# CREATIVE HEALTH & SPINE

PLEASE PRINT

Full Name: _____Email Address: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: _____ Height: _____ Weight:_____

Name of Spouse/Partner if applicable: _____ # of Children & Age(s): _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____Cell or Mobile Phone #: _____

Employer: _____ Employer Address: _____

City: _____ State: _____ Zip: _____ Emergency Name and Number: _____

How did you hear about Creative Health & Spine? If someone referred you, what is their name? _____

**Is there a specific reason for consulting our office, at this time?**

_____

## YOUR HEALTH PROFILE

We are a full spectrum health and wellness facility. Our first goal is to address the issues that brought you to the office. Our second goal is to offer you the opportunity for improved health potential through our wellness services. On a daily basis, we experience physical, chemical and emotional stress that can accumulate and result in a serious decline of your health. Most times the effects are gradual, not even felt until they become symptomatic. Your answers to the following questions will give us a better understanding of the specific stresses you have faced in your lifetime. This allows us to better assess the challenges to your health potential and create a customized plan to improve the quality of your life.

## ADDRESSING THE ISSUES THAT BROUGHT YOU TO THE OFFICE

**If you have no specific symptoms or complaints, and you are here for our wellness services please (X) here _____ and skip to the the next section of this form. All others please briefly describe your chief area of complaint, including the effect it has had on your life.**

_____

If you are experiencing pain, is it… Sharp Dull Burning Numb Tingling Travels Constant w/Motion Other:_____

How did this begin?_____Since the problem started, it is… Same Getting Better Getting Worse

Using a scale of 0-10 (10 being worst) how would you rate your problem? 1 2 3 4 5 6 7 8 9 10

What makes it worse: _____

It interferes with… Work Sleep Walking Sitting Hobbies Leisure

Other Doctors seen for this problem (please list): ie. Chiropractors, Medical Doctors, Therapists, etc.

_____

Please circle **ALL** symptoms you have **EVER** had, even if they do not seem related to your current problem.

| | | | |
|---|---|---|---|
| Headache | High Blood Pressure | Fainting | Diabetes |
| Fatigue | Heart Attack/ Chest Pains | Constipation | Loss of Balance |
| Dizziness | Loss of Smell | Ringing in Ears | Nervousness |
| Numbness in Fingers | Numbness in Toes | Loss of Taste | Abnormal Weight Loss/Gain |
| Pins and Needles in Arms/Legs | Depression | Irritability | Tension |
| Sleeping Problems | Neck Pain/Stiffness | Cold Hands | Cold Feet |
| Diarrhea | Back Pain/Stiffness | Buzzing in Ear | Hot Flashes |
| Cold Sweats | Ulcers | Problem Urinating | Heartburn |
| Menstrual Irritability | Menstrual Pain | Mood Swing | Eyes Sensitive to Light |

List any other symptoms:

_____

List any medications you are now taking:

_____

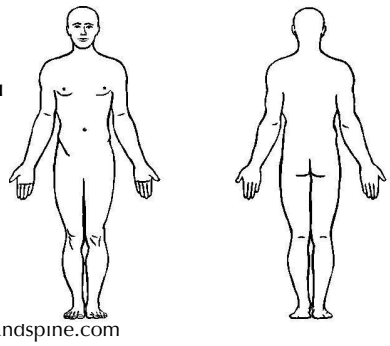
List any surgeries or hospitalizations:

_____

List any allergies:

_____

**Please indicate on diagram where you have symptoms >>>>>>>**



# QUALITY OF LIFE SURVEY

Please answer these questions so we can help you get better.
*(Please circle as many that apply)*

**1**. ***How have you taken care of your health in the past?***

a. Medications
b. Emergency Room
c. Routine Medical
d. Exercise
e. Other (please specify): _____
e. Nutrition/Diet
f. Holistic Care
g. Vitamins
h. Chiropractic

**2**. ***How did the previous method(s) work out for you?***

a. Bad results
b. Some results
c. Great results
d. Nothing changed
e. Did not get worse
f. Did not work very long
g. Still trying
h. Confused

**3**. ***How have others been affected by your health condition?***

a. No one is affected
b. Haven't noticed any problem
c. They tell me to do something
d. People avoid me

