

## Nutrition Patient Questionnaire

Date: \_\_\_\_\_ Patient # \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_

E-Mail \_\_\_\_\_ Zip Code \_\_\_\_\_

By documenting your email address on this page, you are agreeing that health information for yourself can be freely shared via email between yourself and the **OXFORD HEALTH & WELLNESS CENTER**. While usually considered safe, email is not the most secure method of sharing personal information.

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_

Place of Employment \_\_\_\_\_ Occupation \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_ # of Children \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Place of Employment \_\_\_\_\_

In case of emergency, who should we contact?

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

We will provide a receipt for you to submit to your insurance. You are responsible for payment in full at the time of service. By signing below you are stating that you clearly understand that all services rendered at the **OXFORD HEALTH & WELLNESS CENTER** are your responsibility and payment is expected at the time of service.

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

### NUTRITIONAL INFORMED CONSENT

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean:

"Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease."

A Vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented or be classified as a drug by anyone.

Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body.

Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Oxford Health & Wellness Center  
5144 College Corner Pike  
Oxford, OH 45056  
(513)524-4800  
www.gettingubetter.com

# Insurance Billing

**Oxford Health & Wellness Center and Dr. Stacy A. Chidester** are out of network with all insurance companies for nutritional services. While we do not bill your insurance company for you, you are welcome to submit a claim on your own seeking reimbursement. Before you do, please consider the following...

1. If you file a claim with your insurance company, all diagnosis codes and test results will go on file with your insurance company. This can be used to determine future premium costs for you and your family.
2. If your diagnosis includes a hereditary disease like high blood pressure, it will not only be seen on your health records, but also the records for your children and grandchildren and will be used to determine their coverage availability and premium costs.
3. Insurance companies are quick to raise premiums or drop coverage entirely when customers file too many claims, or just one of the wrong kind of claim (like nutritional treatment rather than the medical drug-fix it norm).
4. Your insurance carrier is responsible only for paying benefits covered under your policy and will deny anything they deem "medically unnecessary or experimental". Nutritional services frequently fall under this category and therefore are not covered which means you are supplying them with diagnosis codes, test results, etc (which they can use against you) yet you see no financial benefit.
5. Rescission – if you have a serious illness, insurance companies will search your file to obtain medical records from the last several years and if they find any inconsistency in your application, your policy is rescinded so they can avoid paying for costly treatments or medication. Any information you share with them could be used against you.
6. Preapproval – if you call your insurance company to find out if certain services are covered, it is a warning sign to your provider that bills are coming which may spark a rescission search on your account.

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# PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ O<sub>2</sub> \_\_\_\_\_

