Alternative Health Management

952 Echo Ln. Ste 115 • Houston, TX 77024
Phone: 713-722-2580 • Fax: 713-722-0055
Email: AlternativeHealthManagement@yahoo.com

New Patient Intake & Assessment Packet

📄 Instructions for New Patients

To schedule your first appointment, all new patients must complete this packet in full and submit the completed forms along with the Credit Card Authorization Form by email or fax.

Appointments will not be scheduled until all forms are received.

📜 Office Policies

To ensure appointment availability and maintain efficient scheduling, the following policies apply:

No-Show Policy: Missing an appointment without 24-hour prior notice results in being charged the full cost of the scheduled appointment.

Same-Day Cancellation Fee: Canceling on the same day as your appointment results in a $35 fee.

Late Arrival Policy: Arriving more than 10 minutes late requires rescheduling and results in a $35 late-cancellation fee.

📝 Submission Instructions

Please send your completed packet and credit card authorization form to:

📧 Email: AlternativeHealthManagement@yahoo.com

📠 Fax: 713-722-0055

Once received, our office will contact you to schedule your appointment.

✅ Thank You

We look forward to supporting your health and wellness journey at Alternative Health Management.

Patient Information Form

Patient Name: _____
Date of Birth: _____Current Age:_____
Gender: ☐ Male ☐ Female
Cell Phone: _____
Work Phone: _____
Email Address: _____
Address: _____
City: _____ State: _____ Zip: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact: _____
Phone: _____

Referral Source: _____

Reason for Visit (Major Complaint):_____

When Did Symptoms Start? _____

Medications Currently
Taking:_____
_____

Supplements Currently
Taking:_____
_____

Allergies (Drug, Food, Other):_____

Diagnosed Conditions (Current or
Past):_____
_____

Hospitalizations or Surgeries:
_____
_____

Family History of Health Conditions: _____

Additional Details for the Doctor:_____

Nutritional Assessment Questionnaire
Check the box that applies to each item:

0 = Never • 1 = Monthly • 2 = Weekly • 3 = Daily/Frequent

Diet & Lifestyle Overview
Alcohol ☐0 ☐1 ☐2 ☐3
Artificial sweeteners ☐0 ☐1 ☐2 ☐3
Caffeinated beverages ☐0 ☐1 ☐2 ☐3
Fast foods ☐0 ☐1 ☐2 ☐3
Fried foods ☐0 ☐1 ☐2 ☐3
Refined sugar/desserts ☐0 ☐1 ☐2 ☐3
Water intake: Tap ☐0 ☐1 ☐2 ☐3 • Distilled ☐0 ☐1 ☐2 ☐3
• Well ☐0 ☐1 ☐2 ☐3
Exercise frequency ☐0 ☐1 ☐2 ☐3

Medication Use (Past 30 Days)
Antacids ☐0 ☐1
Antibiotics ☐0 ☐1
Antidepressants ☐0 ☐1
Blood pressure meds ☐0 ☐1
Thyroid meds ☐0 ☐1
Pain relievers (OTC) ☐0 ☐1
Steroids ☐0 ☐1
Recreational drugs ☐0 ☐1

Digestive Health

Heartburn ☐0 ☐1 ☐2 ☐3
Nausea ☐0 ☐1 ☐2 ☐3
Gas/bloating after meals ☐0 ☐1 ☐2 ☐3
Pain Between shoulder blades ☐0 ☐1 ☐2 ☐3
Stomach Upset by greasy foods ☐0 ☐1 ☐2 ☐3
Gallbladder Attacks ☐0 ☐1 ☐2 ☐3
Bad breath ☐0 ☐1 ☐2 ☐3
Diarrhea ☐0 ☐1 ☐2 ☐3
Unformed Stools ☐0 ☐1 ☐2 ☐3
Constipation ☐0 ☐1 ☐2 ☐3
Undigested food in stool ☐0 ☐1 ☐2 ☐3
Blood in stool ☐0 ☐1 ☐2 ☐3
Hemorrhoids ☐0 ☐1 ☐2 ☐3

Food Sensitivities & Allergies

Food allergies ☐0 ☐1 ☐2 ☐3
Dairy sensitivity ☐0 ☐1 ☐2 ☐3
Wheat/grain sensitivity ☐0 ☐1 ☐2 ☐3
Sinus congestion ☐0 ☐1 ☐2 ☐3
Craving bread/noodles ☐0 ☐1 ☐2 ☐3
Craving Sweets ☐0 ☐1 ☐2 ☐3
Coated Tongue ☐0 ☐1 ☐2 ☐3
Anal itching ☐0 ☐1 ☐2 ☐3

