in-health clinic was founded on our commitment to individualized and integrated healthcare. We believe that when doctors work together, the patient experiences better and faster results. At in-heath, our chiropractors, acupuncturists and naturopaths create personalized wellness solutions that cross professions and integrate seamlessly into your healthcare plan.

At in-health, our experience is that a healthy family is a happier family. Regardless of age, we believe in bringing each family member to their optimum health so they can live the life that they choose and not one that is thrust upon them or limited by circumstances of health. We use our training and knowledge to get to the root of a problem, treating the source rather than covering up symptoms. And if we are not the right office for you, we promise to tell you who we would recommend so that you get the highest quality of healthcare for today and the future.

in-health. Your goal. Our passion.

Confidential Patient Record

Name ______ Sex ______ Age ______ DOB ______ Date ______

Address ______ City ______ State ______ Zip ______

Home ______ Business ______ Mobile ______ Email ______

Occupation ______ Employer ______

Names/Ages of Children ______ Marital Status (circle one) MARRIED SINGLE WIDOWED DIVORCED

Name of Spouse ______ Spouse's Employer ______

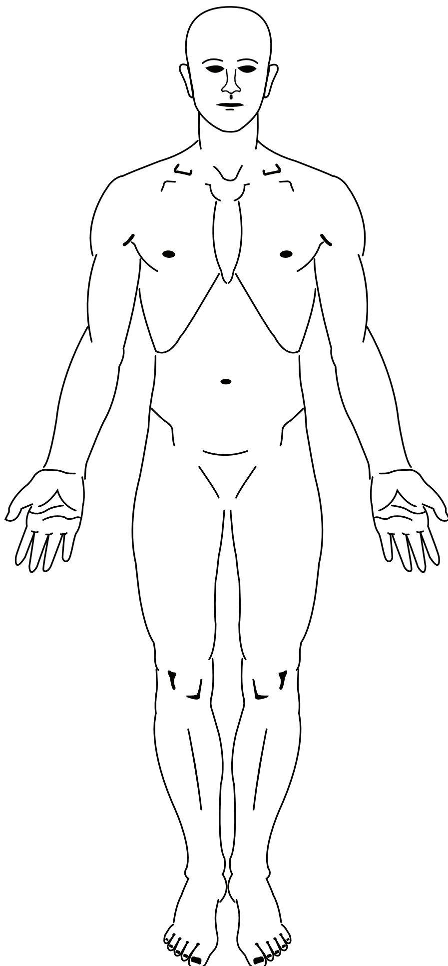
Name and Phone of Emergency Contact ______ Relationship ______

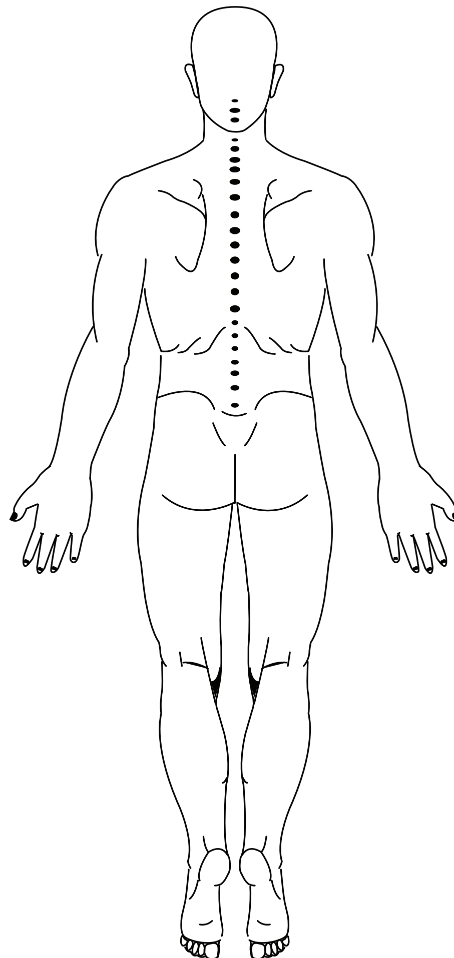
Have you ever been to a chiropractor before? Y N If yes, which doctor? ______

Chose clinic because/Referred to clinic by (please check one box):			☐ Dr.		☐ Insurance Plan	☐ Hospital
☐ Family	☐ Friend	☐ Close to home/work	☐ Yellow Pages	☐ Other		
Email address:			Are you interested in receiving clinic newsletters/special offers via email?			

