PATIENT DATA SHEET DATE________

PLEASE PRINT CLEARLY.

A. Patient Contact information (Please fill this out in full, failure will delay any treatment. Plan on spending at least an hour)

Full Name: _______________________________ E-mail: ___________________
Gender: M F Age:____ Birth Date: _________
Address: ____
City: ___________________ State: ______ Zip: ___________
Social Security#: ______-_____-______ Driver's License #: __________________
Home Phone: (____) ______________ Cell Phone: (____) _____________
Do you live Alone with Spouse and Children Parents Roomate(s) Assisted living
Other if yes Explain _________________________
Marital Status: S M D W Work Status: Full time Part-time Retired
# of Children:____
Highest level of education completed Elementary Junior-high High school Current college student College graduate Post-graduate studies Doctorate
Employer: ______________________________ Occupation:___________________
Work Phone: (____) _____________ Fax: (____) ________________
Employer Address: ____
City: ________________ State:______ Zip: ____________
Name of Spouse, Parent or Guardian: ________________________ Age: _____
Birth Date: __________________ SS#: ______-_____-______
Spouse's Employer: ______________________ Spouse's Occupation:__________
Work Phone: (____) ______________
In case of an emergency Contact: ____
Relationship: ___________________
How did you hear about our clinic? Whom may we thank for referring you?__________
____
Do you currently wear any of the following: orthotics, heel lifts, arch supports? Y N
Do you carry any of the following: 2-way radio, pager, cell phone, walkman, ipod, wifi? Y N
If you answered Y please explain. ____
Best Time to contact/Treatment if accepted Days S M T W R F S Times_________________

B. Privacy Act/ Records and Office Policies **YOU MUST SIGN TO BE CONSIDERED**

We want you to know how your Patient Data Sheet (PDS) will be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used and our policies. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your PDS we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow Health Specialties to use their Patient Data Sheet for the purpose of treatment, payment, health care operations, and coordination of care.
2. The patient has the right to examine and obtain a copy of his/her own health records at any time and request corrections at a reasonable fee. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PDS. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by Health Specialties to assure that your records are not readily available to those who do not need them. Please do not ask about other patients or come into the front office for any reason.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. This is to acknowledge Health Specialties to conduct radiographic studies (x-ray, MRI,CT) and laboratory testing that are reasonable to complete the study and analysis of my current condition.
8. Appointment Scheduling: To save you time on each visit, we ask that you **preschedule** your appointments. To keep your progress on schedule, rescheduled appointments in **Idaho** must be made up **within 24 hours**. **Oklahoma, Minnesota, and Kansas City are 72 hrs notice** Broken appointments are hazardous to your future health. If you repeatedly miss or reschedule appointments, we will regretfully release you from care. **"No show"** appointments are subject to a fee of **$100**. If you or Dr. Trites travels for your treatments, there is increase in daily treatments, on average 2-4, per monthly visit, so that you can maximize your results.
9. Adjusting Hours: To provide the care you need as conveniently and as rapidly as possible, we have established special hours enabling you to receive your adjustments with as little waiting as possible. Please save any detailed questions for an appointment during scheduled consultation times.
10. Children/Family Wellness: Families are very important to the Health Specialties because we recognize that our children are the world's future. We encourage new patients to bring their families in to be checked for spinal disc inflammation. All children are evaluated the same as any adult with the same attention to detail. Prevention is the most important step in preventing silent killers such as heart disease, diabetes, cardiovascular disease and cancer, diseases where the first symptom is often death.
Consent to treat minor: I hereby authorize Health Specialties that he/she designates, to administer chiropractic care to ____________________ (name of child) who is my ____________________________________(Child's relationship to you)
11. Wellness Visits: After your pain management and corrective care programs have been completed to both the satisfaction of the doctor and you, wellness visits and maintenance care programs will be established. If you've chosen optimal health, this is where our mutual efforts should keep the process from continuance.
12. Financial Agreements: Monthly payments do not necessarily reflect the amount of services received for that month. You are paying full fee for all services rendered. There is a $35 fee for returned checks. Fees are based upon individual services and may very each visit based on the doctors recommendations A credit card will be kept on file to cover mishaps, such as misplacing a wallet or checkbook. You will be notified up front if this needs to be utilized to cover services. Understanding of the above and below I agree to pay at the time of service and **will file my own insurance** from the superbill provided. Health Specialties will not participate in my reimbursement outside doing the best billing they know for you. I agree to the above terms and acknowledge that in the event that there is an