**4**. ***What are you afraid this might be (or beginning) to affect or (will affect)?***

a. Job
b. Kids
c. Future ability
d. Marriage
e. Self-esteem
f. Sleep
g. Time
h. Finances
i. Freedom

**5**. ***Are there health conditions you are afraid this might turn into?***

a. Family health problems
b. Heart disease
c. Cancer
d. Diabetes
e. Arthritis
f. Fibromyalgia
g. Depression
h. Chronic fatigue
i. Need surgery

***How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:***

_____

_____

_____

***What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc)***
***Give 3 examples:***

_____

_____

_____

***What are you most concerned with regarding your problem?***

_____

_____

***Where do you see yourself being in the next 1-3 years if this problem is not taken care of? Please be specific***

_____

_____

_____

***What would be different/better without this problem? Please be specific***

_____

_____

***What do you desire most to get from working with us?***

_____

_____

***What would that mean to you?***

_____

_____

# TRUST YOUR GUT WELLNESS EVALUATION

In medicine today, leaky gut (LGS) aka intestinal permeability, isn't typically diagnosed. However, that doesn't mean it's not affecting your health. Many health issues related to LGS go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please take the quiz to help our doctors evaluate how we can help your condition and any underlying triggers limiting your health.

## *Let's get started.*

Please circle any that apply to you prior to taking the quiz below:

***Sub Clinical Symptoms including:***
Headaches and migraines

***Hormone imbalance including:***
PMS
Emotional imbalance

***Gastrointestinal issues including:***
Abdominal bloating and cramps or painful gas
Irritable Bowel Syndrome
Ulcerative Colitis
Crohn's Disease and other intestinal disorders

***Respiratory conditions including:***
Chronic sinusitis
Asthma
Allergies

***Autoimmune conditions including:***
Diabetes Mellitus
Lupus
Rheumatoid Arthritis
Fibromyalgia
Chronic Fatigue

***Developmental and social concerns including:***
Autism
ADD/ADHD

***Skin conditions: (urticaria)***
Eczema
Skin Rashes
Hives

Please complete our TYG wellness quiz. While there's more to it than a single quiz, the answers below can give you a good idea of how happy your gut really is. Circle the number that most closely fits, then add up your results.

## *TYG Wellness Questionnaire*

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Constipation and/or diarrhea | 0 | 1 | 2 | 3 |
| Abdominal pain or bloating | 0 | 1 | 2 | 3 |
| Mucous or blood in stool | 0 | 1 | 2 | 3 |
| Joint pain or swelling, arthritis | 0 | 1 | 2 | 3 |
| Chronic or frequent fatigue or tiredness | 0 | 1 | 2 | 3 |
| Food allergies, sensitivities or intolerance | 0 | 1 | 2 | 3 |
| Sinus or nasal congestion | 0 | 1 | 2 | 3 |
| Chronic or frequent inflammations | 0 | 1 | 2 | 3 |
| Eczema, skin rashes or hives (urticaria) | 0 | 1 | 2 | 3 |

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Asthma, hayfever, or airborne allergies | 0 | 1 | 2 | 3 |
| Confusion, poor memory or mood swings | 0 | 1 | 2 | 3 |
| Use of NSAIDS (Aspirin, Tylenol, Motrin) | 0 | 1 | 2 | 3 |
| History of antibiotic use | 0 | 1 | 2 | 3 |
| Alcohol consumption makes you feel sick | 0 | 1 | 2 | 3 |
| Ulcerative colitis or celiac's disease | 0 | 1 | 2 | 3 |
| Nausea | 0 | 1 | 2 | 3 |
| Weight trouble | 0 | 1 | 2 | 3 |

Your Total: _____

616 Lancaster Ave, Berwyn, PA 19312 610.722.0240 creativehealthandspine.com

***Please Fill Out This Section if you are Interested in or here for our Weight Loss, Body Contouring or Nutrition Programs***

# WEIGHT LOSS/NUTRITION PROGRAM

When did you first become overweight?

_____

How long have you been trying to lose weight?

_____

How did your weight gain start? Describe any circumstances

_____

Present weight _____ lbs. Goal weight _____ lbs.