*This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...*

## Primary Complaints

- |                                                                                            |                                                                              |                                                              |
|--------------------------------------------------------------------------------------------|------------------------------------------------------------------------------|--------------------------------------------------------------|
| 090 <input type="checkbox"/> General Good Health                                           | 039 <input type="checkbox"/> High Blood Pressure 401.9                       | 063 <input type="checkbox"/> Prostate Disorder 602.9         |
| 091 <input type="checkbox"/> Desires Nutritional & Metabolic Analysis                      | 040 <input type="checkbox"/> Low Blood Pressure 458.9                        | 069 <input type="checkbox"/> Hyperthyroidism 242.90          |
| 001 <input type="checkbox"/> Skin Disorder 692.9                                           | 041 <input type="checkbox"/> Tachycardia (High Heart Rate) 785.00            | 070 <input type="checkbox"/> Hypothyroidism 244.9            |
| 002 <input type="checkbox"/> Acne 706.1                                                    | 042 <input type="checkbox"/> Numbness 782.0                                  | 071 <input type="checkbox"/> Systemic Lupus 710.0            |
| 003 <input type="checkbox"/> Psoriasis 696.1                                               | 043 <input type="checkbox"/> Constipation 564.0                              | 072 <input type="checkbox"/> Infertility, female 628.9       |
| 004 <input type="checkbox"/> Urticaria (Hives) 708.9                                       | 044 <input type="checkbox"/> Indigestion 536.8                               | 073 <input type="checkbox"/> Interstitial Cystitis 595.1     |
| 005 <input type="checkbox"/> ADD/ADHD 314.00/314.01                                        | 045 <input type="checkbox"/> Ulcerative Colitis 556.9                        | 074 <input type="checkbox"/> Irregular Menstrual Cycle 626.4 |
| 006 <input type="checkbox"/> Allergies, Unspecified 477.9                                  | 046 <input type="checkbox"/> Depression 311                                  | 075 <input type="checkbox"/> Menopausal Symptoms 627.2       |
| 007 <input type="checkbox"/> Allergic Rhinitis from food 477.1                             | 047 <input type="checkbox"/> Diabetes Mellitus 250.0                         | 076 <input type="checkbox"/> Hot Flashes 627.2               |
| 008 <input type="checkbox"/> Sinusitis 461.9                                               | 030 <input type="checkbox"/> Diabetes Type I 250.01                          | 077 <input type="checkbox"/> Mental Disorder 300.9           |
| 009 <input type="checkbox"/> Alzheimer's 331.0                                             | 031 <input type="checkbox"/> Diabetes Type II 250.02                         | 078 <input type="checkbox"/> Insomnia 780.52                 |
| 010 <input type="checkbox"/> Poor Concentration/Memory 310.1                               | 029 <input type="checkbox"/> Hyperglycemia [high blood sugar] 790.29         | 079 <input type="checkbox"/> Mouth/Throat/Tongue             |
| 011 <input type="checkbox"/> Parkinson's Disease 332.0                                     | 048 <input type="checkbox"/> Hypoglycemia [low blood sugar] 251.2            | 080 <input type="checkbox"/> Canker Sores 528.2              |
| 012 <input type="checkbox"/> Anemia 285.9                                                  | 049 <input type="checkbox"/> Dizziness/Balance Problem 780.4                 | 081 <input type="checkbox"/> Overweight 278.02               |
| 013 <input type="checkbox"/> Arthritic Disorder 716.90                                     | 050 <input type="checkbox"/> Ear Infection 381.4                             | 082 <input type="checkbox"/> Underweight 783.22              |
| 014 <input type="checkbox"/> Osteoporosis 733.00                                           | 051 <input type="checkbox"/> Epstein Barr 075                                | 083 <input type="checkbox"/> Sexual Disorder 302.89          |
| 015 <input type="checkbox"/> Asthma 493.90                                                 | 052 <input type="checkbox"/> Eye Problems 379.91                             | 084 <input type="checkbox"/> Spinal Problems 724.9           |
| 016 <input type="checkbox"/> Emphysema 492.8                                               | 053 <input type="checkbox"/> Cataracts 366.9                                 | 085 <input type="checkbox"/> Obesity 278.00                  |
| 017 <input type="checkbox"/> Cancer                                                        | 054 <input type="checkbox"/> Glaucoma 365.9                                  | 086 <input type="checkbox"/> GERD 530.81                     |
| 018 <input type="checkbox"/> Breast 174.9female 175.9male                                  | 055 <input type="checkbox"/> Macular Degeneration 362.50                     | 087 <input type="checkbox"/> HIV 042                         |
| 019 <input type="checkbox"/> Prostate 185                                                  | 056 <input type="checkbox"/> Fever 780.6                                     | 088 <input type="checkbox"/> Crohn's Disease 555.9           |
| 020 <input type="checkbox"/> Lung 162.9                                                    | 057 <input type="checkbox"/> Fibromyalgia 729.1                              | 089 <input type="checkbox"/> Irritable Bowel Syndrome 564.1  |
| 021 <input type="checkbox"/> Colon and Rectal 153.9                                        | 058 <input type="checkbox"/> Gallbladder Disorder 575.9                      | 092 <input type="checkbox"/> Normal Pregnancy v22.2          |
| 022 <input type="checkbox"/> Skin 173.9                                                    | 059 <input type="checkbox"/> Gout 274.9                                      | **only applicable if currently pregnant                      |
| 023 <input type="checkbox"/> Leukemia w/o remission 208.90<br>Leukemia w/ remission 208.91 | 060 <input type="checkbox"/> Headaches 784.0                                 | 093 <input type="checkbox"/> Shingles 053.9                  |
| 024 <input type="checkbox"/> Lymphoma, malignant 202.8                                     | 061 <input type="checkbox"/> Hearing Loss 389.9                              | 140 <input type="checkbox"/> Migraines 346.90                |
| 025 <input type="checkbox"/> Brain Tumor, malignant 191.9                                  | 062 <input type="checkbox"/> Infertility, male 606.9                         | 141 <input type="checkbox"/> Rheumatoid Arthritis 714.0      |
| 027 <input type="checkbox"/> Anxiety Disorder 300.00                                       | 064 <input type="checkbox"/> Liver Disease 571.9                             | 142 <input type="checkbox"/> Non-Systemic Lupus 695.4        |
| 028 <input type="checkbox"/> Autism 299.00                                                 | 065 <input type="checkbox"/> Hepatitis 573.3                                 | 143 <input type="checkbox"/> Multiple Sclerosis 340          |
| 033 <input type="checkbox"/> Edema 782.3                                                   | 066 <input type="checkbox"/> Hepatitis B 070.30                              | 144 <input type="checkbox"/> ALS (Lou Gerigs) 335.20         |
| 034 <input type="checkbox"/> Eczema 692.9                                                  | 067 <input type="checkbox"/> Hepatitis C 070.51                              | 145 <input type="checkbox"/> Polymyalgia Rheumatica 725      |
| 035 <input type="checkbox"/> Chronic Fatigue 780.71                                        | 068 <input type="checkbox"/> Kidney Disorder 593.9 or Bladder Disorder 596.9 | 146 <input type="checkbox"/> Scleroderma 710.1               |
| 036 <input type="checkbox"/> Circulatory Disorder 459.9                                    |                                                                              | 171 <input type="checkbox"/> Goiter 240.9                    |
| 037 <input type="checkbox"/> Heart Disease 429.9                                           |                                                                              | 178 <input type="checkbox"/> Raynaud's Syndrome 443.8        |
| 038 <input type="checkbox"/> High Cholesterol 272.0                                        |                                                                              | 179 <input type="checkbox"/> Hemochromatosis 275.0           |
|                                                                                            |                                                                              | 180 <input type="checkbox"/> Thalassemia 282.49              |
|                                                                                            |                                                                              | 181 <input type="checkbox"/> Brain aneurysm 431              |

