



**HEALTHBRIDGE**  
MEDICAL CENTER

**SANA EANG NMD, DC**  
HEALTHBRIDGE MEDICAL CENTER  
366 SAN MIGUEL DR #209 NEWPORT BEACH, CA 92660

### **IMPORTANT PATIENT INFORMATION**

#### **APPOINTMENTS**

- For information regarding our cancellation policy please see the cancellation policy section in the Practice Policies document.
- As a courtesy to our patients, we will make an effort to confirm appointments. It is however, the patient's responsibility to keep the scheduled appointment or reschedule.
- Our services are as follows:

#### **INITIAL VISITS - Naturopathic Medical Service**

- Initial Intake/Comprehensive Naturopathic Medical Intake
  - 1.5 hours (allow 2 hours in case we go over)
  - Investment: \$250
- Single Problem Initial intake
  - 30 minutes
  - Investment: \$160

#### **FOLLOW UP VISITS - Naturopathic Medical Service**

- Standard Follow Up
  - 25 minutes
  - Investment: \$110
  - Can be a phone or in person visit
- 12 minute Phone Visit
  - Investment: \$60
- Extended Follow Up
  - 60 minutes
  - This type of visit is scheduled when going over more than one lab test result, and/or when going over ION test results
  - Investment: \$190
  - Can be a phone or in person visit

**NEW PATIENT- Chiropractic Service**

- Initial history & exam
  - Up to 1 hour
  - Investment: \$125
- Initial history & consult
  - Up to 30 minutes
  - Investment: \$95
- Initial problem focused
  - Up to 30 minutes
  - Investment: \$75

**FOLLOW UP VISITS - Chiropractic Service**

- Re-evaluation - Expanded
  - Up to 30 minutes
  - Investment: \$85
- Focused limited
  - Up to 30 minutes
  - Investment: \$75
- Initial problem focused
  - Up to 30 minutes
  - Investment: \$75
- Re-evaluation - Brief
  - Up to 30 minutes
  - Investment: \$65

**BILLING**

Payment for the office visit or phone call is expected prior to service and can be in the form of check, cash or credit card payments.

**INSURANCE**

Dr. Eang does not accept insurance or Medicare. You can request a bill of services, known as a SuperBill, that you can submit to your insurance provider who may reimburse you for some or all of the fee at their discretion. Please note that phone visits may not be reimbursed by your insurance carrier.

**PRIMARY CARE PHYSICIAN**

Please note that Dr. Eang’s practice is a specialized practice and she is not practicing as a *primary care* physician. We strongly advise that you find a primary care physician if you do not have one so that your care can be properly coordinated for the best and highest outcome possible for you.

**PATIENT SIGNATURE** \_\_\_\_\_ Date \_\_\_\_\_

(or Patient Representative)

Indicate relationship if signing for patient \_\_\_\_\_

Initials: \_\_\_\_\_



HEALTHBRIDGE  
MEDICAL CENTER

**SANA EANG NMD, DC**  
HEALTHBRIDGE MEDICAL CENTER  
366 SAN MIGUEL DR #209 NEWPORT BEACH, CA 92660

### **PRACTICE POLICIES**

Dr. Eang's intention is to provide you with a high level of integrative medical care. Your honest and active participation in your own healing processes is vital. Please follow the guidelines and procedures below which will help to ensure that Dr. Eang, in partnership with you, provides you with the utmost level of care.

This packet of information includes detailed forms designed to help Dr. Eang learn more about you. **Please fill out ALL forms and return them back to Dr. Eang's office as soon as possible. The forms should be received in our office prior to your first visit.** If you have any questions or need assistance filling out the forms, please do not hesitate to call the office via the number at the bottom of this document.