outstanding balance, which fails to be cured in 60 days my account with Health Specialties will be turned over to collection and I will be responsible for any and all additional collection fees and/or attorney and court costs. I understand that payment is due in full to Health Specialties at the time of service except when prior arrangements have been made.

13. Third Party Liability**:** Care for, or related to, auto accidents, work injuries, or personal injuries where there is third party liability or pending litigation. In this event, this agreement will be through the third party and you. Health Specialties will help you attain financial reimbursements via a superbill, but will not be participate in insurance filing.

14. Change of Information: We ask that you keep Health Specialties informed in the occurrence of Health Insurance policy changes, change of address and phone number, or referring physician. We will not disseminate your information as protected by the Health Information Privacy Protection Act. You do have the right to your records either in person or in writing

15. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

16. Guarantees**:** We do not guarantee that we can prevent or cure any illness, injury, or disease. In this office we find and remove spinal distress through total body treatments, so that your nervous system will function optimally and so that your spine and entire body does not degenerate prematurely. The only guarantee is that you will have the best service Dr. Trites can provide you. I understand that although the success percentage rate of patients accepted is high that it does not guarantee my success rate regarding my case. I also understand that Dr. Trites will not accept my case unless he sincerely feels confident that he will be able to help me. If he is uncertain, some options may exist;

A recommended trial period only for a reasonable set limit of time

A recommended trial in conjunction with another health professional

I have read and understand how my PDS will be used and I agree to these policies and procedures. I signify that the above information is true. In respect of my privacy and confidentiality, I give permission to the office(s) of Dr. Trites to use the contacts that I have indicated above. I understand that no contacts will be used by Dr. Trites's office unless so indicated by me.

Signature ________________________________ Date ________________________

C. Tell us how we can help you

HEALTH CONCERNS: Please list your top health concerns in order of priority.(Why you are here)

1)____

2)____

3)____

4)____

TREATMENT: What type of treatment are you looking for?

I am looking for the most minimal amount of care to "patch up the symptoms" of my problem.

I want to feel better for the least amount of my time and money I don't care about the cause

I don't care about the scope of care offered at the office of Dr. Trites or optimal genetic health potential, I just want to be popped.

I have a medical diagnosis and wish to continue medical treatment ONLY.

I am looking to resolve my symptoms and then go on to "fix the cause" of my problem.

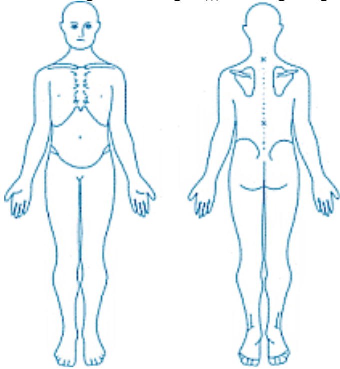
I want to find the cause(s) of my problem(s), correct them, and do what I can to keep them from coming back.
I want to stabilize and retrain the muscles and ligaments of my spine.
I want to do what I can to avoid losing my health.
If my case is accepted and correction is made, I want to maintain and preserve that correction
I want to do all I can to preserve my current health status.
I wish to do what I can, per Dr. Trites's advice to obtain optimum health if that is possible.

