Adult Medical Questionnaire

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance our efficiency and will provide for more effective use of your scheduled consultation time. These questions will help to identify underlying causes of illness and will help us formulate a treatment plan.

First Name: _____ Middle Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Birth Date: _____/____/____ Age: _____

Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Social Security # _ _ _-_ _-_ _ _ _ Sex: _____ ***Email:*** _____

Place of Birth:_____ (city and state; provide country if outside U.S.)

Occupation: _____

How did you hear about our clinic: _____

Or referred by: _____

For X-Ray purposes, are you currently pregnant or think you may be pregnant? _____

Insurance Info: Name of Cardholder: _____

Cardholder date of birth: _____

Today's Date _____

1. Please check appropriate box(es):

☐ African-American	☐ Hispanic	☐ Mediterranean	☐ Asian
☐ Native American	☐ Caucasian	☐ Northern European	☐ Other

2. Please list current problems in order of priority, and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Postnasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			
e.			
f.			
g.			

3. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.)
   Example: Wendy, age 7, sister

   _____

   _____

4. Do you have any pets or farm animals? ☐ Yes ☐ No
   If yes, where do they live? ☐ Indoors ☐ Outdoors ☐ Both indoors and outdoors

5. Have you lived or traveled outside of the United States? ☐ Yes ☐ No
   If so, when and where? _____
   _____

6. Have you or your family recently experienced any major life changes? ☐ Yes ☐ No
   If yes, please comment: _____
   _____

7. Have you experienced any major losses in life? ☐ Yes ☐ No
   If so, please comment: _____
   _____

8. How important is religion (or spirituality) for you and your family's life?
   ☐ Not at all important
   ☐ Somewhat important
   ☐ Extremely important

9. How much time have you lost from work or school in the past year?
   ☐ 0–2 days
   ☐ 3–14 days
   ☐ More than 15 days

10. Previous jobs:
    _____
    _____

11. Unfortunately, abuse and violence of all kinds (verbal, emotional, physical, and sexual) are leading contributors to chronic stress, illness, and immune system dysfunction; witnessing violence and abuse can also be very traumatic. If you have experienced or witnessed any kind of abuse in the past, or if abuse is now an issue in your life, it is very important that you feel safe telling us about it, so that we can support you and optimize your treatment outcomes.

    Please do your best to answer the following questions:
    a. Did you feel safe growing up?
       ☐ Yes ☐ No

    b. Have you been involved in abusive relationships in your life?
       ☐ Yes ☐ No

    c. Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships?
       ☐ Yes ☐ No

    d. Do you currently feel safe in your home?
       ☐ Yes ☐ No

    e. Do you feel safe, respected, and valued in your current relationship?
       ☐ Yes ☐ No

f. Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse?
☐ Yes ☐ No

g. Would you feel safer discussing any of these issues privately?
☐ Yes ☐ No

12. Past Medical and Surgical History:

ILLNESSES	WHEN	COMMENTS
a. Anemia		
b. Arthritis		
c. Asthma		
d. Bronchitis		
e. Cancer		
f. Chronic Fatigue Syndrome		
g. Crohn's Disease or Ulcerative Colitis		
h. Diabetes		
i. Emphysema		
j. Epilepsy, Convulsions, or Seizures		
k. Gallstones		
l. Gout		
m. Heart Attack/Angina		
n. Heart Failure		
o. Hepatitis		
p. High Blood Fats (cholesterol, triglycerides)		
q. High Blood Pressure (hypertension)		
r. Irritable Bowel		
s. Kidney Stones		
t. Mononucleosis		
u. Pneumonia		
v. Rheumatic Fever		
w. Sinusitis		
x. Sleep Apnea		
y. Stroke		
z. Thyroid Disease		
aa. Other (describe)		
INJURIES	**WHEN**	**COMMENTS**
a. Back Injury		
b. Broken Bone (describe)		
c. Head Injury		
d. Neck Injury		

e. Other (describe)		
DIAGNOSTIC STUDIES	**WHEN**	**COMMENTS**
a. Barium Enema		
b. Bone Scan		
c. CAT Scan of Abdomen		
d. CAT Scan of Brain		
e. CAT Scan of Spine		
f. Chest X-ray		
g. Colonoscopy		
h. EKG		
i. Liver Scan		
j. Neck X-ray		
k. NMR/MRI		
l. Sigmoidoscopy		
m. Upper GI Series		
n. Other (describe)		
OPERATIONS	**WHEN**	**COMMENTS**
a. Appendectomy		
b. Dental Surgery		
c. Gallbladder		
d. Hernia		
e. Hysterectomy		
f. Tonsillectomy		
g. Other (describe)		
h. Other (describe)		

13. Hospitalizations:

WHERE HOSPITALIZED	WHEN	FOR WHAT REASON
a.		
b.		
c.		
d.		
e.		