HEALTH EVALUATION

Using the diagram below, mark the areas of your body where you currently feel pain or other abnormal sensation. Also indicate where your pain travels (if appropriate). You can also write notes next to your markings if a description would be helpful. Then, please answer the questions to the right by circling the number that best represents your pain, where 1 is no pain and 10 is pain as bad as you can imagine.





Scars: Use the diagrams to the left to draw any scars (major or minor) that you have.

Rate your pain by circling the one number that best describes your pain at its WORST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain at its LEAST in the past 24 hours.

1 2 3 4 5 6 7 8 9 10

Rate your pain by circling the one number that best describes your pain on AVERAGE for the past WEEK.

1 2 3 4 5 6 7 8 9 10

Pediatric Medical Questionnaire

ALLERGIES

Medication/Supplement/Food	Reaction

COMPLAINTS/CONCERNS

What do you hope to achieve in your visit with us? ______

If you had a magic wand and could help your child in three ways, what would they be?

1. ______
2. ______
3. ______

When was the last time you felt your child was well? ______

Did something trigger your child's change in health? ______

Is there anything that makes your child feel worse? ______

Is there anything that makes your child feel better? ______

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Success: Excellent	Success: Good	Success: Fair
Example: Difficulty Maintaining Attention		*X*		*Elimination Diet*	*X*		

MEDICAL HISTORY

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL
PAST | CURRENT

- ☐ ☐ Irritable Bowel Syndrome ____________
- ☐ ☐ Inflammatory Bowel Disease ____________
- ☐ ☐ Crohn's ____________
- ☐ ☐ Ulcerative Colitis ____________
- ☐ ☐ Gastritis or Peptic Ulcer Disease ____________
- ☐ ☐ GERD (reflux) ____________
- ☐ ☐ Celiac Disease ____________
- ☐ ☐ Other ____________

CARDIOVASCULAR
PAST | CURRENT

- ☐ ☐ Heart Disease ____________
- ☐ ☐ Elevated Cholesterol ____________
- ☐ ☐ Hypertension (high blood pressure) ____________
- ☐ ☐ Rheumatic Fever ____________
- ☐ ☐ Mitral Valve Prolapse ____________
- ☐ ☐ Other ____________

METABOLIC/ENDOCRINE
PAST | CURRENT

- ☐ ☐ Type 1 Diabetes ____________
- ☐ ☐ Type 2 Diabetes ____________
- ☐ ☐ Hypoglycemia ____________
- ☐ ☐ Metabolic Syndrome ____________
  (Insulin Resistance or Pre-Diabetes)
- ☐ ☐ Hypothyroidism (low thyroid) ____________
- ☐ ☐ Hyperthyroidism (overactive thyroid) ____________
- ☐ ☐ Endocrine Problems ____________
- ☐ ☐ Polycystic Ovarian Syndrome (PCOS) ____________
- ☐ ☐ Weight Gain ____________
- ☐ ☐ Weight Loss ____________
- ☐ ☐ Frequent Weight Fluctuations ____________
- ☐ ☐ Bulimia ____________
- ☐ ☐ Anorexia ____________
- ☐ ☐ Binge Eating Disorder ____________
- ☐ ☐ Night Eating Syndrome ____________
- ☐ ☐ Eating Disorder (non-specific) ____________
- ☐ ☐ Other ____________

