.

I understand and am informed that the nutrition consultations may not be made by medical physicians and do not dispense medical advice, diagnose illness or disease, offer prescription drugs, surgery, or other conventional treatments.

I understand and am informed that the nutrition consultations offer nutritional evaluations, nutritional supplementation, and lifestyle consultation along with various methods of testing. I further understand and am informed that the recommendations, discussion, sale of food, nutrition, nutritional supplements, vitamins or minerals, food grade herbs, or other nutrients as foods for special dietary use only provided by the health practitioner and/or his/her staff pertain to the whole body concept of nutrition, and does not relate in the context of any specific ailment or condition.

I understand and am informed that methods of nutritional evaluation or testing made available to me are not intended to diagnose disease. Rather, these assessment tests are intended as a guide to developing an appropriate overall health-supportive program for me, and to monitor my progress in achieving my goals. I further understand that any nutritional recommendations are supportive in nature allowing the body to return to improved health. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued. However, Products are refundable within 30 days of purchase if they are unopened and in original condition, including not past their expiration date.

I understand and am informed that the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients that have been recommended are traditionally considered safe in the practice of nutrition, however, some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be toxic in large doses. I understand that some nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients may be inappropriate during pregnancy, and I will notify the health practitioner and/or his/her staff if I am or become pregnant.

I will also inform the health practitioner and/or his/her staff if I experience any gastrointestinal upset (including but not limited to nausea, gas, stomachache, vomiting), allergic reactions (including but not limited to hives, rashes, tingling of the tongue, headache), or any unanticipated or unpleasant effects associated with the nutritional supplements, vitamins, minerals, food grade herbs, and other nutrients recommended by the health practitioner and/or his/her staff.

I have had an opportunity to ask questions about its content, and by signing below I agree to the above-named services. I intend this consent to cover the entire course of nutritional care/consulting.

I, _____ have read, or have had read to me, the above consent.
(Print Name)

_____ _____
(Signature) *(Date)*

Consent to evaluate and treat a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above consent and hereby grant permission for my child to receive care.

_____ _____
(Signature) *(Date)*

CHIROPRACTIC INFORMED CONSENT

I hereby request and consent to the performance of chiropractic procedures, including various modes of physiotherapy, diagnostic x-rays, and any supportive therapies on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic indicated below and/or other licensed doctors of chiropractic and support staff who now or in the future treat me while employed by, working or associated with or serving as back-up for the doctor of chiropractic named below, including those working at the clinic or office listed below or any other office or clinic, whether signatories to this form or not.

I have had an opportunity to discuss with the doctor of chiropractic named below and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and procedures.

I understand and I am informed that, as is with all Healthcare treatments, results are not guaranteed and there is no promise to cure. I further understand and I am informed that, as is with all Healthcare treatments, in the practice of chiropractic there are some risks to treatment, including, but not limited to, muscle spasms for short periods of time, aggravating and/or temporary increase in symptoms, lack in improvement of symptoms, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I further understand that Chiropractic adjustments and supportive treatment is designed to reduce and/or correct subluxations allowing the body to return to improved health. It can also alleviate certain symptoms through a conservative approach with hopes to avoid more invasive procedures. However, like all other health modalities, results are not guaranteed and there is no promise to cure. Accordingly, I understand that all payment(s) for treatment(s) are final and no refunds will be issued.

I further understand that there are treatment options available for my condition other than chiropractic procedures. These treatment options include, but not limited self-administered, over the counter analgesics and rest; medical care with prescription drugs such as anti-inflammatories, muscle relaxants and painkillers; physical therapy; steroid injections; bracing; and surgery. I understand and have been informed that I have the right to a second opinion and secure other opinions if I have concerns as to the nature of my symptoms and treatment options.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

I, _____ have read and fully understand the above statements.
(Print Name)

_____ _____
(Signature) *(Date)*

Consent to evaluate and adjust a minor child:

I, _____ being the parent or legal guardian of _____ have read and fully understand the above statements and hereby grant permission for my child to receive chiropractic care.