This will allow you to maximize your time spent with Dr. Eang during your first visit. **Investing the time to fill out the forms now, will ensure that you receive the maximum benefit from your first visit with Dr. Eang.**

Your Introductory Packet includes the following documents:

- 1) Important patient information
- 2) Practice policies (this document)
- 3) Informed consent
- 4) Privacy practices
- 5) Consent for use and disclosure of health information
- 6) Arbitration Agreement
- 7) Chiropractic Care Questionnaire

Initials: \_\_\_\_\_

Practice Policies.doc

## **MEDICAL/CHIROPRACTIC RECORDS**

To ensure that Dr. Eang provides you with the best comprehensive care during your time with her, it is important that you have your medical/chiropractic records on hand prior to your first appointment. **The patient is responsible for obtaining medical/chiropractic records from previously seen chiropractors.** If you undergo any new tests or consultations with other healthcare providers after you have begun care, please send or fax to Dr. Eang prior to your next appointment. Please call your chiropractor to request that the appropriate records be sent to Dr. Eang's office. Medical/chiropractic records can only be released with your authorization. The office will fax or mail you an **"Authorization to Release Protected Health Information"** form for you to use with your other healthcare providers. **The records should be mailed or faxed to the location or number at the end of this document.**

## **CANCELLATION POLICY**

Dr. Eang intends to maximize the use of her time and energy towards helping sincere individuals lead a healthier, more joyous life. Due to the high demand to see her, we have implemented the following policy:

**New Patient Initial Intake Appointments – 5 Days prior to scheduled appointment**  
**Existing Patients Follow-up Appointments – 48 hours prior to scheduled appointment**

If you fail to cancel with less notice than listed above you will be charged for the full amount of the visit. You may cancel your appointment by contacting us at the practices phone number listed at the end of this document.

## **OFFICE FEES:**

Dr. Eang's practice is exclusive and limited to a finite number of patients who will receive a high level of care throughout their relationship with Dr. Eang.

**See 'Important Patient Information' document included in this packet for fee information.**

## **PAYMENT POLICIES**

Payment for all services is due 48 hours prior to the time of the appointment and product purchases are due at time of order placed. Payment is accepted via American Express, Visa, MasterCard, Discover, Check, or Cash.

## **INSURANCE INFORMATION**

Dr. Eang does not accept insurance or Medicare. You can request a bill of services rendered otherwise known as a SuperBill, that you can directly submit to your insurance provider for any reimbursements.

## **PHONE APPOINTMENTS, PHONE CALLS, MESSAGES AND FAXES**

1. To schedule an appointment with Dr. Eang contact her office using the information listed at the end of this document.
2. Dr. Eang or office staff will be available Monday to Thursday from 10AM to 5 PM PDT.
3. If you have a medical emergency call 911 or go directly to the nearest emergency room.

Initials: \_\_\_\_\_

Practice Policies.doc

**COORDINATION WITH PHYSICIANS AND OTHER HEALTHCARE PROFESSIONALS**

Dr. Eang is pleased to confer with your primary care physician or specialist(s) as it relates to the protocols that Dr. Eang has designed for you to support your long-term health and wellbeing. Dr. Eang’s primary concern is to ensure that your health care is properly coordinated and integrated, and that the quality of your care remains the top priority. Any requested time spent in consultation/coordination with your physician will be billed in accordance with the fee schedule listed above.

We look forward to the opportunity to help guide you on the path towards a life experienced with a high level of health and vitality. You are in good hands.

Yours in health,

Sana Eang NMD, DC  
HealthBridge Medical Center  
366 San Miguel Dr #209  
Newport Beach, CA 92660  
[FrontDesk@HealthBridgeHealing.com](mailto:FrontDesk@HealthBridgeHealing.com)  
Tel: (949) 715-9321  
Fax: (949) 340-5738

I have read and agree with the above guidelines, information, and costs associated with seeing Dr. Eang as a patient.

