

CONFIDENTIAL PATIENT INFORMATION

Date _____ *****Please use the back of these forms for additional information if necessary*****
Name _____ Sex _____ Marital Status _____ D.O.B. ____/____/____ Age _____
First, MI, Last M or F Mo/Day/Year

Home Phone _____ Work Phone _____ Email _____
Address _____ City _____ State _____ Zip Code _____
Include street type such as St., Ave., etc.

Cell phone number _____ Occupation _____ Company Name _____
Spouse's Full Name _____ Spouse's Employer _____ Names and Ages of Children _____

How did you hear about our office? _____

WHAT WOULD YOU LIKE DR. STONE HELP YOU TO ACHIEVE?

Other Doctors seen for your condition(s)? _____

Type of treatment(s): _____

Results: _____

Please rate your level of commitment to getting your health back(circle): None 0 1 2 3 4 5 6 7 8 9 10 Very Committed

Past Medical History: List all major illnesses, diagnosed diseases, accidents, all surgeries or hospitalizations:

Family Medical History: Include age and cause of death, diagnosed conditions/diseases of mother, father, siblings, children

Please rate your stress level on this scale (circle): No Stress 1 2 3 4 5 6 7 8 9 10 Major Stress

CONDITION / PROBLEM HISTORY Name _____

Primary Condition _____

When did this condition begin? _____ Rate the severity: Mild 1 2 3 4 5 6 7 8 9 10 Very Severe
How often does this problem bother you? Constant Daily Weekly Monthly Other _____
Can you relate it to a particular accident or injury? Y N Describe _____
Has the problem... Gotten Worse Gotten Better Persisted/Stayed the Same ...since it first began?
Describe the worst symptom: _____
What makes the problem worse: _____
What makes the problem better: _____

2nd Condition _____

When did this condition begin? _____ Rate the severity: Mild 1 2 3 4 5 6 7 8 9 10 Very Severe
How often does this problem bother you? Constant Daily Weekly Monthly Other _____
Can you relate it to a particular accident or injury? Y N Describe _____
Has the problem... Gotten Worse Gotten Better Persisted/Stayed the Same ...since it first began?
Describe the worst symptom: _____
What makes the problem worse: _____
What makes the problem better: _____

3rd Condition _____

When did this condition begin? _____ Rate the severity: Mild 1 2 3 4 5 6 7 8 9 10 Very Severe
How often does this problem bother you? Constant Daily Weekly Monthly Other _____
Can you relate it to a particular accident or injury? Y N Describe _____
Has the problem... Gotten Worse Gotten Better Persisted/Stayed the Same ...since it first began?
Describe the worst symptom: _____
What makes the problem worse: _____
What makes the problem better: _____

4th Condition _____

When did this condition begin? _____ Rate the severity: Mild 1 2 3 4 5 6 7 8 9 10 Very Severe
How often does this problem bother you? Constant Daily Weekly Monthly Other _____
Can you relate it to a particular accident or injury? Y N Describe _____
Has the problem... Gotten Worse Gotten Better Persisted/Stayed the Same ...since it first began?
Describe the worst symptom: _____
What makes the problem worse: _____
What makes the problem better: _____

5th Condition _____

When did this condition begin? _____ Rate the severity: Mild 1 2 3 4 5 6 7 8 9 10 Very Severe
How often does this problem bother you? Constant Daily Weekly Monthly Other _____
Can you relate it to a particular accident or injury? Y N Describe _____
Has the problem... Gotten Worse Gotten Better Persisted/Stayed the Same ...since it first began?
Describe the worst symptom: _____
What makes the problem worse: _____
What makes the problem better: _____

OVERALL: Do you feel better or worse in any season or climate? (Hot, cold, damp, dry, windy, snow) Describe _____

MSQ - Metabolic Symptoms Questionnaire

Name: _____ Date: _____

Rate each of the following symptoms based upon your typical health profile for the past 30 days.