14. How often have you have taken antibiotics?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

15. How often have you have taken oral steroids (e.g., cortisone, prednisone, etc.)?

	LESS THAN 5 TIMES	MORE THAN 5 TIMES
Infant/Child		
Teen		
Adult		

16. What medications are you taking now? Include nonprescription drugs.

MEDICATION NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		

Are you allergic to any medications? ☐ Yes ☐ No
If yes, please list: _____
_____

17. List all vitamins, minerals, and other nutritional supplements that you are taking now. Indicate dosage in mg or IU and the form (e.g., calcium carbonate vs. calcium lactate) when possible.

VITAMIN/MINERAL/ SUPPLEMENT NAME	DATE STARTED	DOSAGE
a.		
b.		
c.		
d.		
e.		
f.		
g.		

18. Infancy/Childhood:

QUESTION	YES	NO	DON'T KNOW	COMMENT
a. Were you a full-term baby?				
A preemie?				
b. Were you breast-fed?				
Bottle-fed?				
c. As a child, did you eat a lot of sugar and/or candy?				

19. As a child, were there any foods that you had to avoid because they gave you symptoms?
☐ Yes ☐ No
If yes, please name the food and symptom (Example: milk – gas and diarrhea): _____
_____
_____

20. Place a check mark next to each food/drink that is part of your current diet.

	USUAL BREAKFAST	√		**USUAL LUNCH**	√		**USUAL DINNER**	√
a.	None		a.	None		a.	None	
b.	Bacon/sausage		b.	Butter		b.	Beans (legumes)	
c.	Bagel		c.	Coffee		c.	Brown rice	
d.	Butter		d.	Eat in a cafeteria		d.	Butter	
e.	Cereal		e.	Eat in restaurant		e.	Carrots	
f.	Coffee		f.	Fish sandwich		f.	Coffee	
g.	Donut		g.	Juice		g.	Fish	
h.	Eggs		h.	Leftovers		h.	Green vegetables	
i.	Fruit		i.	Lettuce		i.	Juice	
j.	Juice		j.	Margarine		j.	Margarine	
k.	Margarine		k.	Mayo		k.	Milk	
l.	Milk		l.	Meat sandwich		l.	Pasta	
m.	Oat bran		m.	Milk		m.	Potato	
n.	Sugar		n.	Salad		n.	Poultry	
o.	Sweet roll		o.	Salad dressing		o.	Red meat	
p.	Sweetener		p.	Soda		p.	Rice	
q.	Tea		q.	Soup		q.	Salad	
r.	Toast		r.	Sugar		r.	Salad dressing	
s.	Water		s.	Sweetener		s.	Soda	
t.	Wheat bran		t.	Tea		t.	Sugar	
u.	Yogurt		u.	Tomato		u.	Sweetener	
v.	Other (List below)		v.	Water		v.	Tea	
			w.	Yogurt		w.	Water	
			x.	Other (List below)		x.	Yellow vegetables	
						y.	Other: (List below)	

21. How much of the following do you consume each week?

a.	Candy	
b.	Cheese	
c.	Chocolate	
d.	Cups of coffee containing caffeine	
e.	Cups of decaffeinated coffee or tea	
f.	Cups of hot chocolate	
g.	Cups of tea containing caffeine	
h.	Diet sodas	
i.	Ice cream	
j.	Salty foods	
k.	Slices of white bread (rolls/bagels)	
l.	Sodas with caffeine	
m.	Sodas without caffeine	

22. Are you on a special diet? ☐ Yes ☐ No

☐ Vegetarian ☐ Vegetarian ☐ Other (describe below):
☐ Diabetic ☐ Blood type diet _____
☐ Dairy restricted _____