Name (please print): \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(or Patient Representative)

Indicate relationship if signing for patient: \_\_\_\_\_

Initials: \_\_\_\_\_

**INFORMED CONSENT FOR CHIROPRACTIC CARE**

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by Dr. Sana Eang NMD, DC

- 1) I have had an opportunity to discuss with the doctor of chiropractic named above and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.
- 2) I understand that the Chiropractor will use his/her hands or a mechanical device upon my body to adjust a joint, which may cause an audible “pop” or “click.”
- 3) I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the Chiropractor to be able to anticipate and explain all risks and complications, and I wish to rely upon the Chiropractor to exercise judgment during the course of the procedure which the Chiropractor feels at the time, based upon the facts then known to her, is in my best interest.
- 4) An undesirable result, or side effect, does not necessarily indicate an error in judgment or an improper treatment.
- 5) I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to chiropractic treatment. 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.

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

Patient's Name Printed \_\_\_\_\_

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

## **NOTICE OF PRIVACY POLICIES**

**How We Collect Information About You:** HealthBridge Medical Center. (HealthBridge) and its employees collect data through a variety of means including but not necessarily limited to letters, phone calls, emails, voice mails, and from the submission of applications that is either required by law, or necessary to process applications and provide care.

We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about applicants or clients who apply for or actually receive our services that is considered patient confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

**How We Use Your Information:** Information is only used as is reasonably necessary to process your application or to provide you with health or counseling services which may require communication between HealthBridge and health care providers, medical product or service providers, pharmacies, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to; or to obtain or purchase any type of medical supplies, devices, medications and/or insurance.

**Information We Do Not Collect:** We do not use cookies on our website to collect data from our site visitors. We do not intentionally collect information about site visitors. We do use some affiliate programs that may or may not capture traffic data through our site. To avoid potential data capture that you visited a diabetes website, for example, simply do not click on any of our outside affiliate links.

**Limited Right to Use Non-Identifying Personal Information From Biographies, Letters, Notes, and Other Sources:** Any pictures, stories, letters, biographies, correspondence, or thank you notes sent to us become the exclusive property of HealthBridge. We reserve the right to use non-identifying information about our clients (those who receive services or goods from or through us) for fundraising and promotional purposes that are directly related to our mission. Clients will not be compensated for use of this information and no identifying information (photos, addresses, phone numbers, contact information, last names or uniquely identifiable names) will be used without client's express advance permission. You may specifically request that NO information be used whatsoever for promotional purposes, but you must identify any requested restrictions in writing. We respect your right to privacy and assure you no identifying information or photos that you send to us will ever be publicly used without your direct or indirect consent.

**SANA EANG NMD, DC**  
HEALTHBRIDGE MEDICAL CENTER  
366 SAN MIGUEL DR #209 NEWPORT BEACH, CA 92660

**PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, HEALTHCARE AND CHIROPRACTIC OPERATIONS**

\_\_\_\_\_, hereby states that by signing the CONSENT, I acknowledge and agree as follows:

1. The Practice's Privacy Notice has been provided to me prior to my signing this consent. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations. The Practice explained to me that the Privacy Notice will be available to me in the future at my request. The Practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice carefully prior to my signing this Consent.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders and correspondence that can be used by the Practice: a) mail delivered to me at the address provided by me; b) email; and c) telephoning my home and/or mobile phone, and I allow the practice to leave a message on my answering machine or with the individual answering the phone.
4. The Practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for that treatment, and as necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is not required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, then the restriction is binding on the Practice.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extend the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to uses and disclosures described to me above the contained in the Privacy Notice, then the Practice will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

\_\_\_\_\_  
Name of individual (printed)

\_\_\_\_\_  
Signature of Individual

Date signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.  
PLEASE ASK OUR STAFF FOR A COPY.