Point Scale: 0-1-2-3-4 with (0 for no, 4 for yes)

0 = never, absent, not true 4 = always, constant, very true

Brain	<input type="checkbox"/> My memory is declining <input type="checkbox"/> Difficulty remembering names <input type="checkbox"/> Difficulty focusing <input type="checkbox"/> Harder to learn new things <input type="checkbox"/> Difficulty remembering appointments <input type="checkbox"/> Temperament getting worse <input type="checkbox"/> Losing my attention span <input type="checkbox"/> I fatigue when driving <input type="checkbox"/> I walk into a room and forget why <input type="checkbox"/> I pick up my cell phone and forget why <div style="text-align: right;">/40</div>	Large Intestine	<input type="checkbox"/> Feeling that bowels don't empty completely <input type="checkbox"/> Lower abdominal pain, relief by passing stool <input type="checkbox"/> Constipation (Frequency _____) <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hard, dry or small stool <input type="checkbox"/> Coated tongue <input type="checkbox"/> Foul smelling gassiness <input type="checkbox"/> More than 3 bowel movements per day <input type="checkbox"/> Pain or fullness below naval <input type="checkbox"/> Anus itches <div style="text-align: right;">/40</div>
Adrenal (High)	<input type="checkbox"/> Cannot fall asleep <input type="checkbox"/> Perspire easily <input type="checkbox"/> Under high amounts of stress <input type="checkbox"/> Weight gain when under stress <input type="checkbox"/> Wake up tired even after a full nights sleep <input type="checkbox"/> Chronic low back pain <input type="checkbox"/> Tend to be keyed up, can't calm down <input type="checkbox"/> Tend to be a night person <input type="checkbox"/> Clench or grind teeth <input type="checkbox"/> Allergies or hives <div style="text-align: right;">/40</div>	Stomach	<input type="checkbox"/> Belching or burping <input type="checkbox"/> Gas immediately after meal <input type="checkbox"/> Offensive breath <input type="checkbox"/> Sense of fullness during and after meals <input type="checkbox"/> Difficulty digesting fruits and veggies <input type="checkbox"/> Undigested food in stools <input type="checkbox"/> Pain, burning shortly after eating <input type="checkbox"/> Heartburn or acid reflux <input type="checkbox"/> Feel hungry and hour or two after eating <input type="checkbox"/> Loss of taste for meat <div style="text-align: right;">/40</div>
Adrenal (Low)	<input type="checkbox"/> Cannot stay asleep <input type="checkbox"/> Crave salt or salty foods <input type="checkbox"/> Slow starter in the morning <input type="checkbox"/> Afternoon fatigue <input type="checkbox"/> Dizziness with standing quickly <input type="checkbox"/> Afternoon headaches <input type="checkbox"/> Blood pressure low <input type="checkbox"/> Knee pain <input type="checkbox"/> Sensitivity to sunlight, need sunglasses <input type="checkbox"/> Headache with exertion or stress <div style="text-align: right;">/40</div>	Biliary	<input type="checkbox"/> Greasy or high fat foods upset <input type="checkbox"/> Bloating or gas several hours after eating <input type="checkbox"/> Bitter, metallic taste in mouth <input type="checkbox"/> Itchy skin <input type="checkbox"/> Yellowing of eyes <input type="checkbox"/> Stool color varies from clay to brown <input type="checkbox"/> Reddened skin, palms <input type="checkbox"/> Dry or flaky skin or hair <input type="checkbox"/> History of gallbladder attacks or stones <input type="checkbox"/> Gallbladder removed (Y/N) <div style="text-align: right;">/40</div>