23. Is there anything special about your diet that we should know? ☐ Yes ☐ No
If yes, please explain: _____
_____

24. Do you have symptoms <u>immediately after</u> eating, such as belching, bloating, sneezing, hives, etc.?
☐ Yes ☐ No
If yes, are these symptoms associated with any particular food or supplement(s)? ☐ Yes ☐ No
If yes, please name the food or supplement and symptom(s) (Example: milk – gas and diarrhea):
_____
_____

25. Do you feel you have <u>delayed</u> symptoms after eating certain foods (symptoms may not be evident for 24 hours or more), such as fatigue, muscle aches, sinus congestion, etc.? ☐ Yes ☐ No

26. Do you feel much <u>worse</u> when you eat a lot of :

☐ High-fat foods ☐ Refined sugar (junk food)
☐ High-protein foods ☐ Fried foods
☐ High-carbohydrate foods (breads, pastas, potatoes) ☐ 1 or 2 alcoholic drinks
☐ Other: _____

27. Do you feel much <u>better</u> when you eat a lot of :

☐ High-fat foods ☐ Refined sugar (junk food)
☐ High-protein foods ☐ Fried foods
☐ High-carbohydrate foods (breads, pastas, potatoes) ☐ 1 or 2 alcoholic drinks
☐ Other: _____

28. Does skipping a meal greatly affect your symptoms? ☐ Yes ☐ No

29. Have you ever had a food that you craved or really "binged" on over a period of time?
Food craving may be an indicator that you may be allergic to that food. ☐ Yes ☐ No
If yes, what food(s)? _____
_____

30. Do you have an aversion to certain foods? ☐ Yes ☐ No
If yes, what foods? _____

31. Please fill in the chart below with information about your bowel movements:

a. Frequency	√	c. Color	√
More than 3x/day		Medium brown consistently	
1–3x/day		Very dark or black	
4–6x/week		Greenish	
2–3x/week		Blood is visible	
1 or fewer x/week		Varies a lot	
		Dark brown consistently	
b. Consistency		Yellow, light brown	
Soft and well formed		Greasy, shiny appearance	
Often float			
Difficult to pass			
Diarrhea			
Thin, long, or narrow			
Small and hard			
Loose but not watery			
Alternating between hard and loose/watery			

32. Intestinal gas:
☐ Daily
☐ Occasionally
☐ Excessive
☐ Present with pain
☐ Foul smelling
☐ Little odor

33. Have you ever used alcohol? ☐ Yes ☐ No
If yes, how often do you now drink alcohol?
☐ No longer drinking alcohol
☐ Average 1–3 drinks/week
☐ Average 4–6 drinks/week
☐ Average 7–10 drinks/week
☐ Average more than 10 drinks/week
Have you ever had a problem with alcohol? ☐ Yes ☐ No
If yes, please indicate time period (month/year): from _____ to _____

34. Have you ever used recreational drugs? ☐ Yes ☐ No

35. Have you ever used tobacco? ☐ Yes ☐ No
If yes, number of years as a nicotine user: _____ Amount per day: _____ Year quit: _____.
What type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐Patch/Gum

36. Are you exposed to secondhand smoke regularly? ☐ Yes ☐ No

37. Do you have mercury amalgam fillings? ☐ Yes ☐ No

38. Do you have any artificial joints or implants? ☐ Yes ☐ No

39. Do you feel worse at certain times of the year? ☐ Yes ☐ No
    If yes, when? ☐ Spring ☐ Fall
    ☐ Summer ☐ Winter

40. Have you, to your knowledge, been exposed to toxic metals in your job or at home? ☐ Yes ☐ No
    If yes, which one(s)? ☐ Lead ☐ Cadmium
    ☐ Arsenic ☐ Mercury
    ☐ Aluminum

41. Do odors affect you? ☐ Yes ☐ No

42. How well have things been going for you?

	VERY WELL	FAIR	POORLY	VERY POORLY	DOES NOT APPLY
a. At school					
b. In your job					
c. In your social life					
d. With close friends					
e. With sex					
f. With your attitude					
g. With your boyfriend/girlfriend					
h. With your children					
i. With your parents					
j. With your spouse					

43. Have you ever had psychotherapy or counseling? ☐ Yes ☐ No
    ☐ Currently ☐ Previously If previously, from _____ to _____
    What kind? _____
    Comments: _____