**If necessary, please state your most significant concern...**

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## General Health

- 100  Fingernail base is pink  
101  Fingernail base is purple  
102  Fingernails have ridges or white spots  
103  Fingernails are soft  
104  Fingernails are splitting  
105  Fingernails peel  
106  Pale fingernail beds  
107  Blacks out easily  
108  Balance problems  
109  Difficulty walking  
110  Has tattoos  
111  Brittle hair  
112  Dry hair  
113  Thin hair  
114  Hair loss  
115  Drinks alcoholic beverages daily  
116  Drinks less than 8 glasses of water per day  
117  Currently on Chemotherapy  
118  Currently on radiation treatment  
119  Had chemotherapy in the past  
120  Has had radiation treatments in the past  
121  Gained over 20 lbs in the last 12 months  
122  Somewhat Overweight  
123  Somewhat Underweight
- 124  Unexplained loss of >20lbs in last 4 months  
125  Energy level is worse than it was 5 years ago  
127  Sleeps less than 6 hours per night  
128  Unable to recall dreams the next day  
129  Sensitive to chemicals, paint, fumes, cologne  
130  Had blood transfusion in the past  
131  Had transplant in the past  
138  Takes anti-rejection drugs  
132  Had a major accident or injury  
137  Sleep Apnea  
139  Toxic chemical exposure  
175  Has been out of the country recently  
176  Had childhood vaccines  
177  Had a vaccine in the last 12 months  
147  Had a flu shot last year  
182  Had a pneumonia vaccine last year  
183  Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184  Cancer  
185  Heart Disease  
186  Diabetes  
187  Alcoholism  
188  Depression  
189  Obesity