I especially want the following services offered by Dr. Trites. (Circle all that apply)
Acupuncture with needles   Acupuncture without needles   Auriculotherapy   Weight Control
Pain Control   Contemporary Chiropractic Care   Complete Nutritional Analysis
Cardiovascular Studies   Metabolic Function Studies   Blood Lab Profiles   Mineral Analysis Profile   Applied Kinesiology   Sacro-Occipital Technique   Chiropractic Plus Kinesiology   Contact Reflex Analysis   Activator   Supplementation

Please check all that apply
I have a health condition, I am concerned and I don't know what it is
I have a medical condition and am receiving medical treatment and am unhappy with my results
I have a medical condition and wish to enhance my medical treatment
I am here to see if Natural Chiropractic treatment will help me
I am here for the services Dr. Trites provides to meet my health needs
I have been to other doctors and/or specialty doctors and they gave me answers that don't make sence to me regarding a resolution of my problem(s)
I have been to other doctors and/or chiropractors and continue to have health problems and wish to see if Dr. Trites's approach will help me
I am currently on medications/drugs and wish to get off them
If yes have you suggested this to the prescribing physician
I am currently on medications/drugs and wish to stay on them
I wish to discontinue medical treatment and am seeking an alternative method
I wish to be examined and evaluated from a wholistic "total person" approach where my mental, structural, and physiologic systems are included in the treatment of my health or health problems

CONCERN/PROBLEM: In relation to your primary complaint or concerns:
-When did you first seek treatment for this problem? ____________________________
-Has another doctor(s) treated you for this condition: Y N Length ___________________
-If yes, whom &Treatment(s):____
-Have you had any intolerance or reactions to treatments? Y N Describe: _________________
-If this is a recurrence, when was the **first** time you noticed this problem? ____________________
-What occurred to cause or re-aggrevate your concerns? ________________________________
-Did this begin- Suddenly Gradually or Unknown ? ___________________________
Please use the legend symbols below to accurately mark the areas in which you feel these sensations.

Stabbing/Cutting - ||| Tingling - ::: Burning - XXX Cramping - ^^^ Numbness - === Dull-###



Patient concerns. If you have pain or concerns please indicate by placing an "X" in the box

Area	Left	Right	Both
Neck			
Upper Back			
Mid Back			
Low Back			
Buttocks			
Pelvis			
Ribs			
Shoulder			
Arm			
Elbow			
Forarm			
Wrist			
Hand			
Fingers			
Hip			
Thigh			
Knee			
Shin/Calf			
Ankle			
Foot			
Toes			

-Describe your condition (circle): 1. Tingling ○ 2. Pain○ 3. Numbness○ 4. Stiffness○ 5. Soreness○ 6. Weakness○ 7. Swelling○ 8. Mild○ 9. Moderate○ 10. Severe○ 11. Burning○ 12. Dull○ 13. Sharp○ 14. Shooting○ 15. Aching○ 16. Throbbing○ 17. Occasional○ 18. Intermittent○ 19. Frequent○ 20. Constant○ 21. Improving○ 22. Worsening○ 23. Unchanging○ 24. Resolved ○Other: _________

-Particular time of day of subjectivity- Morning Afternoon Evening Night Always the same

-How frequent is the condition? Constant Daily Intermittent Night only

-How long does it last? All day Few hours Minutes

-Is this condition interfering with your: Work Sleep Daily routine Recreation Other

-How long has it been since you really felt good? Days Weeks Months Years >10

-If this is an accident what environment did this occur? Work accident/Injury Personal Auto Home Sports injury Other_______________

-Is there anything that you can do to relieve the problem? Y N If yes, describe:

____

-If no, what have you tried to do that has not helped?_______________________________________
-What do you believe is wrong with you? ____
-Are there any other conditions or symptoms that may be related to your major symptom? Y N If yes, what? ______________________________
-Have you been in an auto accident? Past year Past 5 years Over 5 years Never
Describe: ____
-How would you rate your overall pain None 0 1 2 3 4 5 6 7 8 9 10 Worse
-What makes your condition better? Circle all that apply Nothing Rest
Sitting Stretching Exercise Standing Heat
Medication Ice Other_____________________________