44. Are you currently, or have you ever been, married? ☐ Yes ☐ No
    If so, when were you married? _____ Spouse's occupation: _____
    When were you separated? _____ ☐ Never
    When were you divorced? _____ ☐ Never
    When were you remarried? _____ ☐ Never Spouse's occupation _____
    Comments: _____

45. Hobbies and leisure activities: _____
    _____

46. Do you exercise regularly? ☐ Yes ☐ No
    If so, how many times a week? ☐ 1 time ☐ 2 times ☐ 3 times ☐ 4 or more times
    When you exercise, how long is each session? ☐ Less than 15 minutes ☐ 16–30 minutes
    ☐ 31–45 minutes ☐ More than 45 minutes
    What type of exercise is it?
    ☐ Jogging/walking ☐ Tennis
    ☐ Basketball ☐ Water sports
    ☐ Home aerobics ☐ Other: _____

47. FAMILY HISTORY: For each member of your family, follow the gray or white line across the page and check the appropriate boxes.

*(Note: Except for **spouse**, family refers to **blood** or **natural** relatives.)* **PRINT NAMES BELOW**	Good Health	Poor Health	Deceased	Write in age and cause of death. Include accidents and suicides.	Alcoholism	Allergies or Asthma	Alzheimer's or Dementia	Anemia	Blood Clotting Problems	Diabetes	Cancer or Tumor	Epilepsy	Genetic Disease	Heart Trouble	High Blood Pressure	Kidney or Bladder Dis.	Nervous Breakdown	Rheumatism or Arthritis	Stomach or Duodenal Ulcer
Father																			
Mother:																			
Brothers/Sisters:																			
Spouse:																			
Child:																			
Child:																			
Child:																			
Child:																			
Paternal relatives (in each box, write in how many affected with condition):																			
Maternal relatives (in each box, write in how many affected with condition):																			

48. Any other family history we should know about? ☐ Yes ☐ No
If so, please comment: _____

49. What is the attitude of those close to you about your illness? ☐ Supportive ☐ Nonsupportive

FOR WOMEN ONLY (questions 50–58):

50. Have you ever been pregnant? (If no, skip to question 51.) ☐ Yes ☐ No

Number of miscarriages: _____ Number of abortions: _____ Number of preemies: _____

Number of term births: _____ Birth weight of largest baby: ___ Birth weight of smallest baby: ___

Did you develop toxemia (high blood pressure)? ☐ Yes ☐ No

Have you had other problems with pregnancy? ☐ Yes ☐ No

If so, please comment: _____

_____

51. Age at first period: _____ Date of last Pap smear: _____ Date of last mammogram:_____
Pap Smear: ☐ Normal ☐ Abnormal
Mammogram: ☐ Normal ☐ Abnormal

52. Have you ever used birth control pills? ☐ Yes ☐ No If yes, when? _____

53. Are you taking the pill now? ☐ Yes ☐ No

54. Did taking the pill agree with you? ☐ Yes ☐ No ☐ Not applicable

55. Do you currently use contraception? ☐ Yes ☐ No
If yes, what type of contraception do you use? _____

56. Are you in menopause? ☐ Yes ☐ No If yes, age at last period: _____
Do you take estrogen? ☐ Ogen® ☐ Estrace® ☐ Premarin® ☐ Other (specify): _____
progesterone? ☐ Provera® ☐ Other (specify): _____

57. How long have you been on hormone replacement therapy (if applicable)? _____

58. In the second half of your cycle, do you have symptoms of breast tenderness, water retention, or irritability (PMS)? ☐ Yes ☐ No ☐ Not applicable

59. Have you ever had trouble getting pregnant? ☐ Yes ☐ No

60. Are your monthly periods heavy? ☐ Yes ☐ No

61. Did/Do you experience migraines around the time of your period? ☐ Yes ☐ No

59. Place a check mark by each symptom that occurs now ***or*** that has occurred in the past 6 months.

GENERAL	Mild	Mod-erate	Severe
Cold hands and feet			
Cold intolerance			
Daytime sleepiness			
Difficulty falling asleep			
Early waking			
Fatigue			
Fever			
Flushing			
Heat intolerance			
Night waking			
Nightmares			
No dream recall			
HEAD, EYES & EARS			
Conjunctivitis			
Distorted sense of smell			
Distorted taste			
Ear fullness			
Ear noises			
Ear pain			
Ear ringing/buzzing			
Eye crusting			
Eye pain			
Headache			
Hearing loss			
Hearing problems			
Lid margin redness			
Migraine			
Sensitivity to loud noises			
Vision problems			