_____ _____
(Signature) *(Date)*

Alternative Health Management

Patient Information

Financial Agreement

I understand that all services rendered on a cash, check, or credit card basis and are to be paid at the time of service for any services or any products I wish to purchase. I also agree to the $25 returned check charge in the event that my check is returned.

Patient's Initials _____

Acknowledgement of Receipt of Notice of Privacy Practices

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operation

Patient's Initials _____

Missed Appointment Policy (No Call/No Show)

I understand that I will be charged a fee if I miss my scheduled appointment time without giving a 24hr notice of cancellation. No Call/ No Shows are subject to the entire amount of the service they are scheduled. Same day cancellations will be subject to $35 cancellation fee. My scheduled time is set aside for me, therefore, another patient cannot be scheduled during that period on that day. I also understand that if I am late for my scheduled appointment or do not have the new patient paperwork complete in its entirety I may be asked to wait allowing the next patient to be seen, or may have to reschedule.

Patient's Initials _____

30 Day Return Policy

I understand the nutritional supplements; homeopathic remedies and/or other supplies are available for purchase. Any product brought in for a refund or exchange must be within the 30 days of the original purchase date. Seals cannot be broken on any packaging and must be in the original boxes if applicable. Returns are subject to a 10% Restocking fee.

Patient's Initials _____

Alternative Health Management
952 Echo Ln. Ste 115
Houston, TX 77024
Phone 713-722-2580 Fax 713-722-0055
AlternativeHealthManagement@yahoo.com

CREDIT CARD AUTHORIZATION FORM

To Schedule an appointment this form must be returned to our office no later than 12:00pm (noon) the day before your scheduled appointment. You may fax or email this form to: Alternativehealthmanagement@yahoo.com **or 713-722-0055 (fax)**
If you have already provided us with your credit card information by phone, please simply sign and date the form, and write "Card on File" Across the credit card account number area and you may bring the form in with you to your scheduled appointment. *

Please note that your debit/credit card will not be charged to hold this appointment.

However, if you **DO NOT** show for your appointment or cancel within 24 hours, your account will be charged for the length of your scheduled appointment time ($85-$150)

Patient paperwork needs to be **COMPLETELY** filled out prior to your scheduled appointment time. If upon arriving your paperwork is not complete, we may need to reschedule your appointment and you will be charged for the time your appointment was scheduled.

Your appointment is very important to Dr. Howell and the staff of Alternative Health Management. Dr. Howell makes every effort to stay on schedule, so you are not inconvenienced by delays. Thank you for your compliance.

Name on Card: _____

Visa_____ Mastercard____ American Express____

Account Number: _____

Expiration Date: _____/_____

Security Code: _____

Billing Address:_____

Phone Number: _____

By Signing this form, you authorize Alternative Health Management to charge your card for any missed appointment fees that you incur if you do not contact their office within 24hrs of your appointment.

Print Name: _____

Sign: _____ Date:_____/_____/_____

HIPAA SHORT FORM NOTICE OF PRIVACY PRACTICES

We understand that health information about you is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us because we need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all the records of your care generated by this office, whether made by your personal doctor, or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private
- Give you this Notice of our legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment
- For payment
- For health care operations
- For appointment reminders
- As required by law
- To avert a serious threat to health and safety
- As required by the military or Veterans' and workers' compensation organizations
- Public health risks
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National security and intelligence activities

Your rights regarding Health Information about you:

- Right to inspect and copy records
- Right to amend records
- Right to an accounting of disclosures
- Right to request restrictions
- Right to request confidential communication, electronically or by paper
- Right to a paper copy of this Notice *(full Notice is available upon request)*

Changes to this Notice:
We reserve the right to change this Notice. We will post a copy of the current Notice in our facility with the current effective date.

Complaints:
If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please address all complaints to:

Alternative Health
Management
952 Echo Lane Ste. #115
Houston, Texas 77024

We will request that you acknowledge your receipt of this notice on the demographics form you complete for us. This acknowledgement will become a part of your records. This acknowledgement provides that you have declined to accept the Complete Notice and instead reviewed this Short Form. We post a copy of the Current Complete Notice of Privacy Practices in our facility and you may also ask for a copy from the receptionist.