Pituitary	<input type="checkbox"/> Diminished sex drive <input type="checkbox"/> Increased sex drive <input type="checkbox"/> Menstrual disorders or lack of menstruation <input type="checkbox"/> Tolerance of sugars <input type="checkbox"/> Splitting type headaches <input type="checkbox"/> Early or delayed sexual development (Y/N) <input type="checkbox"/> Memory failing <input type="checkbox"/> Fat deposits around face and shoulders /32	Small Intestine	<input type="checkbox"/> Fiber causes constipation <input type="checkbox"/> Indigestion and fullness <input type="checkbox"/> Pain, tenderness above naval <input type="checkbox"/> Increased gassiness <input type="checkbox"/> Nausea or vomiting <input type="checkbox"/> undigested food in stool <input type="checkbox"/> Greasy, poorly formed, foul stool <input type="checkbox"/> Mucous in stool /32
Immune	<input type="checkbox"/> Runny, drippy or congested nose <input type="checkbox"/> Catch colds at change of seasons <input type="checkbox"/> Sensitive to change (diet, seasons, stress) <input type="checkbox"/> Never get sick <input type="checkbox"/> History of infections (sinus, bladder, ear, etc.) <input type="checkbox"/> You have a shopping bag of supplements <input type="checkbox"/> You can't take certain supplements <input type="checkbox"/> Your symptoms come and go /32	Hypoglycemia	<input type="checkbox"/> Crave sweets <input type="checkbox"/> Irritable if meal is missed <input type="checkbox"/> Depend on coffee to get going <input type="checkbox"/> Lightheaded if meals are missed <input type="checkbox"/> Feel shaky or jittery <input type="checkbox"/> Agitated, easily upset, nervous <input type="checkbox"/> Blurred vision <input type="checkbox"/> Poor memory, forgetful /32
Thyroid	<input type="checkbox"/> Tired, sluggish <input type="checkbox"/> Feel cold <input type="checkbox"/> Require excessive sleep to function <input type="checkbox"/> Weight gain <input type="checkbox"/> Gain weight easily <input type="checkbox"/> Constipation <input type="checkbox"/> Depression, lack of motivation <input type="checkbox"/> Morning headaches <input type="checkbox"/> Outer third of eyebrows thinning <input type="checkbox"/> Thinning of hair, losing hair <input type="checkbox"/> Dryness of skin or scalp <input type="checkbox"/> Mental Sluggishness /48	Insulin Resistance	<input type="checkbox"/> Fatigue after meals <input type="checkbox"/> Crave sweets <input type="checkbox"/> Eating sweets does not relieve craving <input type="checkbox"/> Must have sweets after meal <input type="checkbox"/> Waist expanding compared to hips <input type="checkbox"/> Frequent urination <input type="checkbox"/> Increased thirst and hunger <input type="checkbox"/> Difficulty losing weight <input type="checkbox"/> Binge or uncontrolled eating <input type="checkbox"/> Sleepy in the afternoon <input type="checkbox"/> Family members with Diabetes <input type="checkbox"/> Abdominal (belly) fat /48
Female (Cycling)	<input type="checkbox"/> Menstrual cycle length changes <input type="checkbox"/> Long cycle, greater than 32 days <input type="checkbox"/> Short cycle, less than 24 days <input type="checkbox"/> Pain and cramping during periods <input type="checkbox"/> Scanty blood flow <input type="checkbox"/> Heavy blood flow <input type="checkbox"/> Breast pain or swelling <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Irritable or depressed during cycle <input type="checkbox"/> Acne break outs <input type="checkbox"/> Facial hair growth <input type="checkbox"/> Hair loss or thinning /48	Female (Menopause)	Date of last menses _____ <input type="checkbox"/> Uterine bleeding <input type="checkbox"/> Hot flashes <input type="checkbox"/> Mental foginess <input type="checkbox"/> Disinterest in sex <input type="checkbox"/> Mood swings <input type="checkbox"/> Depression <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Shrinking breasts <input type="checkbox"/> Facial hair growth <input type="checkbox"/> Acne <input type="checkbox"/> Vaginal pain, dryness or itching /44

Anemia	<input type="checkbox"/> General fatigue or tired feeling <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Muscle cramps or “charley horses” <input type="checkbox"/> Dizzy, faint, or unsteady <input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Poor endurance, fatigue quickly <input type="checkbox"/> Feel run down <input type="checkbox"/> Pale skin, lips, gums <input type="checkbox"/> Unusual cravings such as clay, ice <input type="checkbox"/> Insomnia <input type="checkbox"/> Nail shape changes / spoon shaped <input type="checkbox"/> Cracks / sores at corners of mouth <input type="checkbox"/> Progressive fatigue after stress or exertion <input type="checkbox"/> General weakness <input type="checkbox"/> Bouts of nausea <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Mild yellowing of eyes and/or skin <input type="checkbox"/> Small red dots under the skin <input type="checkbox"/> Cold hands and feet <input type="checkbox"/> Irritable <input type="checkbox"/> Unusual bruising <input type="checkbox"/> Red, sore tongue <input type="checkbox"/> Ringing in ears /96	EFAs	<input type="checkbox"/> Dry Skin, Rough Skin <input type="checkbox"/> Heels cracked <input type="checkbox"/> Dry cracked finger tips <input type="checkbox"/> Dandruff <input type="checkbox"/> Dry Eyes <input type="checkbox"/> Dry, frizzy, unmanageable hair <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Increased thirst <input type="checkbox"/> Bumps, “chicken skin” on backs of arms <input type="checkbox"/> Patches of “alligator skin” <input type="checkbox"/> Soft, brittle finger nails <input type="checkbox"/> Allergies <input type="checkbox"/> Difficulty with attention or focus <input type="checkbox"/> Hyperactivity <input type="checkbox"/> Aggression or hostility <input type="checkbox"/> Irritability <input type="checkbox"/> Depression <input type="checkbox"/> General learning difficulties <input type="checkbox"/> Poor memory <input type="checkbox"/> Irregular heart rhythm <input type="checkbox"/> Muscle or joint pain, aches <input type="checkbox"/> Aspirin/Advil improve my symptoms <input type="checkbox"/> Fatigue <input type="checkbox"/> Diarrhea /96
Male (Prostate)	<input type="checkbox"/> Difficulty urinating <input type="checkbox"/> Dribbling after urination <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain in the thighs or heels <input type="checkbox"/> Feeling of incomplete bowel emptying <input type="checkbox"/> Leg nervousness at night <input type="checkbox"/> Difficulty starting or stopping urine stream <input type="checkbox"/> Waking up at night to urinate /32	Male Hormones	<input type="checkbox"/> Decreased Libido <input type="checkbox"/> Decreased morning erections <input type="checkbox"/> Decreased fullness of erection <input type="checkbox"/> Difficulty maintaining erections <input type="checkbox"/> Mental fatigue <input type="checkbox"/> Inability to concentrate <input type="checkbox"/> Episodes of depression <input type="checkbox"/> Muscle soreness <input type="checkbox"/> Decrease in physical stamina <input type="checkbox"/> Unexplained weight gain <input type="checkbox"/> Increased fat around chest and hips <input type="checkbox"/> Increased sweating <input type="checkbox"/> More emotional than in the past /52