MUSCULOSKELETAL	Mild	Mod-erate	Severe
Back muscle spasm			
Calf cramps			
Chest tightness			
Foot cramps			
Joint deformity			
Joint pain			
Joint redness			
Joint stiffness			
Muscle pain			
Muscle spasms			
Muscle stiffness			
Muscle twitches around eyes			
Muscle twitches in arms or legs			
Muscle weakness			
Neck muscle spasm			
Tendonitis			
Tension headache			
TMJ problems			
MOOD/NERVES			
Agoraphobia			
Anxiety			
Auditory hallucinations			
Blackout			
Depression			
Difficulty with: Concentrating			
Balance			
Thinking			
Judgment			
Speech			
Memory			
Dizziness (spinning)			
Fainting			
Fearfulness			
Irritability			

MOOD/NERVES (continued)	Mild	Mod-erate	Severe
Light-headedness			
Numbness			
Other phobias			
Panic attacks			
Paranoia			
Seizures			
Suicidal thoughts			
Tingling			
Tremor/trembling			
Visual hallucinations			
EATING			
Binge eating			
Bulimia			
Can't gain weight			
Can't lose weight			
Carbohydrate craving			
Carbohydrate intolerance			
Poor appetite			
Salt craving			
DIGESTION			
Anal spasms			
Bad teeth			
Bleeding gums			
Bloating of lower abdomen			
Bloating of whole abdomen			
Blood in stools			
Burping			
Canker sores			
Cold sores			
Constipation			
Cracking at corner of lips			
Dentures with poor chewing			
Diarrhea			
Difficulty swallowing			
Dry mouth			
Farting			

DIGESTION (continued)	Mild	Mod-erate	Severe
Fissures			
Foods "repeat" (reflux)			
Heartburn			
Hemorrhoids			
Intolerance to: Lactose			
All milk products			
Gluten (wheat)			
Corn			
Eggs			
Fatty foods			
Yeast			
Liver disease/jaundice (yellow eyes or skin)			
Lower abdominal pain			
Mucus in stools			
Nausea			
Periodontal disease			
Sore tongue			
Strong stool odor			
Undigested food in stools			
Upper abdominal pain			
Vomiting			
SKIN PROBLEMS			
Acne on back			
Acne on chest			
Acne on face			
Acne on shoulders			
Athlete's foot			
Bumps on back of upper arms			
Cellulite			
Dark circles under eyes			
Ears get red			
Easy bruising			

SKIN PROBLEMS (continued)	Mild	Mod-erate	Severe
Eczema			
Herpes (genital)			
Hives			
Jock itch			
Lackluster skin			
Moles with color/size change			
Oily skin			
Pale skin			
Patchy dullness			
Psoriasis			
Rash			
Red face			
Sensitive to bites			
Sensitive to poison ivy/oak			
Shingles			
Skin cancer			
Skin darkening			
Strong body odor			
Thick calluses			
Vitiligo			
SKIN, ITCHING			
Anus			
Arms			
Ear canals			
Eyes			
Feet			
Hands			
Legs			
Nipples			
Nose			
Penis			
Roof of mouth			
Scalp			
Skin in general			
Throat			

SKIN, DRYNESS	Mild	Mod-erate	Severe
Eyes			
Feet			
Any cracking?			
Any peeling?			
Hair			
And unmanageable?			
Hands			
Any cracking?			
Any peeling?			
Mouth/throat			
Scalp			
Any dandruff?			
Skin in general			
LYMPH NODES			
Enlarged/neck			
Tender/neck			
Other enlarged/tender lymph nodes			
NAILS			
Bitten			
Brittle			
Curve up			
Frayed			
Fungus (fingers)			
Fungus (toes)			
Pitting			
Ragged cuticles			
Ridges			
Soft			
Thickening of fingernails			
Thickening of toenails			
White spots/lines			