-What makes your conditions worse? Circle all that apply Nothing Sneezing
Bending Coughing Lifting Walking Reaching Sitting
Standing Pulling Turning Straining at stool Lying
Twisting Dressing Meal Prep Cleaning Vacuuming
Housework Driving car Riding in car Stairs Walking
Running Sleeping Typing Occupation Recreation
Yard work Reading Intercourse Shopping Dropping items
Child Care Other____

-Have any of your complaints existed in the Past? Yes No
If yes indicate below where by circling-
Neck Upper back Mid Back Low back Ribs Shoulder
Arm Elbow Forearm Wrist Hand
Fingers Hip Buttocks Thigh Knee Leg/Calf
Ankle Foot Others____________________________________

-Since your symptoms began, have you noticed a change in?
Bowel function Yes No
Bladder function Yes No
Sexual function Yes No

D. Headaches If you are experiencing headaches please fill out this section, otherwise skip to section **E**
-What seems to bring on your headaches? Circle all that apply
Physical Activity Excessive Stress Alcohol Caffeine Certain Foods
Menstrual Period Other ______
What date did your headaches begin? / /
-How often do they occur?Time/week _________ Times/month ___________ Other_________
-How long do they last? Less than an hour 1-3 hours Longer than 3 hours
All waking hours Several hours to days Other____________
-Do you headaches wake you from sleep? No Sometimes Always
-Do any of the following occur with your headaches? Circle all that apply
Nausea/vomiting Weakness Tremor Dizziness Vision problems Light/Sound sensitivity Other_______

-What makes your headaches better? Circle all that apply
Nothing Rest Lying down Ice/Cold packs Massage
Standing NSAIDS(aspirin, tyelonol) Medication Other_______

-When do you headaches usually start? Circle all that apply Constant/Anytime awake
Midday Upon waking up in the morning During the evening

-What describes your pain? Circle all that apply
Burning Dull Sharp Shooting Aching Throbbing
Deep Vice-Like Other ___________________

-How would you rate your overall headache None 0 1 2 3 4 5 6 7 8 9 10 Worse

E. Review of systems Please circle any conditions and place and X or number in the appropriate boxes

General Fatigue	Weakness	Fever (continuous)	Chills (continuous)	Loss of sleep
Weight change	**Headaches**	Fainting	Convulsions	Nigh Sweats
Nervousness	**Anxiety**	Depression	Pbobias	Memory loss
Mood swings	**Nose/Sinus pain**	Excessive drainage	Nose bleeds	Nasal infections
Absence of smell	**Mouth sores**	Bleeding gums	Enlarges glands	Absence of taste
Abnormal taste	Tonsillitis (infected)	Difficulty swallowing	**Heat/cold intolerance**	Sugar in urine
Goiter, large thyroid	Tremor, shaking	**Skin rash**	Redness of skin	Skin itching
Skin dryness	Eczema	Hair changes	Nail changes	Bruise easily
Cough chronic	Wheezing	Difficulty breathing	Swollen extremities	Blue extremities
Varicosities	Rapid heart beat	Chest pain	Heart palpitations	Heart murmur
Decreased appetite	Increased appetite	Abdominal pains	Hemorrhoids	Excess gas
Vomiting	Diarrhea	Constipation	Heartburn	Indigestion
Painful urination	Inability to hold urine	Frequent urination	Urinary retention	Bed-wetting
Irregular menstruation	Painful menstruation	Abnormal vaginal bleeding	Sterility	Impotence
Lumps in breast	Redness, itching of breast	Dimpling of breast	Discharge from breast(s)	Breast pain
		Left	Right	
	Ringing in ears			
	Pain in ears			
	Ear discharge			
	Vision trouble			
	Pain in eyes			
	Eye discharge			
	Hearing trouble			
	None	1-2 per day	2-4 per day	5+
Smoking/day				
Caffeinated drinks/day				
Alcohol consumption/week				
Drug/substance abuse, ever?				
Exercise/week type?				
	None	1-2 per day	2-4 per day	5+
Water/day in cups				