## **Arbitration Agreement**

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by state and federal law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties to all claims, including claims arising out of or relating to treatment or services provided by health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptor ship interns who now or in the future treat the patient while employed by, working or associated with or serving as back up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, company, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of state and federal law, where applicable, establishing the right to introduce evidence of any amount payable as a benefit to the patient to the maximum extent

Permitted by law, limiting the right to recover non-economic losses, and the right to have a judgment for future damages conformed to periodic payments shall apply to disputes within this Arbitration Agreement. The parties further agree that the commercial Arbitration Rule or the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services rendered by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here \_\_\_\_\_. Effective as the date of first receiving professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

\_\_\_\_\_

Patient Signature

\_\_\_\_\_

Date

\_\_\_\_\_

Or Patient representative

\_\_\_\_\_

(indicate relationship to if signing for patient)

\_\_\_\_\_

Office Signature

\_\_\_\_\_

Date

## Chiropractic Care Questionnaire

### Initial Chiropractic Intake

Name: _____		Middle Initial: _____		Last Name: _____	
Address: _____					
City: _____		State: _____		Zip: _____	
Home Phone: (____) _____ - _____		Birth Date (m/d/y): ____/____/____		Age: ____	
Mobile Phone: (____) _____ - _____		Work Phone: (____) _____ - _____			
Place of Birth: _____		Occupation: _____		Sex:   Female   Male	
Race/Ethnicity: _____					
Date of Service: _____		Email: _____			
Current Primary Physician (PCP): _____				Phone: (____) _____ - _____	
Emergency Contact: (Name & Number) _____					

### Chief Complaints:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Nature of Injury:   work related       accident       other

Please describe: \_\_\_\_\_

Date if Injury: \_\_\_\_\_ Date symptoms appeared: \_\_\_\_\_

Have you ever had this condition? \_\_\_\_\_ If yes, when? \_\_\_\_\_

List of other practitioners seen for this injury/condition: \_\_\_\_\_

Have you ever been under chiropractic care? (circle one) Yes / No

If yes, please describe:

\_\_\_\_\_

\_\_\_\_\_

### History of Present Injury:

Do you experience pain every day? Y / N

Do your symptoms interfere with daily life? Y / N

Does pain wake you up at night? Y / N

Are your symptoms worse during certain times of the day? Y / N

Do changes in weather affect your symptoms? Y / N

Do you wear orthotics? Y / N

What activities aggravate your symptoms? \_\_\_\_\_

\_\_\_\_\_

### Past Medical History

a. List all Illnesses/Diagnosis, including date occurred:

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_
- iv. \_\_\_\_\_
- v. \_\_\_\_\_

b. List all Surgeries and Hospitalizations, including date occurred:

- i. \_\_\_\_\_
- ii. \_\_\_\_\_
- iii. \_\_\_\_\_
- iv. \_\_\_\_\_

c. Please note when & why you had the following studies done:

- i. X-rays: \_\_\_\_\_
- ii. MRI: \_\_\_\_\_
- iii. CAT Scans: \_\_\_\_\_
- iv. Ultrasounds: \_\_\_\_\_
- v. Dexa Scan: \_\_\_\_\_
- vi. Last Eye Exam: \_\_\_\_\_ Last Dental Exam: \_\_\_\_\_

d. List all Prescription Medications & Nutritional Supplements/Herbs (please include dosages):