RESPIRATORY	Mild	Mod-erate	Severe
Bad breath			
Bad odor in nose			
Cough (dry)			
Cough (productive)			
Hay fever (spring)			
Hay fever (summer)			
Hay fever (fall)			
Hay fever (change of season)			
Hoarseness			
Nasal stuffiness			
Nosebleeds			
Postnasal drip			
Sinus fullness			
Sinus infection			
Snoring			
Sore throat			
Wheezing			
Winter stuffiness			
CARDIOVASCULAR:			
Angina/chest pain			
Breathlessness			
Heart attack			
Heart murmur			
High blood pressure			
Irregular pulse			
Mitral valve prolapse			
Palpitations			
Phlebitis			
Swollen ankles/feet			
Varicose veins			

URINARY	Mild	Mod-erate	Severe
Bed wetting			
Hesitancy			
Infection			
Kidney disease			
Kidney stone			
Leaking/incontinence			
Pain/burning			
Prostate enlargement			
Prostate infection			
Urgency			
MALE REPRODUCTIVE			
Discharge from penis			
Ejaculation problem			
Genital pain			
Impotence			
Infection			
Lumps in testicles			
Poor libido (sex drive)			
FEMALE REPRODUCTIVE			
Breast cysts			
Breast lumps			
Breast tenderness			
Ovarian cyst			
Poor libido (sex drive)			
Endometriosis			
Fibroids			
Infertility			
Vaginal discharge			
Vaginal odor			
Vaginal itch			
Vaginal pain			

FEMALE REPRODUCTIVE (continued)	Mild	Mod-erate	Severe
Premenstrual: Bloating			
Breast tenderness			
Carbohydrate craving			
Chocolate craving			
Constipation			
Decreased sleep			
Diarrhea			
Fatigue			
Increased sleep			
Irritability			
Menstrual: Cramps			
Heavy periods			
Irregular periods			
No periods			
Scanty periods			
Spotting between			

Informed Consent Regarding Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at *Natural Wellness & Pain Relief Centers of Michigan*

You are under no obligation to purchase nutritional supplements at our clinic.

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____,

have read and understand the above statement on _____ (date),

witnessed by _____, _____ (date).

Consent for Purposes of Treatment, Payment and Healthcare Operations

I acknowledge that Natural Wellness & Pain Relief Centers "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review Natural Wellness & Pain Relief Centers' Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of. The Notice of Privacy Practices for Natural Wellness & Pain Relief Centers is also provided on request at the main administration desk of this practice on the website at **www.Michiganwellnessandpainrelief.com**. This Notice of Privacy Practices also describes my rights and Natural Wellness & Pain Relief Centers' duties with respect to my protected health information.

Natural Wellness & Pain Relief Centers reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by accessing the website, calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_____ _____

Signature of Patient or Personal Representative Date

_____

Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

An Explanation of Our Financial Policy

As doctors and staff, we are passionate about what we do, and we feel that we have a calling to provide as many people as possible with the highest quality natural health care possible. Just as our services are unique to this region, our financial policies set us apart from traditional chiropractors and mainstream medicine. We have prepared this handout to answer questions you or your family members may have about the rationale for our financial policies. If, after reading this, you still have questions, feel free to speak with our staff.

Why We Do Not Accept Insurance Assignment

When clinics bill health insurance companies directly, the doctors have two options: they can accept whatever fee the insurance company deems appropriate, called their 'maximum allowable fee,' or they can reject the insurance companies' maximum allowable fee. When doctors accept these fees, they are often significantly less than what the doctors' billed fee. Many times it can be less than 50%. Because doctors accepting this maximum fee are making half the money, they must see twice as many patients each day to make the same amount. The more patients a doctor sees means less face-to-face time with each patient, and hence quality suffers. Traditional medical offices are usually okay with this since they see 30-40 patients per day. However, Dr. Strauchman never sees more than 12 patients per day, or about one per hour. This allows her to spend quality time with her patients to help them find a comprehensive solution to their problem. A spinal rehabilitation visit with Dr. Strauchman or Dr. Morningstar typically runs about 25-35 minutes, whereas visits to other traditional chiropractors often last only 5-10 minutes. Again, more time is required to achieve a better result that lasts much longer. In general, insurance companies are not focused on any preventive or wellness services. They are heavily invested in the conventional model of health care that too often relies on drugs and surgery. We are committed to the integrative, anti-aging medicine model that addresses the underlying causes of your symptoms with specific spine care, nutrition/hormone therapies and lifestyle recommendations.