Meals/day				
Sleep in hours				
Work hard				
Level of stress				
Use sweetener				
Fruits and veggies				

-Other Complaints – Do you have any complaints/concerns not covered in this form? If so reply below. ____

F. Medical History

a. Have you ever been to a chiropractor? ______________________
b. If so whom? ____
c. May we contact them if necessary? ________________________
d. May we have the contact information? ______________________
e. Do you have a personal physician? _________________________
f. If so whom?____
g. May we contact them if necessary? _________________________
h. May we have their contact information? ______________________
i. Date of last lab work _____________________________________
   i. Results____
j. Date of last X-ray or MRI _________________________________
   i. Results ____
k. What prompted these examinations __________________________
l. Have you had previous treatment for this problem?
   i. List dates and physicians ____________________________________
   ii. Have you had any intolerance or reactions to treatments? ____________
   iii. Has the conditions been the same, better or worse since initial treatment?_________________________
   iv. How frequent is the conditions-Circle those that apply Constant Daily Intermittent Night only
   v. How long does it last? (circle) All day Few hours minutes
   vi. Does the condition interfere with your? (circle) work sleep daily routine recreation other
   vii. How long has it been since you felt really good? (circle) Days weeks months years >10 years
m. Have you been hospitalized in the past?
   i. List date and reason _____________________________________
n. Have you ever had surgery?
   i. List date and reason _____________________________________
o. Have you ever had a serious accident or injury? If yes list dates
   i. Auto ___________________________
   ii. Work related ______________________
   iii. Personal _________________________
   iv. Sports ___________________________
   v. Other _________________________________
   vi. Past or current lawsuit or planning to propose any health related lawsuit? ☐Y ☐N

p. Are you currently taking any type of medication? ☐Y ☐N if yes fill in following below

MEDICATIONS: Please check and list all medications that you are currently taking with the date you began taking them.

	Medication Name	Date Started	Who Prescribed
☐ Antacids	______________________	__________	_____________
☐ Antibiotics	______________________	__________	_____________
☐ Antidepressants	______________________	__________	_____________
☐ Anti-Diabetics	______________________	__________	_____________
☐ Anti-Inflammatory	______________________	__________	_____________
☐ Blood Pressure Lowering Meds.	______________________	__________	_____________
☐ Cholesterol Lowering Meds.	______________________	__________	_____________
☐ Hormone Replacements (HRT)	______________________	__________	_____________
☐ Oral Contraceptives	______________________	__________	_____________
☐ Other	______________________	__________	_____________

What conditions are you taking these medication for? ________________________________

Are you currently taking any over the counter medications? If so for what condition(s)?
____

ALLERGIES: Please check and list all allergies.

☐ Food:____

☐ Medications:____

☐ Seasonal/**Other**:____

SUPPLEMENTS: Do you take Vitamins/Supplements or Herbs? ☐Y ☐N If yes, who recommended them and why are you taking them?
____
____

Has anyone ever tested you for you supplements? ☐Y ☐N How?____________________________

SCARS / SURGICAL PROCEDURES: List all scars and surgical procedures you have had.
____

Dental questions: Do you have any silver amalgam fillings? Y N
If yes, when and where? ______________________________________
Have you ever had a root canal? Y N How many and when?

Women only –

i. To your knowledge are you pregnant or suspect to be?______________
ii. If pregnant in the past, were the pregnancies normal? ________________
iii. Are you seeing and OBGYN regularly? __________________
iv. Number of births _______________________
v. Date of last exam _________________________
vi. Physicians name ___________________________
vii. When was you last breast exam? _________Who performed? _________
viii. Do you perform self breast exams? Y N
ix. Address of OBGYN and Ph# _____________________
x. Do you have difficulty urinating Y N
xi. I have decreased libido Y N
xii. I have fertility problems Y N
xiii. I have a weak bladder Y N
xiv. I get headaches Y N
xv. I have foul flatulence Y N
xvi. I have indigestion Y N
xvii. I have belching Y N