Energy & Mood

Fatigue ☐0 ☐1 ☐2 ☐3
Depression ☐0 ☐1 ☐2 ☐3
Anxiety ☐0 ☐1 ☐2 ☐3
Irritability ☐0 ☐1 ☐2 ☐3
Worries often ☐0 ☐1 ☐2 ☐3
Difficulty Going to Sleep ☐0 ☐1 ☐2 ☐
Difficulty Staying Asleep ☐0 ☐1 ☐2 ☐3

Immune Function
Frequent colds ☐0 ☐1 ☐2 ☐3
Chronic infections ☐0 ☐1 ☐2 ☐3
Skin issues (acne, rashes) ☐0 ☐1 ☐2 ☐3
Runny or dripping nose ☐0 ☐1 ☐2 ☐3
Mucous producing cough ☐0 ☐1 ☐2 ☐3
Nighttime urination ☐0 ☐1 ☐2 ☐3
History of: Epstein Bar ☐ Mono ☐ Herpes ☐ Shingles ☐ Hepatitis ☐

Men's Health (If Applicable)
Prostate concerns ☐0 ☐1 ☐2 ☐3
Urination difficulty ☐0 ☐1 ☐2 ☐3
Decreased sexual function ☐0 ☐1 ☐2 ☐3

Women's Health (If Applicable)
PMS symptoms ☐0 ☐1 ☐2 ☐3
Irregular cycles ☐0 ☐1 ☐2 ☐3
Hot flashes ☐0 ☐1 ☐2 ☐3
Breast tenderness ☐0 ☐1 ☐2 ☐3
Skipped Periods ☐0 ☐1 ☐2 ☐3
Vaginal Discharge ☐0 ☐1 ☐2 ☐3
Pain During Intercourse ☐0 ☐1 ☐2 ☐3
Thinning Hair ☐0 ☐1 ☐2 ☐3
Vaginal Dryness ☐0 ☐1 ☐2 ☐3

💳 Credit Card Authorization Form

Required to schedule any appointment.

Patient Name: _____

Cardholder Name: _____

Billing Address: _____

Card Type: ☐ Visa ☐ MasterCard ☐ AmEx ☐ Discover

Card Number: _____

Expiration Date: _____ CVV: _____

Phone Number: _____

Authorization:

I authorize Alternative Health Management to charge my card for:

Missed appointments without 24-hour notice (full appointment cost)

Same-day cancellations ($35 fee)

Late arrivals over 10 minutes requiring rescheduling ($35 fee)

Signature: _____ Date: _____

By signing the Credit Card Authorization Form, you acknowledge and accept these policies.

Alternative Health Management

HIPPA AND OFFICE POLICY PATIENT FORMS

1. HIPAA Short Form Notice of Privacy Practices

Health information about you is personal. Alternative Health Management is committed to protecting it and maintaining records needed to provide quality care and comply with legal requirements. This short notice explains how health information may be used/disclosed, your rights, and our obligations.

Required by law:

- Keep health information that identifies you private.
- Provide this Notice of our legal duties and privacy practices.
- Follow the terms of the Notice currently in effect.

Permitted uses/disclosures:

- Treatment
- Payment
- Health care operations
- Appointment reminders
- As required by law
- To avert a serious threat to health or safety
- As required by the military, Veterans' organizations, or 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:

- Inspect and copy records.
- Request amendment of records.
- Receive an accounting of disclosures.
- Request restrictions.
- Request confidential communication electronically or by paper.
- Request a paper copy of the full Notice (available upon request).

Changes:

We reserve the right to change this Notice. A current copy with the effective date will be posted in the facility.

Complaints:

If you believe your privacy rights have been violated, you may file a written complaint with us. Address complaints to Alternative Health Management, 952 Echo Lane, Ste. #115, Houston, Texas 77024.

Patient Acknowledgement: _____ Date: _____

2. Patient Policies & Agreements

Financial Agreement

All services and products are payable at the time of service by cash, check, or credit card. A $25 returned-check charge applies if a check is returned.