List your top three life stressors: _____

Describe your greatest disappointment: _____

Describe your greatest achievement: _____

BSQ - Brain Symptoms Questionnaire

Point Scale:

0 = Never or almost never have the symptom
 1 = Slightly noticeable, occasional and mild

2 = Mildly noticeable, occasional, moderate to severe
 3 = Moderately noticeable, more frequent, more severe
 4 = Very noticeable, very often, and severe

NAME _____

DATE _____

FRONTAL LOBES	<input type="checkbox"/> Can't stay attentive or focused <input type="checkbox"/> Make careless mistakes <input type="checkbox"/> Distractibility <input type="checkbox"/> Lack of clear goals <input type="checkbox"/> Difficulty expressing empathy <input type="checkbox"/> Excessive daydreaming <input type="checkbox"/> Boredom <input type="checkbox"/> Talking too much <input type="checkbox"/> Difficulty waiting your turn <input type="checkbox"/> Trouble listening <input type="checkbox"/> Poor follow through, finishing projects <input type="checkbox"/> Poor planning skills <input type="checkbox"/> Difficulty expressing feelings <input type="checkbox"/> Apathy or lack of motivation <input type="checkbox"/> Feeling of spaciness or "in a fog" <input type="checkbox"/> Restlessness or trouble sitting still <input type="checkbox"/> Conflict seeking <input type="checkbox"/> Blurting answers before question is complete <input type="checkbox"/> Interrupting others <input type="checkbox"/> Trouble learning from mistakes <p style="text-align: right;">TOTAL _____</p>	BASAL GANGLIA	<input type="checkbox"/> Nervousness or anxiety <input type="checkbox"/> Panic attacks <input type="checkbox"/> Nausea or abdominal upset <input type="checkbox"/> Dizzy, faint, or unsteady <input type="checkbox"/> Tendency to predict the worst <input type="checkbox"/> Avoid public places <input type="checkbox"/> Persistent phobias <input type="checkbox"/> Low motivation <input type="checkbox"/> Shy or timid <input type="checkbox"/> Muscle tremors or twitching <input type="checkbox"/> Heart pounding or palpitations <input type="checkbox"/> Feeling smothered or trouble breathing <input type="checkbox"/> Sweating, hot or cold flashes, cold hands <input type="checkbox"/> Fear of dying <input type="checkbox"/> Avoid conflict <input type="checkbox"/> Fear of being judged or scrutinized <input type="checkbox"/> Worry about what others think <input type="checkbox"/> Embarrassed easily <p style="text-align: right;">TOTAL _____</p>
LIMBIC/AMYGDALA	<input type="checkbox"/> Feelings of sadness <input type="checkbox"/> Negativity <input type="checkbox"/> Irritability <input type="checkbox"/> Low or decreased interest in others <input type="checkbox"/> Feeling dissatisfied or bored <input type="checkbox"/> Excessive guilt <input type="checkbox"/> Suicidal feelings <input type="checkbox"/> Crying <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Low self esteem <input type="checkbox"/> Moodiness <input type="checkbox"/> Low energy <input type="checkbox"/> Feelings of hopelessness about the future <input type="checkbox"/> Decreased or low interest in having "fun" <input type="checkbox"/> Changes in sleep habits (too much or too little) <input type="checkbox"/> Appetite changes (too much or too little) <input type="checkbox"/> Decreased interest in sex <input type="checkbox"/> Poor concentration <input type="checkbox"/> Sensitivity to smells or odors <p style="text-align: right;">TOTAL _____</p>	TEMPORAL LOBES	<input type="checkbox"/> Short fuse, extremely irritable <input type="checkbox"/> Interpret comments as negative <input type="checkbox"/> Spaciness or confusion <input type="checkbox"/> Visual or hearing changes <input type="checkbox"/> Sensitivity or mild paranoia <input type="checkbox"/> History of head injury <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Reading comprehension problems <input type="checkbox"/> Rage with little provocation <input type="checkbox"/> Irritability, builds to rage, explodes, then tired <input type="checkbox"/> Panic or fear for no reason <input type="checkbox"/> Frequent déjà vu <input type="checkbox"/> Headaches or abdominal pain <input type="checkbox"/> Preoccupation with moral or religious ideas <input type="checkbox"/> Dark thoughts, suicide, homicide <p style="text-align: right;">TOTAL _____</p>
CINGULATE GYRUS	<input type="checkbox"/> Excessive or senseless worrying <input type="checkbox"/> Upset with things out of place <input type="checkbox"/> Tend to have repetitive negative thoughts <input type="checkbox"/> Intense dislike of change <input type="checkbox"/> Trouble shifting attention <input type="checkbox"/> Difficulty seeing options <input type="checkbox"/> Upset unless things are done a certain way <input type="checkbox"/> You worry too much <input type="checkbox"/> Upset when things don't "go your way" <input type="checkbox"/> Oppositional or argumentative <input type="checkbox"/> Hold grudges <input type="checkbox"/> Hold your own opinion, don't listen to others <input type="checkbox"/> Get locked in a course of action <input type="checkbox"/> Say no without thinking it over <p style="text-align: right;">TOTAL _____</p>	RESULTS	FRONTAL..... LIMBIC..... BASAL GANGLIA..... CINGULATE..... TEMPORAL.....