## Lifestyle & Environment

Do you use?  Well Water  City Water Filtered?  Yes  No Filter Type? \_\_\_\_\_

What kind of pipes are in your home?  Steel  CPVC  Copper  Pex  Other \_\_\_\_\_

What year was your home built? \_\_\_\_\_ Any renovations in the past year? \_\_\_\_\_

Do you use chlorine bleach or other heavy duty cleaners in your home/work?  Yes  No

Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry?  Yes  No

Explain: \_\_\_\_\_

Have you ever worked around industrial solvents, chemicals or pesticides?  Yes  No

Explain: \_\_\_\_\_

- 380  Drinks beverages from a can  
370  Drinks alcohol  
371  Drinks caffeinated coffee  
372  Drinks caffeinated pop/soda  
373  Drinks caffeinated tea  
374  Drinks decaffeinated coffee  
375  Drinks decaffeinated pop/soda  
376  Drinks decaffeinated tea  
377  Drinks >3 cups of coffee daily  
378  Drinks >3 cups of tea per day  
388  Drinks diet pop/soda
- 379  Drinks >1 pop/sodas per day  
I had 4 alcoholic drinks in one day:  
172  never  
173  more than 3 months ago  
174  less than 3 months ago  
381  Has >5 alcoholic drinks/week  
391  Craves sugar / starches  
382  Currently smokes  
383  Quit smoking in last 5 years  
384  Smoked for >5 years  
385  Smokes >1 pack per day
- 126  Rarely exercises  
133  Regularly exercises  
386  Takes Vitamins  
134  Vegetarian  
135  Eats no red meat  
136  Eats no meat, no dairy  
387  Frequent use of artificial sweeteners  
389  Anorexia  
390  Bulimic

## Surgeries

- |                                                            |                                                |                                                    |
|------------------------------------------------------------|------------------------------------------------|----------------------------------------------------|
| 700 <input type="checkbox"/> Tonsillectomy and/or Adenoids | 707 <input type="checkbox"/> Breast implants   | 714 <input type="checkbox"/> Splenectomy           |
| 701 <input type="checkbox"/> Appendix                      | 708 <input type="checkbox"/> Cancer            | 715 <input type="checkbox"/> Radiated thyroid      |
| 702 <input type="checkbox"/> Gallbladder                   | 709 <input type="checkbox"/> Coronary by-pass  | 716 <input type="checkbox"/> Cataract surgery      |
| 703 <input type="checkbox"/> Thyroid                       | 710 <input type="checkbox"/> Spinal surgery    | 717 <input type="checkbox"/> Hemorrhoidectomy      |
| 704 <input type="checkbox"/> Hysterectomy, complete        | 711 <input type="checkbox"/> Extremity surgery | 718 <input type="checkbox"/> Bariatric/Weight loss |
| 705 <input type="checkbox"/> Hysterectomy, partial         | 712 <input type="checkbox"/> Hip replacement   | Type: _____                                        |
| 706 <input type="checkbox"/> Tubal ligation                | 713 <input type="checkbox"/> Knee replacement  |                                                    |