CANCER
PAST | CURRENT

- ☐ ☐ ____________

GENITAL AND URINARY SYSTEMS
PAST | CURRENT

- ☐ ☐ Kidney Stones ____________
- ☐ ☐ Urinary Tract Infections ____________
- ☐ ☐ Yeast Infections ____________
- ☐ ☐ Other ____________

MUSCULOSKELETAL/PAIN
PAST | CURRENT

- ☐ ☐ Arthritis ____________
- ☐ ☐ Fibromyalgia ____________
- ☐ ☐ Chronic Pain ____________
- ☐ ☐ Other ____________

INFLAMMATORY/AUTOIMMUNE
PAST | CURRENT

- ☐ ☐ Chronic Fatigue Syndrome ____________
- ☐ ☐ Autoimmune Disease ____________
- ☐ ☐ Rheumatoid Arthritis ____________
- ☐ ☐ Lupus SLE ____________
- ☐ ☐ Immune Deficiency Disease ____________
- ☐ ☐ Severe Infectious Disease ____________
- ☐ ☐ Poor Immune Function ____________
  (frequent infections)
- ☐ ☐ Food Allergies ____________
- ☐ ☐ Environmental Allergies ____________
- ☐ ☐ Multiple Chemical Sensitivities ____________
- ☐ ☐ Latex Allergy ____________
- ☐ ☐ Other ____________

RESPIRATORY DISEASES
PAST | CURRENT

- ☐ ☐ Frequent Ear Infections ____________
- ☐ ☐ Frequent Upper Respiratory Infections ____________
- ☐ ☐ Asthma ____________
- ☐ ☐ Chronic Sinusitis ____________
- ☐ ☐ Bronchitis ____________
- ☐ ☐ Pneumonia ____________
- ☐ ☐ Other ____________

SKIN DISEASES
PAST | CURRENT

- ☐ ☐ Eczema ____________
- ☐ ☐ Psoriasis ____________
- ☐ ☐ Acne ____________
- ☐ ☐ Hives ____________
- ☐ ☐ Other ____________

in health

MEDICAL HISTORY

NEUROLOGIC/MOOD

PAST | CURRENT

- ☐ ☐ Depression ____
- ☐ ☐ Anxiety ____
- ☐ ☐ Bipolar Disorder ____
- ☐ ☐ Schizophrenia ____
- ☐ ☐ Headaches ____
- ☐ ☐ Migraines ____
- ☐ ☐ ADD/ADHD ____
- ☐ ☐ Sensory Integrative Disorder ____
- ☐ ☐ Autism ____
- ☐ ☐ Mild Cognitive Impairment ____
- ☐ ☐ Multiple Sclerosis ____
- ☐ ☐ ALS ____
- ☐ ☐ Seizures ____
- ☐ ☐ Other Neurological Problems ____

PREVIOUS EVALUATIONS

Check box if yes and provide date

- ☐ Full Physical Exam ____
- ☐ Psychological Evaluations ____
- ☐ Wechsler Preschool & Primary Scale of Intelligence ____
- ☐ Speech and Language Evaluations ____
- ☐ Genetic Evaluation ____
- ☐ Neurological Evaluations ____
- ☐ Gastroenterology Evaluations ____
- ☐ Celiac/Gluten Testing ____
- ☐ Allergy Evaluation ____
- ☐ Nutritional Evaluation ____
- ☐ Auditory Evaluation ____
- ☐ Vision Evaluation ____
- ☐ Osteopathic ____
- ☐ Acupuncture ____
- ☐ Physical Therapy ____
- ☐ Occupational Therapy ____
- ☐ Sensory Integration Therapy ____
- ☐ Language Classes ____
- ☐ Sign Language ____
- ☐ Homeopathic ____
- ☐ Naturopathic ____
- ☐ Craniosacral ____
- ☐ Chiropractic ____
- ☐ MRI ____
- ☐ CT Scan ____
- ☐ Upper Endoscopy ____
- ☐ Upper GI Series ____
- ☐ Ultrasound ____