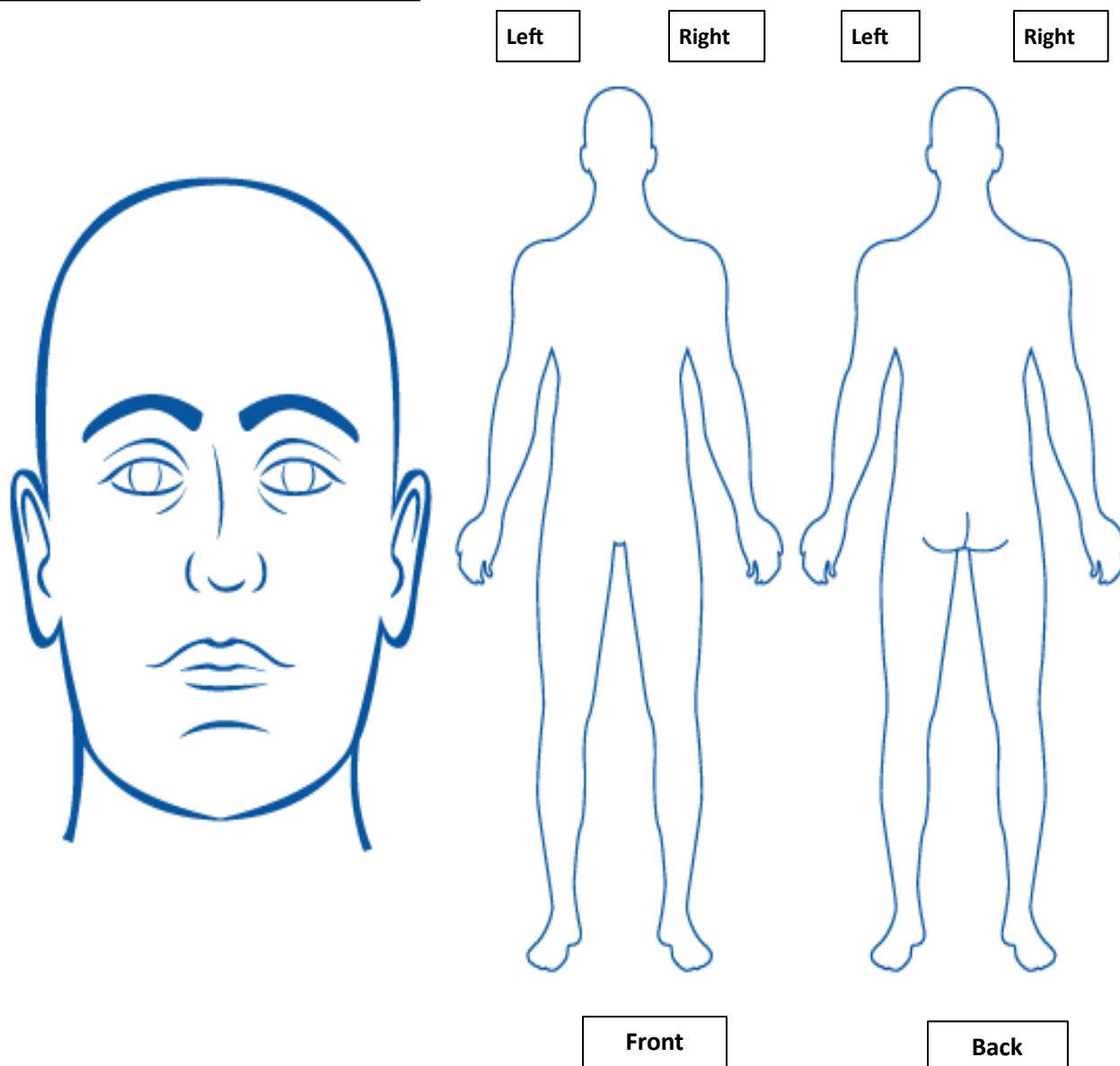
- i. \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Family History:**

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for Death:						
Cancer Type:						
High Blood Pressure	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Heart Disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Heart Attack/Stroke	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Asthma/Allergies	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Mental Illness	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
TB	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Auto-Immune Disease	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Diabetes Mellitus	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Osteoporosis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Arthritis	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N
Genetic Disorders	Y/N	Y/N	Y/N	Y/N	Y/N	Y/N

Please mark the diagram using the key below:

**KEY:**  
A = Achy  
P = Pain  
N = Numbness  
R = Radiating  
O = pins & needles



**Review of Systems:**

Present Weight: \_\_\_ Weight one year ago: \_\_\_ Height: \_\_\_ Ideal Weight: \_\_\_

Energy (check one): Good \_\_\_ low \_\_\_ High \_\_\_ Fatigue \_\_\_

If you have fatigue, when in the morning, afternoon, evening is it worst? \_\_\_\_\_

Can you do what you need to do during the day? Yes \_\_\_ No \_\_\_

For the following Questions please circle one: (Y = Yes, N = No or P = Past)

**Skin:**

Rash	Y N P	Color Change	Y N P
Hives	Y N P	Lump	Y N P
Psoriasis / Eczema	Y N P	Itchy	Y N P
Dry	Y N P	Warts/Moles	Y N P
Cancer	Y N P	Perspiration	Y N P