DIET & LIFESTYLE HISTORY

Name _____

Date _____

DESCRIBE 2 OR 3 EXAMPLES OF TYPICAL OR AVERAGE MEALS EATEN DURING A DAY:

AM Breakfast _____

Drink _____

Snack/Drink _____

NOON Lunch _____

Drink _____

Snack/Drink _____

Dinner _____

Drink _____

BED Snack/Drink _____

What foods do you crave? _____

What foods do you dislike? _____

What are your favorite foods? _____

What foods do you eat the most of? _____

ANSWER THE FOLLOWING QUESTIONS : D=Daily W=Weekly M=Monthly (rarely) N=None

How often do you drink: Juice _____ Soda _____ Coffee _____ Tea _____ Water _____ Milk _____

How often do you eat: Fast Food _____ Chips _____ Deep Fried _____ Corn _____ Soy _____

Sweets/Desserts _____ Nuts (kinds) _____ Grains (cereal, bread, pasta) _____

Butter _____ Margarine/Shortening _____ Sugar Substitute (brand) _____

Meats _____ Fish _____ Fruit _____ Vegetables _____ if D: servings/day _____

Do you prefer foods: Hot / Cold / Spicy / Bitter / Sweet / Salty / Bitter Do you choose organic foods? Y / N

Do you use alcohol (frequency/amount) _____ Do you use tobacco (frequency/amount) _____

How many hours per night do you sleep: _____ What time do you normally go to bed? _____ Do you fall asleep easily: Y/N

Do you wake refreshed: Y / N Do you sleep through the night without waking: Y / N How often do you wake? _____

Why do you wake (if known)? _____ Do you remember your dreams: Y / N Do you nap during the day? Y / N

Describe your current exercise regimen, including frequency (ie. Walking, jogging, weights, machines, cardio, none, etc):

What are your favorite social activities or what types of social activities do you most often engage in:

MEDICATIONS / SUPPLEMENTS

Name: _____

Please list all medications (and supplements) you are currently taking including over the counter drugs, aspirin, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

