



Thank you for choosing and putting your trust in Advanced Chiropractic and Wellness, LLC.

We welcome you to our office. To insure that your visit is a pleasant one, here is an outline of the procedures you can expect on your first visit. Please feel free to ask questions at any time in your treatment here. You can expect your first visit to take approximately 45-60 minutes, as we want to know as much about you as we can, so that we have the best chance of guiding you to reach your health goals.

Please take the time to fill out the health questionnaire in its entirety; it will help us to create a better understanding of your current symptoms, concerns, health goals and an overall picture of your health.

Your first exam will include a physical, orthopedic, neurological, chiropractic, acupuncture, and kinesiologic exam. From the findings, we will together compile a treatment and wellness plan. During this time, we you will discuss the options for your care, the doctor will advise you as to the necessity of additional procedures, that in some cases may include laboratory work, such as X-rays. X-rays may be recommended to visualize the location of any spinal problems, reveal any pathology, and make your care more precise.

Dr. Yomtov will review his findings of your "initial examination", and together you will develop a treatment and wellness plan to meet your overall health goals. If you feel comfortable with the findings; treatment will begin and continue until all of your health goals have been met and sustained.

We will also discuss the possibility of optimizing your treatment via a home care treatment plan, as well as nutritional consultation, stress reduction techniques, exercise/rehab, and other follow up recommendations specific to you and your case.

You will also be advised concerning financial arrangements and insurance coverage as appropriate.

Guidelines:

- We ask that all patients avoid wearing any type of fragrance when coming to the office due to the large number of allergic and chemically sensitive patients that we treat.
- Please be courteous to other patients by turning off or place cell phones on silent.
- Whenever possible, wear loose, comfortable clothing and remove belts and shoes to allow for freedom of movement. We prefer women to avoid wearing one piece dresses and panty hose. Two piece slack or skirt outfits are a better option, and shorts are great for both men and women. If men are wearing a suit and tie, please remove them before seeing the doctor. Feel free to bring in a change of clothing for treatments.

I have (check all that apply): Swollen joints Arthritis/joint pain Tendonitis Bone pain
 Muscle cramping Muscle pain Repetitive Strain Injury
 Fractured Bone(s) Where? _____
 Other _____

Have you ever been to a chiropractor before? Yes No Explain: _____

Have you ever been to an acupuncturist? Yes No Explain: _____

Nature of problem you were treated for _____

Did you experience any relief? _____ Approximate date of last visit _____

Are you currently under care for your problem with another doctor? Yes No How long? _____

Doctor's name: _____ Have you had X-rays in the last 6 months? Yes No

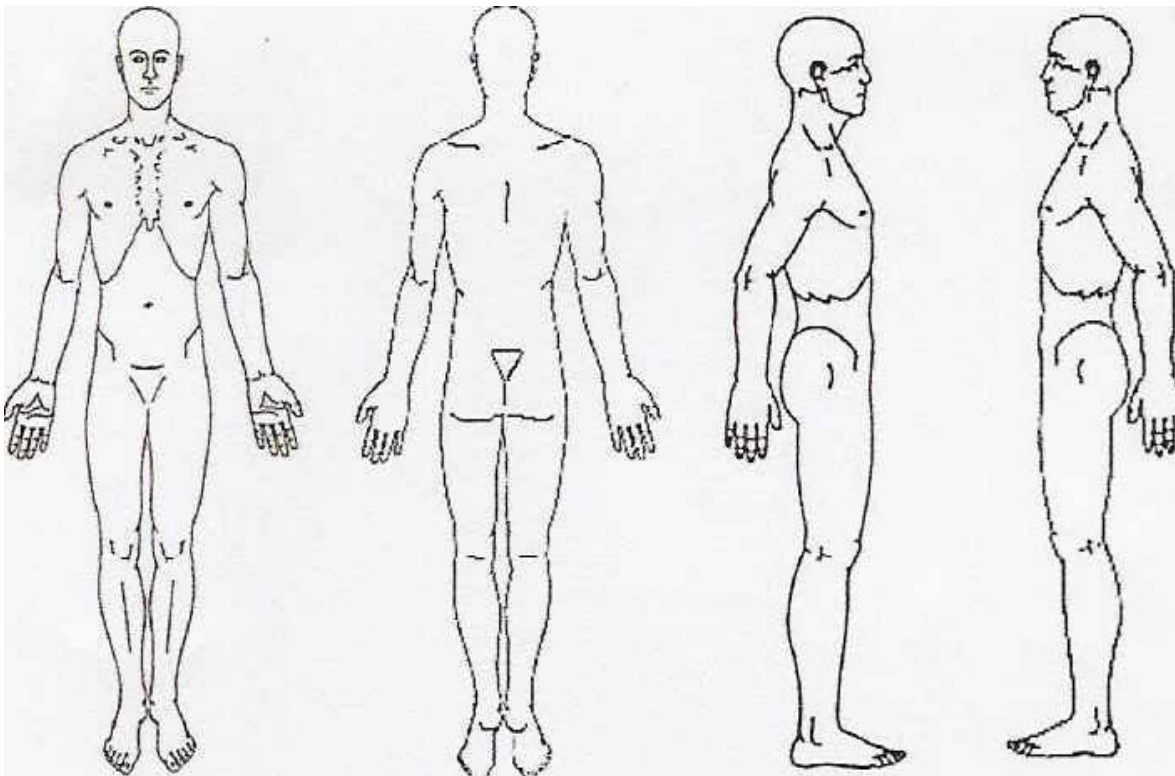
Type of X-ray and where were these X-rays taken? (Name of facility) _____

