

## PATIENT INTRODUCTION

Date: \_\_\_\_\_ Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Patient's Name: \_\_\_\_\_

Gender:  male  female Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

Marital Status:  single  married Race or ethnic background: \_\_\_\_\_  
 separated  divorced \_\_\_\_\_  
 widowed  significant other \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Personal e-mail Address: \_\_\_\_\_

### Employment Information

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Website: \_\_\_\_\_

Nearest relative not living with you:

\_\_\_\_\_ Phone Number \_\_\_\_\_

Who can we contact in case of an emergency?

\_\_\_\_\_ Phone Number \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

\_\_\_\_\_ I understand that Dr. Francis does not accept insurance assignment and that I am responsible for all fees incurred under her care. If I wish to have insurance payment, I will submit my receipts for reimbursement myself.

\_\_\_\_\_ I understand that due to the extended length of visits under the care of Dr. Francis, that it is necessary to cancel my appointment 24 hours in advance or I will be charged full price for the visit at the discretion of Dr. Francis. However, if my appointment is able to be filled by Dr. Francis or me, I will not be charged.

\_\_\_\_\_ I wish to receive Dr. Francis' e-newsletter.

\_\_\_\_\_  
Please sign your name



Dr. Gabrielle Francis  
Chiropractor | Naturopath | Acupuncture

## **PRIVACY POLICIES**

Our office is dedicated to providing service with respect to human dignity. Protecting your privacy and your healthcare information is fundamental in the course of our relationship. This notice will remain in effect until it is replaced or amended by changes in the law. This notice provides an explanation as to how we may collect information about you and what we will do with the "Protected Information" (personal information, financial information and health information). This protected information is received from you, your healthcare provider or any other source in the normal course of health care operations. We are concerned about protecting the privacy of our patients and will use our best efforts to safeguard your protected information.

We gather personal information and health information in several ways:

- Information we receive from you.
- Information we receive from other healthcare providers.
- Information we receive from third party payors.

This information is used for treatment, payment and other healthcare operations.

You should be aware that during the course of our relationship with you we will likely use and disclose health information about you for the treatment, payment and healthcare operations.

You may specifically authorize us to use protected health information for any purpose or to disclose your health information by submitting the authorization in writing. Such disclosure will be made to any personal representation you choose to have your protected health information.

### **Marketing**

This office WILL NOT use your health information for marketing communication without your written authorization. However, this office may send birthday cards, newsletters and appointment reminders, by telephone calls, or mail.

### **Disclosure**

This office may use or disclose your Protected Health Information when required to by law.

### **Patient Rights**

- Upon written request you have the right to access, review or receive copies of your healthcare records. There is a copy fee of \$15 and allow 10 working days to process it.
- Upon written request you have the right to receive a list of items this office disclosed about your healthcare information.
- You have the right to request that this office place additional restrictions on the disclosure of your Protected Health Information.
- You have the right to request that we amend your Protected Health Information; the request must be in writing.
- You have a right to receive all notices in writing.



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## RECEIPT OF NOTICE OF PRIVACY POLICIES

I \_\_\_\_\_, have read, reviewed, and understand and agree to the statement of the Privacy Policy for healthcare services in this Office.

This practice has attempted to provide each patient with a statement of Privacy Policies.

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

## PATIENT HEALTH HISTORY AND ASSESSMENT

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Purpose of this appointment \_\_\_\_\_

Have you been seen by other physicians for this problem? \_\_\_\_\_

If yes, what physicians? \_\_\_\_\_

Have you ever tried or do you currently use (name technique or practitioner):

Chiropractic \_\_\_\_\_

Massage Therapy \_\_\_\_\_

Acupuncture and Oriental Medicine \_\_\_\_\_

Naturopathic medicine \_\_\_\_\_

Other Wholistic therapies \_\_\_\_\_

Psychotherapy \_\_\_\_\_

Other \_\_\_\_\_

How does this problem affect your life? \_\_\_\_\_

Please list up to 8 major health concerns in order of importance:

1. \_\_\_\_\_ 5. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_

4. \_\_\_\_\_ 8. \_\_\_\_\_

### FAMILY HISTORY

Please state if anyone in your family has or has had any of these diseases:

- |  |  |   |                                       |
|--|--|---|---------------------------------------|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Asthma/Hayfever | <input type="checkbox"/> Epilepsy       | <input type="checkbox"/> Alzheimers   |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Anemia          | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Alcoholism   |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney          | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Obesity      |
| <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Neurological   | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Stroke              | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Allergies      |                                       |

### CURRENT MEDICATIONS Please include the dosages if available For Doctor Use Only

- |          |       |
|----------|-------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |
| 5. _____ | _____ |
| 6. _____ | _____ |
| 7. _____ | _____ |
| 8. _____ | _____ |

**CURRENT VITAMINS AND SUPPLEMENTS**

For Doctor Use Only

1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____

**Please check if you have now or have had in the past, any of these symptoms.**

**ALLERGIES** Please list any known allergies next to the item

For Doctor Use Only

<input type="checkbox"/> Drugs _____	<input type="checkbox"/> Chemicals _____	_____
<input type="checkbox"/> Foods _____	<input type="checkbox"/> Animals _____	_____
<input type="checkbox"/> Environmental _____	<input type="checkbox"/> Other _____	_____
What happens when you have an attack? _____		_____
_____		_____
Have you ever had allergy testing? _____		_____
When? _____		_____
By Whom? _____		_____
What kind of test? _____		_____