INJURIES

Check box if yes and provide date

- ☐ Back Injury ____
- ☐ Neck Injury ____
- ☐ Head Injury ____
- ☐ Broken Bones ____
- ☐ Other ____

SURGERIES

Check box if yes and provide date

- ☐ Appendectomy ____
- ☐ Circumcision ____
- ☐ Hernia ____
- ☐ Tonsils ____
- ☐ Adenoids ____
- ☐ Dental Surgery ____
- ☐ Tubes in Ears ____
- ☐ Other ____

BLOOD TYPE: ○ A ○ B ○ AB ○ 0 ○ Rh+ ○ Unknown

HOSPITALIZATIONS ☐ None

Date	Reason

IMMUNIZATIONS

Is your child up to date with immunizations? ○ Yes ○ No

Do you feel immunizations have had an impact on your child's health? ○ Yes ○ No

If relevant, attach a copy of your child's immunization record or see addendum.

STRESS/COPING

Has your child experienced any major life changes that may have impacted his/her health? ○ Yes ○ No

Has your child ever experienced any major losses? ○ Yes ○ No

Have you ever sought counseling for your child? ○ Yes ○ No

Is your child or family currently in therapy? ○ Yes ○ No Describe:____________________

Does your child have a favorite toy or object? ○ Yes ○ No

Does your child practice stress release methods? ○ Yes ○ No If yes, then check all that apply:

☐ Yoga ☐ Meditation ☐ Imagery ☐ Breathing ☐ Tai Chi ☐ Prayer ☐ Other: ____________

Has your child ever been abused, a victim of a crime, or experienced a significant trauma? ○ Yes ○ No

SLEEP/REST

Average number of hours your child sleeps per night: ○ >12 ○ 10-12 ○ 8-10 ○ < 8

Does your child have trouble falling asleep? ○ Yes ○ No

Does your child feel rested upon awakening? ○ Yes ○ No

Does your child snore? ○ Yes ○ No

ROLES/RELATIONSHIP

List Family Members:

Family Member and Relationship	Age	Gender

Who are the main people who care for your child?____________________

Their employment/occupation:____________________

Resources for emotional support?

Check all that apply: ☐ Spouse ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: ____________

GYNECOLOGIC HISTORY *(for females only)*

MENSTRUAL HISTORY

Age at first period:______ Menses Frequency:______ Length:______ Pain: ○ Yes ○ No Clotting: ○ Yes ○ No

Has your period ever skipped?______ For how long?______

Last Menstrual Period:__________

Does your child use contraception? ○ Yes ○ No ☐ Condom ☐ Diaphragm ☐ IUD ☐ Partner Vasectomy

Use of hormonal contraception such as: ☐ Birth Control Pills ☐ Patch ☐ Nuva Ring How long?______

GI HISTORY

Has your child traveled to foreign countries? ○ Yes ○ No Where? ______________________________

Wilderness Camping? ○ Yes ○ No Where? ______________________________

Ever had severe: ○ Gastroenteritis ○ Diarrhea

DENTAL HISTORY

☐ Silver Mercury Fillings How many? __________

☐ Gold Fillings ☐ Root Canals ☐ Implants ☐ Tooth Pain ☐ Bleeding Gums

☐ Gingivitis ☐ Problems with Chewing

Do you floss regularly? ○ Yes ○ No

PATIENT BIRTH HISTORY

MOTHER'S PAST PREGNANCIES

Number of: Pregnancies: __________ Live births: __________ Miscarriages: __________

PREGNANCY

Total weight gain during pregnancy: ________lb Total weight loss during pregnancy: ________ lb

Please describe diet during pregnancy: ______________________________

____

____

Please describe labor: ______________________________

____

____

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your child's usual food and beverage intake as a part of the treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your child's eating behavior at this time, as the purpose of this food record is to analyze present eating habits.
- Record information as soon as possible after the food has been consumed.
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded), coffee (decaffeinated, with sugar, ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your child's eating habits on this form (ex. craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.).