**Head:**

Headache	Y N P	Migraine	Y N P
Dandruff	Y N P	Head Injury	Y N P
Oil / Dry Hair	Y N P	Hair Loss	Y N P

**Nose:**

Frequent Colds	Y N P	Nosebleeds	Y N P
Congestion	Y N P	Post Nasal Drip	Y N P
Polyps	Y N P	Seasonal Allergies	Y N P

**Eyes:**

Dry/Watery	Y N P	Blurry Vision	Y N P
Double Vision	Y N P	Cataracts	Y N P
Glaucoma	Y N P	Styes	Y N P
Strain	Y N P	Discharge	Y N P
Itchy	Y N P	Dark under Eyelid	Y N P

**Mouth/Throat:**

Canker sores	Y N P	Cold sores	Y N P
Sore throat	Y N P	Gum disease	Y N P
Dentures	Y N P	Cavities	Y N P
Loss of taste	Y N P	Hoarseness	Y N P

**Neck:**

Stiffness	Y N P	Swollen Glands	Y N P
Limited movement	Y N P	Tension	Y N P

**Respiratory:**

Shortness of breath	Y N P	Bronchitis	Y N P
Wheezing	Y N P	Pneumonia	Y N P
TB	Y N P	Asthma	Y N P
Painful Breathing	Y N P	COPD	Y N P

**Cardiovascular:**

High Blood Pressure	Y N P	Rheumatic Fever	Y N P
Low Blood Pressure	Y N P	Murmurs	Y N P
Arrhythmias	Y N P	Palpitations	Y N P
Edema	Y N P	Chest Pain	Y N P

**Urinary Tract:**

Incontinence	Y N P	Pain w/Urination	Y N P
Frequent infections	Y N P	Kidney Stones	Y N P
Urgency	Y N P	Discharge/Blood	Y N P

**Gastrointestinal:**

Heartburn	Y N P	Bowel Movement (BM) Frequency	Y N P
Indigestion	Y N P	Recent BM change	Y N P
Bloating	Y N P	Diarrhea/Constipation	Y N P
Nausea	Y N P	Hemorrhoids	Y N P
Vomiting	Y N P	Gall Bladder disease	Y N P
Change in Appetite	Y N P	Liver Disease	Y N P
Pancreatitis	Y N P	Ulcer	Y N P

**Musculoskeletal:**

Weakness	Y N P	Arthritis	Y N P
Stiffness	Y N P	Leg Cramps	Y N P
Tremors	Y N P	Pain	Y N P

**Nervous:**

Paralysis	Y N P	Sciatica	Y N P
Tingling/Numbness	Y N P	Carpal Tunnel Syndrome	Y N P
Seizures	Y N P	Fainting	Y N P

**Social History:**

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_

Key: Yes (Y), No (N) or Past (P)

I. Antacids: Y N P      Steroids: Y N P      Analgesics: Y N P      Laxatives: Y N P

Smoking: Y N P      Packs per day & # of years: \_\_\_\_\_

Coffee: Y N P      Cups per day: \_\_\_\_\_      Soda Pop: Y N P      Ounces per day: \_\_\_\_\_

Alcohol: Y N P      How Often & How Much: \_\_\_\_\_

II. Addictions:

a. Alcohol: \_\_\_\_\_      Any past treatment: \_\_\_\_\_

b. Recreational Drugs: \_\_\_\_\_      Any past treatment: \_\_\_\_\_

III. Exercises:

How often: \_\_\_\_\_      What Type: \_\_\_\_\_

How long: \_\_\_\_\_      Hobbies: \_\_\_\_\_

IV. Sleep:

Hours per night: \_\_\_\_\_      If you wake up frequently, what is the reason? \_\_\_\_\_

Nightmares: Y N P      Wake Refreshed: Y N P      Naps during the Day: Y N P

Sleep Walk: Y N P      Grind teeth: Y N P      Snore: Y N P