**RESPIRATORY**

<input type="checkbox"/> Frequent colds and flus	<input type="checkbox"/> Swollen glands	_____
<input type="checkbox"/> Sore throats	<input type="checkbox"/> Chest congestion	_____
<input type="checkbox"/> Fevers		_____
<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Itchy eyes	_____
<input type="checkbox"/> Nasal drip	<input type="checkbox"/> Ear aches	_____
<input type="checkbox"/> Nose bleeds frequent	<input type="checkbox"/> Laryngitis	_____
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Wheezing	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Difficulty breathing	_____
<input type="checkbox"/> Cough	<input type="checkbox"/> Pain on breathing	_____
Color of sputum _____	<input type="checkbox"/> Emphysema	_____
Thin or thick mucous _____	<input type="checkbox"/> Positive TB test ever?	_____
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Shortness of breath when	_____
<input type="checkbox"/> Shortness of breath lying	exercizing	_____
down	<input type="checkbox"/> Air hunger	_____
<input type="checkbox"/> Shortness of breath in cold	<input type="checkbox"/> Sigh frequently	_____













**GENERAL WEIGHT**

For Doctor Use Only

- Overweight
- Underweight
- Weight gain
- Weight loss
  - Height \_\_\_\_\_
  - Weight \_\_\_\_\_
- Where do you tend to gain weight? \_\_\_\_\_
- Is it difficult to loose or gain weight? \_\_\_\_\_
- Diets you have tried \_\_\_\_\_
- Desire to loose or gain weight \_\_\_\_\_

**ENERGY**

- What is you energy level on a scale of 1-10? 10 being the highest. \_\_\_\_\_
- Fatigue \_\_\_\_\_
- Tired after eating
- More energy in the evening
- Morning person
- Night person
- How many hours of sleep do you get per night? \_\_\_\_\_
- Difficult to fall asleep
- Wakes at night and can't fall back to sleep
- Slow starter in the AM
- What time of day does energy drop? \_\_\_\_\_
- Insomnia
- Chronic fatigue \_\_\_\_\_
- Reduced initiative/motivation
- Desires naps in the middle of the day
- Remembers dreams
- Nightmares
- Wakes at night to urinate
- Wakes rested
- Wakes tired

**TEMPERATURE**

- Body temperature is
  - Warm
  - Cold
  - Alternating
- Prefers
  - Warm weather
  - Cool weather
  - Warm drinks
  - Cold drinks
- Flush easily
- Night sweats
- Sweats easily
- Hotflashes
- Cold hands and feet
- Aversion or Intolerance to
  - Heat
  - Cold
  - Wind
  - Damp
- Slight fever sensation in body
- Afternoon fevers
- Abnormal thirst

**PAST MEDICAL HISTORY** Please List

For Doctor Use Only

List any disease you have had or have now

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Immunizations and vaccines

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Surgeries and dates

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Hospitalizations and dates

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Fractures and dates

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Accidents and dates

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Traumas

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**LIFESTYLE**

For Doctor Use Only

Date of last physical

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What type of exercise do you do

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How often do you exercise

Do you smoke?

How many packs per day?

How many years?

How many alcoholic drinks do you drink per week?

What recreational drugs do you do?

What hobbies and activities do you do in your free time

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Relaxation activities

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## INSTRUCTIONS FOR COMPLETING A DIET DIARY

### DATE

Write in the date of the diary entries.

### TIME

Write down, as accurately as possible, the time you eat.

### FOODS EATEN

Be sure to include fluids, vitamins, and medications, as well as foods.

Write in the amount of food you eat, like "bowl of Cheerios, with a cup of milk and banana." Among the measurements you may use are fluid ounce, ounce-weight, cup, gram, teaspoon (jam, butter), slice (bread), tablespoon, gallon, liter, or milliliters. If you list something as a "cup" (as in coffee or tea), a "glass" (milk, beer, water, etc.), or a "bottle" or "can," estimate the size of the container. You may also write in just the quantity of the food when the amount is obvious, like "1 hamburger, 2 apples, 3 cookies", or a "serving of McDonald's fries" (but write in whether it was a small or large order).

It is also important that you write in brand names of foods that you eat, as nutrient content will vary by manufacturer.

And finally, write in the contents of foods where appropriate. For example, instead of writing "vegetable soup", write in "soup with carrots, vegetable broth, onion, garlic, etc."

### FEELINGS

Write in your emotions, as well as energy and physical stress levels. This is the place to chart your ups and downs during the day. Typical entries might include: "sad, depressed, high energy, low energy, very happy, tired, poor sleep last night, sleepy, runny nose, caught a cold, feeling very irritable, fighting with partner." Do not limit yourself to just these entries. What is important is that you depict a picture of the ebbs and flows of your day. Try to correlate the entries as closely as possible with the times listed to the left on the diet diary form.

### BOWEL, URINE HABITS, GAS

List your bowel movements, urine voids and any flatulence. Again, try to correlate these entries with the times. As well, note any changes or abnormalities in bowel movements or urine, such as constipation, diarrhea, excessive quantity of urination, color changes, etc.

### MAJOR ACTIVITIES

List your activity level (i.e., whether you are sedentary or active). Typical listings might include, "short walk, worked in the garden, ran three miles, sat in the office all day."

# Diet Diary

Name: \_\_\_\_\_

Please Use Both Sides

<b>Date</b>	<b>Time</b>	<b>Foods Eaten:</b> Include fluids, vitamins and medications	<b>Feelings:</b> Emotions, Physical Stress Levels	<b>Bowel/Urine Habits, Gas</b>	<b>Major Activities</b>

Please Use Both Sides

# Diet Diary *continued*

Name: \_\_\_\_\_

<b>Date</b>	<b>Time</b>	<b>Foods Eaten:</b> Include fluids, vitamins and medications	<b>Feelings:</b> Emotions, Physical Stress Levels	<b>Bowel/Urine Habits, Gas</b>	<b>Major Activities</b>