DIET DIARY

Name: ______________________ Date: ______________

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color) ______________________

Stress/Mood/Emotions ______________________

Other Comments ______________________

Other ______________________

Informed Consent

I, the undersigned, have voluntarily requested that in-health clinic, Ly Ho Chiropractic Corporation assist me in the management of my health concerns. I have understood and agree to all policies and terms provided in the Office Policies and Procedures. I understand that in-health clinic, Ly Ho Chiropractic Corporation is a chiropractic services that are not to be construed or serve as a substitute for standard medical care. in-health clinic, Ly Ho Chiropractic Corporation recommends that I undergo regular routine medical check-up by my medical doctor.
Medical doctors, doctors of chiropractic, osteopaths, and physical therapists who perform manipulation are required by law to obtain your informed consent before starting treatment. I, the undersigned do hereby give my consent to the performance of conservative noninvasive treatment to the joints and soft tissues. I understand that the procedures may consist of manipulations/adjustment involving the movement of the joints and soft tissues. Physical therapy, home exercises, and nutritional supplements/dietary recommendations may also be used.
Routine chiropractic examination and treatment involve some of the following methods:

Observation: General assessment/appraisal in all postures.
Inspection: Viewing/looking at your body parts. Visualization includes general body viewing in a standing position, front, back, and side. All symptomatic (painful) body parts may be viewed. Women may continue wearing their bra in the course of examination unless it obscures visualization/viewing of injured/abnormal body parts. Women may request a female observer be present at any time during examination and/or treatment.
Auscultation: Using a stethoscope to listen for blood pressure and other body sounds.
Palpation: This means the doctor will touch you. The doctor will feel for tenderness, heat, swelling, nodularity, laxity/integrity of tissues, and other abnormalities.
Percussion: Using a rubber hammer and tapping on bones or tendons
Orthopedic/neurological testing: These are standard tests to assess your neuromusculoskeletal systems.

Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:
Risks from Treatment
Soreness: I am aware that like exercise it is common to experience muscle soreness in the first few treatments.
Dizziness: Temporary symptoms like dizziness and nausea can occur but are relatively rare. Please inform in-health clinic, Ly Ho Chiropractic Corporation if you experience these symptoms.
Fractures/Joint Injury: I further understand that in isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution.
Stroke: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are rare. I am aware that nerve or brain damage including stroke is reported to occur once in one million to once in ten million treatments. Once in a million is about the same chance as getting hit by lightning. Once in ten million is about the same chance as a normal dose of aspirin or Tylenol causing death.
Physical Therapy Burns: Some of the therapies used in this office generate heat and may rarely cause a burn. Despite precautions, if a burn is obtained, there will be a temporary increase of pain and possible blistering. This should be reported to the doctor immediately.
A thorough health history and tests will be performed on me to minimize the risk of any complication from treatment and I freely assume these risks.

Treatment Results
I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits.
I realize that the practice of medicine as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.
I agree to the performance of these procedures by my doctor and such other persons of the doctor's choosing.

Alternative Treatments Available
Reasonable alternatives to these procedures have been explained to me including rest, home applications of therapy, prescription or over-the-counter medications, exercises and possible surgery.
Medications: Medication can be used to reduce pain or inflammation. I am aware that long-term use or overuse of medication is always a cause for concern. Drugs may mask pathology, produce inadequate or short-term relief, undesirable side-effects, physical or psychological dependence, and may have to be continued indefinitely. Some medications may involve serious risks.
Rest/Exercise: It has been explained to me that simple rest is not likely to reverse pathology, although it may temporarily reduce inflammation and pain. The same is true of ice, heat, or other home therapy. Prolonged bed rest contributes to weakened bones and joint stiffness. Exercises are of limited value but are not corrective of injured nerve and joint tissues.
Surgery: Surgery may be necessary for conditions such as joint instability or serious disk rupture, among others. Surgical risks may include unsuccessful outcome, complications, pain or reaction to anesthesia, and prolonged recovery.
Non-treatment: I understand the potential risks of refusing or neglecting care may include increased pain, scar/adhesion formation, restricted motion, possible nerve damage, increased inflammation, and worsening pathology. The aforementioned may complicate treatment making future recovery and rehabilitation more difficult and lengthy.