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

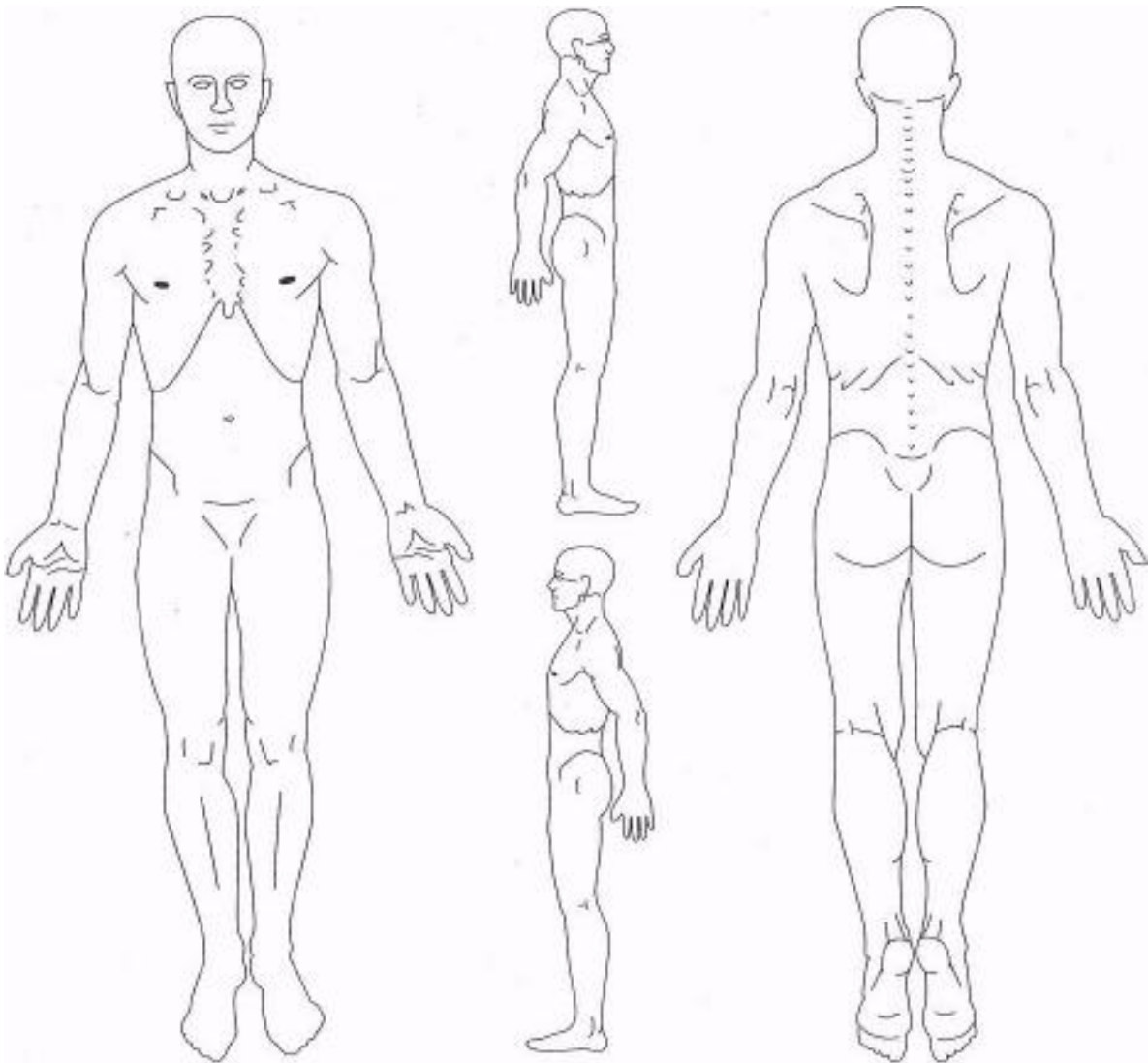
Please list all medications taken within the last year including over the counter drugs, antibiotics, aspirin, inhalers, etc. Also, list how long you have taken each drug and the condition for which it was prescribed.

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

Name: _____

HISTORY OF PAIN / INJURY / SCARS

Please circle, "X", or shade any areas of discomfort, pain, numbness or tingling. Indicate what type of discomfort or pain it is by labeling the body part with: dull, sharp, stabbing, burning, pinching, throbbing, aching, numbness, tingling, cramping, paralyzing, gripping, etc... ALSO...Identify and label past injuries, including fractures, sprains, whiplash, surgical scars, other scars, etc...



On the line below, draw an "X" through the line representing your level or grade of pain and/or discomfort (you may mark the line for current pain, worst, and average if there is a difference.)

NONE

MILD

MODERATE

SEVERE

I-----I

HEALTH IMPACT QUESTIONNAIRE (HIQ)

Name: _____

Date: ____/____/____.

Directions: For questions 1 - 11, please circle the number that best describes how you did overall for the *past week*. If you don't normally do something that is asked, cross the question out.