Men Only-

a. Do you have difficulty urinating Y N
b. I have an enlarged prostate Y N

c. I have decreased libido Y N
d. I have erectile dysfunction Y N
e. I have fertility problems Y N
f. I have a weak bladder Y N
g. I get headaches Y N
h. I have foul flatulence Y N
i. I have indigestion Y N
j. I have belching Y N

G. Family History Please place an "X" in the appropriate box if anyone and your family has had any of these conditions

	Self	Father	Mother	Grandparents	Siblings	Children
Cancer						
Diabetes						
Heart disease						
High blood pressure						
Stroke						
Kidney disease						
Anemia						
Mental illness						
Headaches						
Osteoporosis						
Arthritis						
Joint problems						
Scoliosis						
Back problems						
Disc problems						
Congenital defects						
Genital disease						
Alcoholism						
Emphysema						
Mumps						
Ulcers						
Pneumonia						
Gout						
Polio						
HIV/AIDS						
Detached retina						
Rheumatic fever						
Eczema						
Epilepsy						
Pleurisy						
Miscarriage						
Cold sores						
Goiter						
Vein clots						
OTHER??						

If checked X please put dates for self ____

H. Conditions or Illness Please indicate if you NOW HAVE or HAVE HAD IN THE PAST any of the following conditions by placing an "X" in the box

Condition	NOW HAVE	IN PAST
Sinus trouble		
Hay Fever		
Allergies		
Emphysema		
Tuberculosis		
History of infection		
Fever		
Cancer/Tumor		
Diabetes		
Visual Disturbances		
Dizziness/ fainting		
Epilepsy/ seizures		
Thyroid trouble		
High Blood pressure		
Low blood pressure		
Pacemaker		
Heart trouble		
Stroke		
Aortic aneurysm		
Rheumatic fever		
Polio		
Multiple sclerosis		
Ulcer		
Liver trouble		
Kidney trouble		
Urinary retention		
Frequent urination		
Prostate trouble		
Arthritis		
Osteoporosis		
Scoliosis		
Dislocated joints		
Spinal disc disease		
Mental-Emotional difficulties		
Sexually transmitted diseases		
HIV		
AIDS/ARC		
Abnormal weight gain		
Abnormal weight loss		
Numbness groin or buttock		
Bone fracture		
Facial Pain		
Blurred Vision		
Dizziness		
Earache		
Forgetfulness		
Confusion		
Sinusitis		
Teeth grinding		

Walking problems		
Eye Pain		
Abdominal pain		
Sore muscles		
Blurred vision		
Nausea/vomiting		
Weak muscles		
Tingling in feet		
Paralysis		
Earache		
Fullness of bladder		
Shakiness		
Urination difficulty		
Sweating excess		
Lack of sweat		
Confusion		
Insomnia		
Constipation		
Fainting		
Hemorrhoids		
Convulsions		
Dry mouth		
Decreased libido		
Irritability		
Excessive thirst		
Menstrual irregularities		
Impatience		
Unpleasant thirst		
Elbow/hand pain		
Fatigue		
Neck pain		
Tingling in hands		
Feeling for Loss of control		
Sore throat		
Clammy hands		
Lump in throat		
Low back pain		
Swallowing pain		
Hip pain		
Unsteady voice		
Knee pain		
Poor circulation		
Persistent cough		
Swollen joints		
Slow heart rate		
Rapid heart rate		
Swollen ankles		
Poor appetite		
OTHER		

I. Occupational information activities of daily living

a. Are you left or right handed
b. Job type Retired Unemployed Full-time student Full-time Part-Time Temporary Self-Employed Other_______________
c. How many hour per day do you work 0-3 4-6 7-9 10 11 12+
d. How many days per week do you work 0 1 2 3 4 5 6 7
e. How long have you been with your present employer Years_____Mo__
f. Do you present concerns affect the number of hours your work? Yes No
g. What is your primary work position and location? Seated Standing Desk Counter Workbench Other
h. What movements does your job require? Bending Twisting Turning Walking Stooping Walking Repetitive hand use Carrying
i. Does your work include any of the following? Prolonged computer continuous phone
j. Does your job require lifting? Never Occasional Frequently Constantly How many lbs on average less than 20# 20-50 50+
k. What best describes your stress level at work? None Minimal moderate Extreme
l. How do you rate you physical activity at work? Seated more than 50%
   i. Manual labor Light Moderate Extreme
m. Does work activities aggravate your present complaints? Yes No