Are you taking medication for this problem? (If yes, type) _____

Are you, or might you be pregnant? Yes No Do you have a pacemaker or any other implants? Yes

No Please list (or provide a copy) of **ALL** other medications, vitamins or minerals you are presently taking:

Which of the following factors affect your problem? Pain Diagram (please mark all areas of pain on diagram below)
 (A=aching B=burning N=numbness P=pins and needles S=stabbing pain O=other type of sensation)



Have you lost or gained any weight the past 5 years? (Yes No) Gained? _____ Lost _____ Weight

Have you had any of this condition(s)? Check all that apply:

- AIDS/HIV Alcoholism Asthma Birth Trauma Cancer Diabetes
Emphysema Fibromyalgia Heart Disease Hepatitis A/B/C Herpes
Joint Replacements Lyme's Disease Lymph Nodes removed Multiple Sclerosis
Polio Rheumatic Fever Scarlet Fever Seizures
Sinus Infections Tuberculosis (Ever Exposed to? Yes No When? _____)

Operations _____

Other _____

Do you have a family history of: Diabetes Cancer Heart Disease Low Blood Pressure

High Blood Pressure Hypoglycemia Other _____

If disabled from work, please give information and dates _____

List your MAJOR car accidents, falls and injuries and approximate dates: _____

List your MAJOR surgeries and approximate dates _____

List any type of MAJOR dental work and approximate dates _____

Do you exercise on a regular basis? If so, what type? _____

How is your **Energy**? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you **Fatigue** easily? _____

How do you feel emotionally? _____

Do you have (check all that apply): Panic attacks Depression Anxiety Bad temper

Nervousness Fear attacks Poor memory Difficult concentration

Are you in a relationship? Yes No how do you feel about your relationship? _____

How do you hold **Stress**? _____

How do you **Relax**? _____

How do you feel about your work? _____

How long do you normally sleep? _____ hours per night

I have difficulties with (check all that apply): Falling asleep Staying asleep Dream-disturbed sleep

Waking up at about _____ am/pm and not being able to fall asleep again

Please list your usual forms of exercise and sports, including # of times per week and # of minutes per session:

List any **Allergies** (food, latex, etc.) _____

Do you smoke? Yes No _____per day, for _____years

Describe, if any recreational drug use: _____ Typical alcohol intake (# of drinks per week) _____

Caffeine intake per day / week? _____day_____week How much water do you drink? _____oz

I have (check all that apply): Belching Nausea Vomiting vomiting of blood Ulcers
Bloating Acid regurgitation Heartburn Hernia Indigestion severe stomach pain

Bowel movements: How often? _____time(s)/day _____days/week

I have (check all that apply): Irregular Constipation Diarrhea Gas Burning sensation

Hemorrhoids Undigested food in stool loose stool Hard stool

Blood in stool Itchiness Painful bowel movements

Urination: How often? _____times per day Color: Pale yellow Dark yellow/orange Clear