Were you able to:	Always	Most	Occasionally	Never
1. Do shopping?	0	1	2	3
2. Do laundry with a washer and dryer?	0	1	2	3
3. Prepare meals?	0	1	2	3
4. Wash dishes/cooking utensils by hand?	0	1	2	3
5. Vacuum a rug?	0	1	2	3
6. Make beds?	0	1	2	3
7. Walk several blocks?	0	1	2	3
8. Visit friends or relatives?	0	1	2	3
9. Do yard work?	0	1	2	3
10. Drive a car?	0	1	2	3
11. Climb stairs?	0	1	2	3

12. Of the 7 days in the past week, how many days did you feel good?
 0 1 2 3 4 5 6 7

13. How many days last week did you miss work, including housework?
 0 1 2 3 4 5 6 7

Directions: For the remaining items, mark the point on the line that best indicates how you felt overall for the past week.

14. When you worked, how much did pain your health interfere with your ability to do your work, including housework?

No problem with work ● ___I ___I ___I ___I ___I ___I ___I ___I ___I ● Great difficulty with work

15. How bad has your pain been?

No pain ● ___I ___I ___I ___I ___I ___I ___I ___I ___I ● Very severe pain

16. How tired have you been?

No tiredness ● ___I ___I ___I ___I ___I ___I ___I ___I ___I ● Very tired

17. How well have you slept?

No problem with sleep ● ___I ___I ___I ___I ___I ___I ___I ___I ___I ● Great difficulty with sleep

Name: _____

18. How have you felt when you get up in the morning?

Wake well rested ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Wake up exhausted

19. How nervous or anxious have you felt?

Not anxious ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Very anxious

20. How depressed or blue have you felt?

Not depressed ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Very depressed

21. How much has your health interfered with your ability to be gainfully employed and/or deal effectively with finances?

No problem with finances ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Great difficulty w/ finances

22. How much has your health interfered with your ability to be considerate, patient, and loving in your relationships?

No problem with relationships ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Great difficulty

23. How much has your health interfered with your ability to socialize and/or do things you consider fun?

No problem with social life ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Great difficulty

24. How much has your health interfered with your ability to be present, available, and loving with your family?

No problem with family life ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Great difficulty

25. How much has your health interfered with your ability to be happy and enjoy life?

No problem with happiness ● ___I ___I ___I ___I ___I ___I ___I ___I___ ● Great difficulty

What is the *one thing* you will be able to do again, or do with greater enjoyment, if we are able to help you with this problem?

True Health Family Wellness Center
Office Policy

1. Appointment Policy – This office works with patients who are concerned about the underlying cause and correction of health problems. As such, it is important to follow up with changes made to your diet, exercise, supplements, and lifestyle in a timely manner. If you have to miss an appointment, it is necessary to reschedule as soon as possible, and you must give 24 hours notice to reschedule.

Failure to provide 24 hours notice will result in the time based fee (\$125 / half hour) to be charged directly to you. I schedule my appointments by the half hour and hour, so you must understand that skipping or not showing up for an appointment affects my time and ability to help you and others.

I also try to run exactly on time, so promptness ensures an efficient transition to your evaluation. If you are late for an appointment, our policy is to charge for the whole hour or half hour. Please respect the timing of your and others appointments.

2. Services: I offer specialized and unique services based on my advanced degrees and certifications in clinical nutrition, kinesiology, neurology, and neuro-emotional techniques. Some of these services are not considered standard medical or chiropractic care, and may not be covered under your chiropractic policy. As such, you may be responsible for more than your typical co-pay or co-insurance. I have personally found that handling nutritional, neurological and emotional issues actually accelerates your progress and will save you time and money in the long run. We will discuss your payments and insurance prior to your being charged for anything, so that there will be no surprises. Your fees are expected to be collected at the time of service unless prior arrangements are made with Dr. Stone.

3. Wellness – Although our programs are based on health and wellness. These principles are effective for any stage of health or disease. Very often chronically ill people will find they will need less or NO drugs on our program, because of improved body function. It is important to work with your medical doctor to remove your medications. ***We do not prescribe or un-prescribe medications.***

4. Confidentiality – Our work together is completely confidential, as are your records. Your explicit permission is required to release any information regarding you or your care. We require your signed statement of release of information in order to copy records for family, or other physicians.

5. If we are billing insurance: Please read and sign the following assignment of benefits if you would like us to file your insurance for you.

Assignment of Benefits

I authorize Dr. Todd Stone / Total Life Solution P.A., DBA True Health Family Wellness Center to release any medical or other information necessary for the processing of insurance claims. I authorize payment of medical benefits to the above Doctor and Clinic for services rendered. I accept personal responsibility for any balance remaining for services rendered, including those that may be determined “not medically necessary” by my insurance carrier.