## Gastrointestinal

- |                                                                 |                                                                         |
|-----------------------------------------------------------------|-------------------------------------------------------------------------|
| 265 <input type="checkbox"/> 4-5 bowel movements per week       | 284 <input type="checkbox"/> Immediate indigestion upon eating          |
| 266 <input type="checkbox"/> 3 or less bowel movements per week | 285 <input type="checkbox"/> Indigestion in 2 hours or more after meals |
| 267 <input type="checkbox"/> 6 or more bowel movements per week | 286 <input type="checkbox"/> Indigestion within 1 hour after meals      |
| 268 <input type="checkbox"/> Black tarry stools                 | 287 <input type="checkbox"/> Difficulty swallowing                      |
| 269 <input type="checkbox"/> Pale or yellow colored stool       | 288 <input type="checkbox"/> Eating relieves fatigue                    |
| 270 <input type="checkbox"/> Blood stools                       | 289 <input type="checkbox"/> Eats when nervous                          |
| 271 <input type="checkbox"/> Constipation                       | 290 <input type="checkbox"/> Excessive hunger                           |
| 272 <input type="checkbox"/> Hemorrhoids                        | 291 <input type="checkbox"/> Poor appetite                              |
| 273 <input type="checkbox"/> Loose bowel movements              | 292 <input type="checkbox"/> Experiences fainting spells when hungry    |
| 274 <input type="checkbox"/> Frequent diarrhea                  | 293 <input type="checkbox"/> Feels shaky when hungry                    |
| 275 <input type="checkbox"/> Frequent nausea                    | 294 <input type="checkbox"/> Frequently drowsy after eating a meal      |
| 276 <input type="checkbox"/> Frequent vomiting                  | 295 <input type="checkbox"/> Gall bladder disease                       |
| 277 <input type="checkbox"/> Abdominal gas                      | 296 <input type="checkbox"/> Has had intestinal worms                   |
| 278 <input type="checkbox"/> Belching and burping after eating  | 297 <input type="checkbox"/> Reflux/Hiatal hernia                       |
| 279 <input type="checkbox"/> Bloating after eating              | 298 <input type="checkbox"/> Liver disease                              |
| 280 <input type="checkbox"/> Severe abdominal pains             | 299 <input type="checkbox"/> Irritable Bowel Syndrome                   |
| 281 <input type="checkbox"/> Stomach ulcers                     | 300 <input type="checkbox"/> Diverticulitis                             |
| 282 <input type="checkbox"/> Uses digestive aids                | 301 <input type="checkbox"/> Diverticulosis                             |
| 283 <input type="checkbox"/> Uses laxatives                     |                                                                         |

## Respiratory

- |                                                      |                                                        |                                              |
|------------------------------------------------------|--------------------------------------------------------|----------------------------------------------|
| 485 <input type="checkbox"/> Catches severe colds    | 491 <input type="checkbox"/> Frequent colds            | 497 <input type="checkbox"/> Night sweats    |
| 486 <input type="checkbox"/> Chronic chest condition | 492 <input type="checkbox"/> Frequent nose bleeds      | 498 <input type="checkbox"/> Post nasal drip |
| 487 <input type="checkbox"/> Chronic cough           | 493 <input type="checkbox"/> Frequent sinus infections | 499 <input type="checkbox"/> Sneezing spells |
| 488 <input type="checkbox"/> Constant runny nose     | 494 <input type="checkbox"/> Frequent stuffy nose      | 500 <input type="checkbox"/> Spits up blood  |
| 489 <input type="checkbox"/> COPD                    | 495 <input type="checkbox"/> Hay fever                 | 501 <input type="checkbox"/> Spits up phlegm |
| 490 <input type="checkbox"/> Difficulty breathing    | 496 <input type="checkbox"/> Nasal polyps              | 502 <input type="checkbox"/> Wheezes         |

## Mouth and Throat

- |                                                                             |                                                              |                                                                              |
|-----------------------------------------------------------------------------|--------------------------------------------------------------|------------------------------------------------------------------------------|
| 400 <input type="checkbox"/> Bad breath                                     | 407 <input type="checkbox"/> Frequent fever blisters         | 414 <input type="checkbox"/> Tongue has grooves or fissures                  |
| 401 <input type="checkbox"/> Bitter taste in the mouth<br>in the morning    | 408 <input type="checkbox"/> Frequent sore throats           | 415 <input type="checkbox"/> Tongue is coated                                |
| 402 <input type="checkbox"/> Dry mouth                                      | 409 <input type="checkbox"/> Frequently has a sore<br>tongue | 416 <input type="checkbox"/> Gums bleed when brushing teeth                  |
| 403 <input type="checkbox"/> Excessive saliva                               | 410 <input type="checkbox"/> Sore gums                       | 417 <input type="checkbox"/> Toothaches                                      |
| 404 <input type="checkbox"/> Sores or cracks in the<br>corners of the mouth | 411 <input type="checkbox"/> Swollen gums                    | 418 <input type="checkbox"/> Amalgam dental fillings                         |
| 405 <input type="checkbox"/> Glands often swell                             | 412 <input type="checkbox"/> Swollen tongue                  | 420 <input type="checkbox"/> Other dental fillings<br>(gold, composite, etc) |
| 406 <input type="checkbox"/> Frequent canker sores                          | 413 <input type="checkbox"/> Tongue burns                    | 419 <input type="checkbox"/> Has had root canal(s)                           |