I have or had (check all that apply): Trouble starting stream Frequent urination Incontinence Pain

Burning Dribbling when sneezing Blood in urine Kidney stones Urinary tract infections

Other _____

I have (check all that apply): Frequent colds Chronic runny nose Frequent sore throat

Chronic cough Coughing blood Cough up mucous Pain inhaling

Shortness of breath on exertion/at rest Asthma Nose bleeds

Painful/red eyes Poor vision See spots/floaters Dizziness

Cold sores Bleeding gums Dry mouth Ear pain

Ringing in ears Clogged/popping in ears

Frequent headaches/migraines, describe: _____

I have (check all that apply): Chest pain Palpitation Varicose veins Phlebitis

Cold hands and feet Irregular heart beat Poor circulation

I have or often have (check all that apply): Dry skin Skin rashes Itching Acne Eczema

Hives Hair loss Premature graying Other: _____

Additional Information or concerns: _____

Patient Signature: _____ **Date:** _____

ADVANCED CHIROPRACTIC & WELLNESS, LLC.
INFORMED CONSENT FOR ACUPUNCTURE TREATMENT AND CARE

Please read this information carefully and ask your practitioner if there is anything that you do not understand.

I hereby request and consent to the performance of acupuncture treatments and other procedures within the scope of the practice of acupuncture on me (or on the patient named below, for whom I am legally responsible) by the doctor.

I understand I may be given recommendations on diet, lifestyle and nutritional or herbal supplements and it is my decision whether or not to follow these recommendations. The procedures involved in this treatment have been explained to me. I understand I may be treated with the insertion of needles or other non-insertion techniques; electrical stimulation; touch/palpation; with the application of cupping or Gua Sha to the skin.

I have been informed that acupuncture is a safe method of treatment. Single-use, sterile, disposable needles are used in the clinic. I am aware that it may have side effects including:

- Drowsiness occurs after treatment in a small number of patients, and, if affected, you are advised not to drive;
- Minor bleeding or bruising occurs after acupuncture in about 3% of treatments;
- Pain during treatment occurs in about 1% of treatments;
- Existing symptoms can get worse after treatment (less than 3% of patients). You should tell your acupuncturist about this, but it is usually a good sign;
- Fainting can occur in certain patients, particularly at the first treatment.

In addition, if there are particular risks that apply in your case, your practitioner will discuss these with you.

I have informed the doctor apart from the usual medical details if:

- I have ever experienced a fit, faint or funny turn;
- I have a pacemaker or any other electrical implants;
- I have a bleeding disorder;
- I am taking anti-coagulants or any other medications;
- I have damaged heart valves or have any other particular risk of infection.
- I am pregnant (or will notify the doctor if I become pregnant)

I do not expect the doctor to be able to anticipate and explain all risks and complications of treatment, and I wish to rely on the doctor to exercise judgment during the course of treatment which the doctor thinks at the time, based upon the facts then known, is in my best interest. I understand that results are not guaranteed.

By voluntarily signing below I show that I have read, or have had read to me, this consent to treatment, have been told about the risks and benefits of acupuncture and other procedures, and have had an opportunity to ask questions. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Print patient's name in full: _____

Signature: _____ **Date:** _____

If the patient is a minor or is physically or legally incapacitated:

Print Name of Patient Representative _____ **Relationship:** _____

Signature of Patient Representative _____ **Date:** _____

ADVANCED CHIROPRACTIC & WELLNESS, LLC.

Acupuncture Financial Policy

Name of person responsible for payment: _____ **Date:** _____

I clearly understand and agree that all services rendered are charge directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Cash and check are accepted as payment options.

I understand I may submit a bill to my insurance company for direct reimbursement to myself. I assume full responsibility for tracking my insurance claims with my insurance company. Advanced Chiropractic and Wellness LLC. will fill out any additional forms necessary and will also provide an itemized bill to submit to your insurance company.

I understand that each and every appointment is important. The doctor has set aside that time to meet with me, and if I can not make the appointment I will call the office and give 24 hours advanced notice. If I do not give 24 hours notice, I understand that I will be charged and administrative cancellation fee of \$25.

SIGNATURE OF PATIENT/GUARDIAN: _____ **DATE:** _____

SIGNATURE OF INSURED/GUARDIAN: _____ **DATE:** _____