I have read or have had read to me the above explanation of chiropractic treatment. The doctor has also asked me if I want a more detailed explanation; but I am satisfied with the explanation and do not want any further information. I have made my decision voluntarily and freely. To attest to my consent to these examination and treatment procedures, I hereby affix my signature to this Informed Consent document.

Signature of patient/legal guardian ____ Date: ___________________________

I discussed the procedures, alternatives, and risks in conference with the patient.

Doctor's signature:__________________________________ Date: ___________________________

Notice of Privacy Practices

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.

in-health clinic, Ly Ho Chiropractic Corporation is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

Disclosure of Your Health Care Information

Treatment: We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (Example)

"It is our policy to provide a substitute healthcare provider, authorized by in-health clinic, Ly Ho Chiropractic Corporation to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary healthcare provider's absence due to vacation, sickness, or other emergency situation."

Every effort will be made to protect your privacy. If you are at all uncomfortable, please inform any of our staff. Our answering machine is not a closed system. When messages are retrieved, there is a chance your message could be overheard. Again every effort is made to take messages off the machine with your privacy considered. Staff monitors our filing area at all times, as it is separate from the treatment rooms.

Worker's Compensation: We may disclose health information as necessary to comply with State Workers' Compensation Laws.

Emergencies: We may disclose health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of emergency or of your death.

Public Health: As required by law, we may disclose health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to law enforcement officials for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons: We may disclose your health information to coroners or medical examiners.

Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety: It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies: We may disclosure health information for military, national security, prisoner and government benefit purposes.

Marketing: We may contact you for marketing purposes as described below:

As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this reporting or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment.

As a service to our patients, it is our policy to occasionally send a health newsletter or a flyer regarding upcoming health classes offered on our premises. It is not our policy to disclose any personal health information about your condition for the purposes of these marketing mailings.

It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, postcard, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the type of activity, the date and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purposes of in-health clinic, Ly Ho Chiropractic Corporation fund-raising events.

Occasionally we will send birthday or holiday greetings or health reminders to our patients. It is not our policy to disclose any personal health information about your condition in these mailings.

Change of Ownership: In the event that in-health clinic, Ly Ho Chiropractic Corporation is sold or merged with another organization, your health information/record will become the property of the new owner.

Changes to this Notice of Privacy Practices

in-health clinic, Ly Ho Chiropractic Corporation reserves the right to amend this Notice of Privacy Practice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, in-health clinic, Ly Ho Chiropractic Corporation is required by law to comply with this Notice.

in-health clinic, Ly Ho Chiropractic Corporation is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: in-health clinic, Ly Ho Chiropractic Corporation by calling this office at 408-358-0270. If in-health clinic, Ly Ho Chiropractic Corporation is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints

Complaints about your Privacy Rights, or how in-health clinic, Ly Ho Chiropractic Corporation has handled your health information should be directed to in-health clinic, Ly Ho Chiropractic Corporation by calling this office at 408-356-0270. If in-health clinic, Ly Ho Chiropractic Corporation is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide in-health clinic, Ly Ho Chiropractic Corporation with my authorization and consent to use and disclose my protected health care information for the purpose of treatment, payment and health care operations as described in the Privacy Notice.

____
Patient's Name (print)

______________________________ _____________
Patient's Signature Date