## Endocrine

- 245  Coarse hair  
246  Coarse skin  
247  Diabetic  
248  Excessive thirst  
249  Frequently feels cold  
250  Frequently feels hot  
251  Gets lightheaded when standing quickly  
252  Heals slowly  
253  Unusually jumpy or nervous  
254  Unusually tired most of the time

## Cardiovascular

- 190  Cold feet  
191  Cold hands  
192  Experiences shortness of breath while sitting still  
193  Heart skips beats  
194  Tendency of High blood pressure  
195  Leg cramps during bedtime  
196  Leg cramps during daytime  
197  Low blood pressure at times  
198  Pain in leg/hips when walking  
199  Frequent swollen ankles  
200  Pains in the heart or chest  
201  Spells of rapid heart rate  
202  Troubled with blood clots  
203  Unusually slow pulse rate  
204  Varicose veins  
205  Heart palpitations

## Skin

- 520  Bruises easily  
521  Excessive perspiration  
522  Frequent goose bumps  
523  Has acne  
524  Has Psoriasis  
525  Hives  
526  Itchy skin  
527  Problems with Eczema  
528  Has moles which are changing in size and/or color  
530  Skin is rough, especially on the back of the arms  
529  Skin eruptions  
531  Skin is tender  
532  Sores that heal slowly  
533  Troubled with boils  
534  Dry skin

## Ears

- 220  Discharge from ears  
221  Hard of hearing  
222  Punctured ear drum  
223  Recurrent ear infection  
224  Ringing or noises in the ears  
225  Tinnitus

## Eyes

- 320  Bloodshot eyes  
321  Blurred vision  
322  Cross eyes  
323  Eye pain  
324  Eyes feel gritty  
325  Eyes watery  
326  Mild Glaucoma  
327  Far sighted  
328  Developing cataracts  
329  Mild Macular degeneration  
330  Itchy eyes  
331  Near sighted  
332  Dry Eyes

## Feet

- 350  Corns  
351  Frequent foot cramps  
352  Heel spurs  
353  Painful feet  
354  Plantar warts  
355  Swelling in the feet and/or ankles  
356  Plantar fasciitis  
357  Fungal Infection

## Neuromuscular

- 440  Bites nails  
441  Frequent muscle soreness  
442  Muscle spasms  
443  Muscle weakness  
444  Tremors  
445  Frequent headaches  
446  Often dizzy  
447  Frequently feels faint  
448  Has Epilepsy  
449  Has motion sickness  
450  Has Osteoarthritis  
451  Has Rheumatism  
452  Rheumatoid Arthritis  
453  Joint stiffness in the morning  
454  Swollen joints  
455  Leg pain at rest  
456  Spinal curvature  
457  Low back pain  
458  Neck pain  
459  Pain between the shoulders  
460  Shoulder/arm pain  
461  Numbness/tingling in the body  
462  Sleep walks  
463  Stutters or stammers  
464  Nerve pain

## Behavior Patterns

- 150  Afraid to eat anywhere except home
- 151  Always needs someone to advise
- 152  Cries often
- 153  Difficulty concentrating
- 154  Difficulty falling asleep
- 155  Difficulty staying asleep
- 156  Easily angered
- 157  Feelings are easily hurt
- 158  Frequently becomes scared for no reason
- 159  Frequently miserable or blue
- 160  Has to be on guard even with friends
- 161  Often annoyed by people
- 162  Recurrent bad dreams
- 163  Sometimes wishes to be dead or away from it all
- 164  Upset by criticism
- 165  Poor memory
- 166  Scared to be alone
- 167  Strange people or places cause fear
- 168  Under considerable emotional stress
- 169  Unhappy when other are happy
- 170  Brain fog

## Urinary

- 555  Urinates more than 2 times per night
- 556  Bed wetting
- 557  Blood in the urine
- 558  Difficulty starting urination
- 559  Painful urination
- 560  Frequent urination
- 561  Troubled by urgent urination
- 562  Incontinence when sneezing or laughing
- 563  Loses bladder control
- 564  Frequent bladder infections
- 565  Frequent kidney infections
- 566  Kidney stones