In today's healthcare environment, the actual cost for doctors to provide services continues to rise, while the percentage of reasonable fees that insurance payments cover is declining. At the same time, the profits of health insurance companies and the salaries of their top executives continue to rise to record levels.

Ironically, some of our patients complain about their extremely brief and unsatisfactory office visits in other chiropractic and medical practices, while at the same time expressing frustration that we do not accept insurance assignment. Unfortunately, we have found that we cannot do this and still provide the time-intensive, well-researched, expert intensive care that we do.

Why Our Doctors Must Charge for Your Follow-up Consultations

Some patients have asked why we charge for follow-up consultations regarding lab results and exams, as well as for telephone consultations, when other doctors do not. Our doctors are not salaried, as are doctors who are employed in large clinics and hospitals and whose salaries are partially subsidized by expensive diagnostic and surgical procedures and hospital fees. Our doctors' pay is based solely on the time and services they provide. Like all non-salaried professionals, including lawyers and accountants, our doctors must charge for their time so we can afford to provide you with care and remain in business. In general, we charge only for our face-to-face time with you. Our doctors spend considerable non-reimbursed time each week consulting with each other (and other providers) regarding your care, reviewing your records, and meeting with staff to improve the quality of our services.

In follow-up visits, our doctors spend significant time discussing your results with you. For example, it is relatively simple to inform a patient that her mammogram is negative; but it is entirely different to discuss the results of more complex functional evaluations and to recommend practical lifestyle and dietary strategies that may help to prevent breast cancer. Patients often complain that conventional doctors do

little to nothing in the way of truly preventive medicine. We want you to understand that preventive health care takes considerable time and expertise on the part of the doctor and that someone has to pay for that time and expertise.

About the Charges for Our Doctors' Services

Some patients may have the mistaken impression that our doctors take home the majority of the fees we charge for their services and that the doctors have a great deal of leeway to offer discounts for those fees. In fact, our doctors take home only a fraction of the fees collected for their services. This is because a clinic like ours requires highly trained staff and extensive, expensive professional continuing education. The majority of our fees support the overall mission of providing high-quality natural health care, not the doctors' paychecks. Our doctors have chosen this work because it is their passion and their calling and certainly not because it is a way to make a lucrative income. In fact, most medical doctors and chiropractors who choose to practice integrative/anti-aging medicine know that their income will be substantially lower than it would be if they were practicing in a more conventional manner that is fully supported by the healthcare reimbursement system.

Why We Sell Nutritional Supplements and How We Price Them

We recommend nutritional supplements as an adjunct to dietary and lifestyle modification. This approach is central to the well-researched and science-based practice of integrative/anti-aging medicine, which all of our professional staff have studied. We sell therapeutic, quality nutritional supplements as a service to our patients. With a few exceptions, we do not sell nutritional products of similar quality to those that are widely available over the counter. We purchase high-quality nutritional products from the top nutritional research laboratories in North America and Great Britain, and we price them to cover our costs of providing them. However, we keep our markups as low as possible, and we intentionally do not profit from the sale of nutritional products. Many other clinics have commended our pricing policy as ethical and fair.

For more information on our nutritional supplement policy, please read our "Informed Consent Regarding Nutritional and Herbal Supplements," which is available at the front desk.

Why We Require Full Payment at the Time Services are Rendered

For ongoing spine and posture care, and massage therapy, all patients are required to maintain a credit card pre-authorization on file with us. As we bill the patients insurance weekly, patients can typically expect an insurance check within 21 days from the time of each visit that covers that visit. At this point, the patient has two options: they can either bring in those insurance checks to the office along with the explanation of benefits so that they're account is credited, or they can cash the checks themselves and we will bill their credit card on file every 30 days for the current outstanding balance. Should a credit card transaction be declined, the patient will not be allowed another visit until the balance is cleared.

For anti-aging visits, all fees are due in entirety the same day the service is rendered. If the patient cannot pay their full amount, the patient may set up an interest free payment plan through CareCredit. The office does not offer in-house payment plans to anti-aging patients.

I, the undersigned patient, hereby acknowledge that I have read and understand the above described financial policy. My signature below indicates that I fully agree with this policy and choose to receive clinical services at the Natural Wellness & Pain Relief Center under these pretenses.

Patient: _____ Date: _____