I have read and accept True Health Family Wellness Center Office Policy:

Name _____

Patient or Guardian Signature

Date

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information. Other than the uses and disclosures we described below, we will not sell or provide any of your health information to any outside marketing organization.

We must abide by the terms of this notice while it is in effect, but we reserve the right to change the terms of our privacy notices. If we make a change, it will apply for all of your health information in our files, and we will notify you in writing if /when you come in for treatment.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

A correspondence should be addressed to: Attn: **Sami McKinney, HIPAA Compliance Officer**
True Health Family Wellness Center
1119 Hendersonville Rd. Suite 330, Asheville, NC 28803

USES AND DISCLOSURES

Here are some examples of how we might have to use or disclose your health care information:

1. We may have to disclose your health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, email and your clinical records to contact you to provide appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results). 164.520 (b)(1)(iii)(A). If you are not at home to receive an appointment reminder, a message will be left on your answering machine and/ or mailed or emailed.

You have the right to refuse to give us authorization to contact you regarding your case at this office. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care including billing you by mail or collection proceedings. You may inspect or copy the information that we use to contact you regarding your care at any time (i.e. appointment reminders, care alternatives and etc.

YOUR RIGHT TO LIMIT USES OR DISCLOSURES

You have the right to request that we do not disclose your health information to specific individual, companies, or organizations. Any restriction should be requested in writing. We are not required to honor these requests. However, if we agree with your restrictions, the restriction is binding on us.

PERMITTED USES AND DISCLOSURES WITHOUT YOUR CONSENT OR AUTHORIZATION

Under federal law, we are also permitted or required to use or disclose your health information without your consent or authorization in the following circumstances:

1. We are providing health care services to you based on the orders (referral) of another health care provider.
2. We provide health care services to you in an emergency and we are unable to obtain your consent after attempting to do so.
3. If there are substantial barriers to communicating with you, but in our professional judgement we believe that you intend for us to provide care.

REVOKING YOUR AUTHORIZATION

You may revoke your authorization to us at any time in writing. There are two circumstances under which we will not be able to honor your revocation request:

1. If we have already released your health information before we receive your request to revoke your authorization. 164.508(b)(5)(I)
2. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

CONFIDENTIAL COMMUNICATION We will attempt to accommodate any reasonable written request regarding how/ where (i.e. mailing address or contact number) you would like to receive information about your health or the services that we provide.

Initial Here _____

AMENDING YOUR HEALTH INFORMATION You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require a written request to amend your records that includes a valid reason to support the change. We have the right to refuse your request.

INSPECTING/ COPYING YOUR HEALTH INFORMATION

You have the right to inspect the health information contained in your files while in our office and/ or have a copy made for you. The health information is available up to seven years from the date that the record was created or as long as the information remains in our files. Your request must be in writing to inspect the records and/ or have them copied. **There will be a charge of \$.50 per page copied. Copies can be made of your x-rays for a charge of \$10.00 for each film.** The original film is the property of this office because we are required by law to keep it in our records. Original films can only be released on referral to another physician.

ACCOUNTING OF DISCLOSURES OF YOUR RECORDS

You have the right to request an accounting of any disclosures (not listed below) made of your health information for six years prior to the date of your request. The request must be in writing. The accounting will exclude the following disclosures:

- required for your treatment, to obtain payment for services, to run our practice, and/or made to you.
- necessary to maintain a directory of the individuals in our facility or to individuals involved with your care.
- for national security, intelligence purposes, or law enforcement officers.
- that were made prior to the effective date of the HIPAA privacy law (April 14, 2003).

We will provide the first accounting within a 12 month period without any charge, but any additional requests will be charged a fee. When you make your request we will tell you the amount of the fee and you will have the opportunity to withdraw or modify your request.

RE-DISCLOSURE

We cannot control the actions of others to whom we have released your information for treatment. Information that we use or disclose may be subject to re-disclosure by these individuals/facilities and may no longer be protected by the federal privacy rules.

COMPLAINTS

You may complain to us or to the Secretary for Health and Human Services if you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take any action against you if you file a complaint. Written comments should be addressed to our office address or Secretary for Health and Human Services, 200 Independence Ave .S.W., Room 509F, HHH Bldg, Washington, D.C. 20201.

This notice is effective as of January 1, 2003. This notice will expire six years after the date upon which the record was created. By signing below, I acknowledge that I was given the opportunity to read and ask questions.

Patient Name Printed

Date

Patient Signature

Authorized Staff Person

Personal Representative Printed

Personal Representative Signature

Description of personal representative's authority to act for the patient.