## Men Only

- 585  Difficulty completing intercourse
- 586  Difficulty getting or keeping an erection
- 587  Discharge from the urethra
- 588  Had a vasectomy
- 589  Had difficulty fathering children
- 590  Lumps in the testicles
- 591  Painful genitals
- 592  Prostate troubles
- 593  Sores on external genitalia
- 594  Herpes
- 595  Sexual diseases

## Women Only

- 610  Heavy hair growth on face or body
- 611  Cycles are every 27-29 days
- 612  Abnormal cycle >29 days and/or <26 days
- 613  PMS
- 614  Menstrual cramps
- 615  Painful periods
- 616  Acne worse at menstruation
- 617  Excessive menstrual flow
- 618  Retains fluid during periods
- 619  Pre-menstrual depression
- 620  Currently taking birth control medication
- 621  Has taken birth control medication more than 1 year
- 622  Has taken birth control medication within the last year
- 623  Has had miscarriage
- 624  Hot flashes
- 625  Takes hormone replacement medication
- 627  Diminished sexual desire
- 628  Painful intercourse
- 629  Poor or infrequent orgasm
- 630  Lumps in the breasts
- 631  Tender breasts
- 633  Vaginal discharge
- 634  Bloody spotting discharge
- 635  Yeast infections
- 636  Sores on external genitalia
- 637  Herpes
- 638  Sexual diseases
- 639  Endometriosis
- 640  Breast reduction
- 641  Breast augmentation
- 642  Abortion
- 643  D&C
- 644  Tubal pregnancy
- 645  Uterine fibroids
- 646  Ovarian fibroids
- 647  Breast fibroids
- 648  Currently Breastfeeding

## Medications

Please list all drugs you are currently taking on a daily basis.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

- |                                      |                                 |                                    |                                      |
|--------------------------------------|---------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dairy       | <input type="checkbox"/> Gluten | <input type="checkbox"/> Ragweed   | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Eggs        | <input type="checkbox"/> Mold   | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Tree nuts   |
| <input type="checkbox"/> Garlic      | <input type="checkbox"/> Peanut | <input type="checkbox"/> Soy       | <input type="checkbox"/> Wheat       |
| <input type="checkbox"/> Other _____ |                                 |                                    |                                      |

## Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



## AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires that you give us this disclosure, please understand that we have, and always will, respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.
- We may have to disclose your health information to Science Based Nutrition™ to obtain test results and reports.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form (§ 164.520). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy for our privacy notices.

I authorized Oxford Health & Wellness Center to contact me with information related to my personal health needs and interests. The physician's office may use any phone number or email in my personal records to contact me. If contact is made by phone and I am unable to respond, a message may be left with my home answering machine or voice mail service. I may be contacted about the following:

- Appointment reminders or schedule changes.
- Information about alternative treatments, presentations or events
- Other health related information that may be of interest to me

To contact me, I authorize Oxford Health & Wellness Center to use and disclose the following information:

- My Name, Address, Email and Phone Numbers
- The Name of my Physician and the Clinic where I was treated

**NOTE: NO DIAGNOSIS OR TREATMENT INFORMATION WILL BE USED OR DISCLOSED.**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(PLEASE PRINT)

Address of Patient: \_\_\_\_\_ Phone: \_\_\_\_\_  
(STREET)

\_\_\_\_\_  
(CITY, STATE, ZIP CODE) Email: \_\_\_\_\_

Oxford Health & Wellness Center fully supports the protection of health information. Only the physician and office staff will use this information to contact you. While we retain the standard rights of disclosure as provided under HIPAA, this authorization allows us to access only the above authorized information for contact purposes.

This authorization will remain valid for ten (10) years from the date of signature. You may revoke this authorization at any time or request to receive a copy of the protected health information to be used by writing to: Oxford Health & Wellness Center - 5144 College Corner Pike - Oxford, OH 45056. In this case, every effort will be made to discontinue future communications.

\_\_\_\_\_  
Signature (PATIENT OR PERSON AUTHORIZED)

\_\_\_\_\_  
Date