Patient Initials: _____

Missed Appointment Policy (No Call/No Show)

A fee applies if I miss a scheduled appointment without at least 24 hours' notice. No Call/No Shows are charged the entire amount of the scheduled service. Same-day cancellations are subject to a $35 cancellation fee. Because my appointment time is reserved for me, another patient cannot be scheduled during that period. If I arrive late or do not have required new-patient paperwork completed, I may have to wait while the next patient is seen or may need to reschedule.

Patient Initials: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I have been provided a Notice of Privacy Practices with a more complete description of information uses and disclosures. I understand I may review the Notice before signing; object to use of my health information for directory purposes; and request restrictions on how my health information may be used or disclosed for treatment, payment, or health care operations.

Patient Initials: _____

30-Day Return Policy

Nutritional supplements, homeopathic remedies, and other supplies may be purchased. Products returned for refund or exchange must be returned within 30 days of purchase, with seals unbroken and in original boxes when applicable. Returns are subject to a 10% restocking fee.

Patient Initials: _____

Patient Signature: _____ Date: _____

Alternative Health Management

3. Chiropractic & Nutrition Consulting Informed Consent

CHIROPRACTIC INFORMED CONSENT

I request and consent to chiropractic procedures, including various modes of physiotherapy and supportive therapies, provided by the named chiropractor and/or other licensed chiropractors and support staff who treat me now or in the future while employed by, working with, associated with, or serving as backup for the chiropractor. This includes staff at the listed clinic/office or another office/clinic, whether or not they sign this form.

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

I understand that results are not guaranteed and there is no promise to cure. Chiropractic treatment may involve risks, including muscle spasms for short periods, aggravation or temporary increase in symptoms, lack of improvement, fractures, disc injuries, strokes, dislocations, and sprains. I understand the doctor may not be able to anticipate or explain every risk or complication, and I authorize the doctor to exercise professional judgment during the procedure based on the facts known at the time.

I understand chiropractic adjustments and supportive treatment are intended to reduce and/or correct subluxations and may alleviate certain symptoms through a conservative approach intended, when possible, to avoid more invasive procedures. Results are not guaranteed and there is no promise to cure. Payments for treatment are final; no refunds will be issued.

I understand other options may be available, including rest and supportive self-care; medical evaluation and care; physical therapy; steroid injections; bracing; and surgery. I understand I have the right to a second opinion and may seek other opinions about my symptoms and treatment options.

I have read or had the above consent read to me, had an opportunity to ask questions, and agree to the named procedures. This consent is intended to cover the entire course of treatment for my present condition and any future condition(s) for which I seek treatment.

Patient/Responsible Adult: I have read and fully understand the above statements.

Print Name: _____

Signature: _____

Date: _____

Consent for Minor Child

Parent/Guardian Signature: _____

Date: _____

NUTRITION CONSULTING INFORMED CONSENT

I request and consent to nutritional care/consulting for myself or the client for whom I am legally responsible, provided by the health practitioner and/or staff.

Nutrition consultations may not be provided by medical physicians and do not provide medical advice, diagnose illness or disease, perform surgery, or provide other conventional treatments. Services may include nutritional evaluations, nutritional supplementation, lifestyle consultation, and various testing methods.

Recommendations, discussions, and sale of food, nutrition, supplements, vitamins, minerals, food-grade herbs, and other nutrients for special dietary use relate to the practitioner's whole-body concept of nutrition and are not made in the context of a specific ailment or condition.

Nutritional evaluation/testing is not intended to diagnose disease; it is intended to guide an overall health-supportive program and monitor progress toward goals.

Recommendations are supportive in nature. Results are not guaranteed and there is no promise to cure.

Payments for treatment are final and nonrefundable.

Products are refundable within 30 days of purchase only if unopened, in original condition, and not past the expiration date.

Recommended supplements, vitamins, minerals, food-grade herbs, and other nutrients are traditionally considered safe in nutritional practice, but some may be toxic in large doses or inappropriate during pregnancy. I will notify the practitioner/staff if I am or become pregnant.

I will notify the practitioner/staff if I experience gastrointestinal upset (including nausea, gas, stomachache, or vomiting), allergic reactions (including hives, rashes, tongue tingling, or headache), or any unexpected or unpleasant effects associated with recommended nutritional products.

I have had an opportunity to ask questions and, by signing, agree to the named services. This consent covers the entire course of nutritional care/consulting.

Patient/Responsible Adult: I have read or had the above consent read to me.

Print Name: _____

Signature: _____

Date: _____

Consent for Minor Child

Parent/Guardian Signature: _____

Date: _____