Circle ALL PROGRAMS THAT YOU HAVE TRIED IN ORDER TO LOSE WEIGHT

Weight Watchers Overeaters Anonymous NutriSystem Jenny Craig Obesity Surgery OTC Diet Pills

Other:_____

Circle any of the dietary problem areas listed below that apply to you:

Meal Skipping Carbohydrate Craving Large Portion Size Too Much Alcohol Eating Foods Too High in Fat

Frequent Snacking Eating Too Many Meals Out Eating Before Going to Bed Eating When Not Hungry

Other:_____

Do you feel tired , run down, and out of energy?

_____

How many times a year do you diet?

_____

Why do you think you have not been successful before?

_____

Is successful weight loss a top priority?

_____

What new activities will you become involved in after losing weight?

_____

On a scale of 1(not willing) to 5 (very willing), please indicate your readiness/willingness to do the following:

| **To Improve Your Health, How Ready/Willing Are you to….** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| Significantly modify your diet | | | | | |
| Take nutritional supplements each day | | | | | |
| Keep a record of everything you eat each day | | | | | |
| Modify your lifestyle (ie. Work demands, sleep, exercise) | | | | | |
| Practice relaxation techniques | | | | | |
| Engage in regular exercise/physical activity | | | | | |
| Attend check ins/have periodic lab tests if needed | | | | | |

## FINANCIAL INFORMATION

Payment in full is expected on all **FIRST VISIT** services. All other fees are to be paid at the time of service until other arrangements have been made and agreed upon in writing.

## CANCELLATION POLICY

To better serve our patients:
It is very common to forget an appointment due to last minute schedule changes, double booking, and even just forgetting you even have one. We understand that this happens. However, to make sure we can see all the patients that need to be seen when they are available, we reserve appointments to keep them in line with their treatment plans.

Due to a recent increase in missed appointments and last minute cancelations, we will be enforcing our cancelation policy. If you cancel in less than 24 hours you are subject to a cancelation fee. This is in place to preserve our ability to give the care needed to our patients in a fair and timely manner. A missed or last minute cancelation obstructs our ability to provide care to other patients that we were unable to schedule due to availability. We will charge you $50 for your missed appointment. If there are multiple services, it will be an additional $25 per service. For example, if you have a Massage and a Chiropractic visit scheduled in the same day, you will be charged $75 for the cancellation.

Please be respectful of our schedule so we are able to provide the services you expect so you can get the results you desire.

## INSURANCE & CREDIT CARD INFORMATION

Insurance coverage varies greatly. We cannot predict whether your policy will cover services we provide in our office. Please have your insurance card and license available for our staff to make a copy. We will obtain the necessary information from your insurance company to determine the amount and extent of coverage. This information will be gone over in detail during your 1st visit or during your Report of Findings. Please write the name of your **Insurance Company**. _____

If you have **Medicare**, we are considered a Participating Provider. We will bill Medicare for the services we provide that they will cover. Not all services are covered by Medicare. You will be required to sign an Advanced Beneficiary of Notice for Non Coverage (ABN) and will be financially responsible for all services rendered that are not covered by Medicare.

If this is an **Auto Accident** or a **Work-Related** injury, please provide us with the following information:
Name of Auto/WC Insurance Company _____ Claim # _____
Insurance Company Address _____ City _____ State/Zip _____
Claim Adjuster Name _____ Contact Phone # _____
Have you been treated elsewhere? If yes, where? _____
What services were provided? _____

**Credit Card Information:** VISA MASTERCARD DISCOVER AMEX
**#**_____ **Expiration Date:** _____ **CID:** _____

## PLEASE READ & SIGN BELOW

The information I have provided on this form, is true and accurate to the best of my knowledge. I give the Doctors and staff of Creative Health and Spine permission to render care to me. This initial visit includes a Health History Consultation, Exam & Evaluation, and any Initial Care that is determined to be clinically necessary and mutually agreed upon. I have also been provided a copy of current HIPAA Guidelines and I accept and understand the laws and guidelines set forth in the document.

Signature: _____ Today's Date: _____

Signature of Parent (for minor): _____. Today's Date: _____

**Thank You For Choosing Creative Health & Spine!**

**We Look Forward to Helping You!**

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