J. Health Status Questionnaire Can you do these tasks? How well. Leave blank if no problems exist

Limited mostly	Limited little	None	
			Vigorous exercise & strenuous
			Moderate exercise
			Lifting or carrying
			Climbing several flights of stairs
			Climbing any stairs
			Bending, kneeling, stooping
			Walking more than a mile
			Walking several blocks
			Bathing or dressing yourself

-During the past four weeks have your experienced any of the following as a result of physical or mental health? If yes explain ____
-Cutting down on the amount of time you spend on work or other activities?_________________
-Accomplishing less than you would like? ____
-Were limited in the kind of work or other activities? _________________________________
-Had difficulty performing the work or other activities? _______________________________
-How much bodily pain have you had in the past four weeks? None Mild Very mild Moderate Severe Very severe
-During the past month how did pain interfere with your normal work in and outside the home?
None Little moderately Severe

Please place and "X" in the box for what describes you best

	Always	Mostly	Moderately	Some	Little	None
Full of pep						
Nervousness						
Calm						
Full of energy						
Unable to cheer up						
Worn out						
Happy						
Tired						
Blue						

	True	Mostly true	Don't know	Mostly false	False
I get sick a lot					
I am healthy					
I expect to get worse					
My health is excellent					

-Do you feel your diet is adequate? Y N Where do you eat? Lunch ________Dinner______
-Do you eat breakfast? Y N if no why not? ______________________
-Which do you eat the most of? Chips, Candy, Pop, Fruit, Veggies, Bread?
-Has your diet affected your quality of life? Y N
-Are you primarily responsible for preparing you own meals? Y N
-How many of your weekly meals do you eat out? _____________
-What are your favorite foods?____
-Do you often add spices, pepper or salt to your food? Y N Before tasting? Y N
-What foods do you dislike?________________________________
-More than 50% of my food is: Raw Cooked Micro-waved Canned Packaged
-Are you on a special diet or particular diet? Y N If yes explain ______________________

Your beliefs

Y N The body cannot heal itself without the use of drugs and surgery
Y N Once you have a disease you will have it for life
Y N The food I eat have no influence on my health or mental state
Y N My attitude towards treatment will have no affect on results
Y N What I think has no affect on my health
Y N Natural health should never be attempted before medical procedures
Y N Drugs and medicines are normal and safe
Y N Cholesterol is not necessary for my existence
Y N To be well I must visit a doctors a few times a year
Y N A disease is only chemical imbalances and has nothing to do with function
Y N All fevers and headaches are bad and should be suppressed by medication

Tally up you Yes answers to No for your beliefs Y________ N________

ALL PATIENTS MUST COMPLETE

I believe to the best of my abilities that all contained in this document is true to my knowledge and that I am of sound mind and body willing to seek treatment. I also understand that by completing the PDS does not "guarantee" Health Specialties will accept me as a patient.

Signature _____________________ Date ___________________ Time ____________

Current President of the United States and their place of residence _________________________

(Medicare Patients only) Waiver of Liability/Advance Beneficiary Notice This includes all services in our office throughout your treatment.

Provider Notice: Medicare will only pay for services that determines to be "reasonable and necessary" under section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is 'not reasonable and necessary' under Medicare program standards, Medicare will deny payment for that service. I believe that, in you case, Medicare is likely to deny payment.

Beneficiary Agreement:" I have been notified by my provider that he/she believes that, in my case, Medicare is likely to deny payment for service. If Medicare denies payment, I agree to be personally and fully responsible for payment."

Signature ____________________Date_________