INNOVATIVE HEALTH & WELLNESS GROUP

New Allergy Patient

PATIENT INFORMATION

Name: _____ Birthday (M/D/Y): _____ Age: _____ Gender: _____

Address: _____
(Street) (City) (Zip Code)

Cell: _____ Email: _____

Check your preferred method of communication: __ Call __ Text __ Email

Occupation:_____ Employer:_____

Marital status: __ Single __Married __Divorced __Widowed

Spouse's Name:_____ Spouse's Occupation:_____

# of Children: _____ Names and Ages: _____

How did you hear about us?_____

Have you ever consulted a Doctor of Chiropractic? __Y __N Who?_____ When?_____

HEALTH CONCERNS

Please list, in order of importance, your health concerns:

1. _____ 3. _____

2. _____ 4. _____

PERSONAL HEALTH HISTORY

Please list hospitalizations, surgeries, major illnesses and/or medical procedures and the year they occurred.

_____

_____

Please list any concussions, major accidents or injuries and the year they occurred.

_____

_____

New Allergy Patient

Do you have now or have ever suffered from:

__Headaches
__Sinus pain/Congestion
__Dizziness
__Balance/Coordination Decline
__Speech Changes
__Heart Disease
__High Blood Pressure
__Heart Palpitations or Arrhythmia
__Cancer
__Stroke
__Anemia
__Poor Circulation
__Cold/Tingling/Numbness in Hands or Feet
__Muscle Aches or Arthritis
__Frequent infections

__Skin Irritations
__Acne
__Thyroid Dysfunction
__Hormone Dysfunction
__PCOS
__Painful Breasts
__Frequent UTIs
__Menstrual Pain/Difficulty
__Kidney Stones
__Asthma
__Allergies
__Frequent Colds/URIs
__Diabetes
__Digestive Difficulty
__Heartburn
__Reflux

__Adrenal Dysfunction
__Difficulty Sleeping
__Low Energy
__Tire Easily
__Cognitive Challenges
__Concentration Challenges
__ Memory Decline
__Hyperactivity
__Restlessness
__Anxiety
__Brain Fog
__Depression
__Mood Swings
__Irritability
__Frequent Cravings
__Frequent antibiotic use

Have you ever suffered from an autoimmune condition? __Y __N Which one(s)_____

Please list all prescription and over-the-counter medications with dosage that you are taking and for what symptom.

If not currently on medications, please indicate that below by writing “NONE”.

1. _____ (Name) (Symptom)
2. _____ (Name) (Symptom)
3. _____ (Name) (Symptom)
4. _____ (Name) (Symptom)
5. _____ (Name) (Symptom)
6. _____ (Name) (Symptom)
7. _____ (Name) (Symptom)
8. _____ (Name) (Symptom)
9. _____ (Name) (Symptom)
10. _____ (Name) (Symptom)

On a scale of 1-10, rate the stress level of your typical week ____

Please list any sources of emotional stress that are currently affecting your daily life.

_____

_____

DIET AND LIFESTYLE

Please describe your current diet. Are you avoiding any foods? Why?

_____

_____

Are you currently taking any nutritional supplements? Why are you taking these supplements?

_____

_____

List any real or suspected allergies/sensitivities to drugs, food, or environmental sources and your reaction.

_____

_____

Do you use tobacco? __Y __N Number of caffeinated beverages per day ___

Number of alcoholic beverages per week ___ How often do you work out each week?____

INNOVATIVE HEALTH & WELLNESS GROUP

New Allergy Patient

PLEASE CHECK ALL OF THE FOLLOWING THAT APPLY TO YOU: **Date: _____**

Digestive Track
__nausea & vomiting
__diarrhea
__constipation
__bloated feeling
__stomach pains or cramps
__heart burn
__blood and/or mucous in stools

Ears
__itchy ears
__ear aches/ear infections
__drainage from ear
__ringing in ears
__hearing loss
__reddening of ears

Emotions
__mood swings
__anxiety/fear/nervousness
__anger/irritability/aggressiveness
__argumentative
__frustrated/cries easily
__Depression **S**

Eyes
__watery or itchy eyes
__red/swollen/itchy eyelids
__bags or dark circles under eyes
__blurred or tunnel vision

Head
__headaches
__faintness
__dizziness
__insomnia/sleep disorder
__facial flushing
__Irregular/Skipped Heartbeat **S**
__Rapid/Pounding Heartbeat **S**
__Chest Pains

Joints & Muscles
__pains/aches in joints
__arthritis/osteoarthritis
__stiffness/limited movement
__pain/aches in muscles
__feeling weak/tired
__swollen/tender joints
__growing pains in legs
__Psoriatic/Gouty Arthritis **S**
__Rheumatoid Arthritis **S**

Lungs
__chest congestion
__bronchitis
__shortness of breath
__difficulty breathing
__persistent cough
__wheezing

Mind
__poor memory
__difficulty completing projects
__difficulty with mathematics
__underachiever
__poor/short attention span
__confusion
__easily distracted
__difficulty making decisions
__mild learning Disabilities

Mouth & Throat Thrush
__chronic coughing
__gagging/clearing throat often
__sore throat/hoarse voice/voice loss
__swollen/discolored tongue/lips
__canker sores
__itching on roof of mouth

Nose
__stuffy nose
__chronically red/inflamed nose
__sinus problems
__hay fever
__sneezing attacks
__excessive mucous formation

Skin
__acne
__itching
__hives/rash/dry skin
__hair loss
__flushing/hot flashes

Weight
__binge eating/drinking
__craving certain foods
__excessive weight
__compulsive eating
__water retention

General
__frequent illness
__frequent/urgent urination
__genital itch/discharge
__anal itching

Genitourinary
__kidney problems
__urinary tract
__bladder
__yeast infections

Other Conditions
__Autism
__A.D.H.D.
__A.D.D.
__Psoriasis
__Eczema
__Auto Immune Disorder
__Chronic Fatigue
__Multiple Chemical Sensitivities
__Asthma
__Congestive Heart Failure
__Severe Diabetic
__Severe Depression
__Obsessive Compulsive Disorder

Please list your allergies of concern in order of importance:

_____

_____

_____

Please circle the appropriate number on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	0 1 2 3
Lower abdominal pain relieved by passing stool or gas	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Diarrhea	0 1 2 3
Constipation	0 1 2 3
Hard, dry, or small stool	0 1 2 3
Coated tongue or "fuzzy" debris on tongue	0 1 2 3
Pass large amount of foul-smelling gas	0 1 2 3
More than 3 bowel movements daily	0 1 2 3
Use laxatives frequently	0 1 2 3

Category II

Increasing frequency of food reactions	0 1 2 3
Unpredictable food reactions	0 1 2 3
Aches, pains, and swelling throughout the body	0 1 2 3
Unpredictable abdominal swelling	0 1 2 3
Frequent bloating and distention after eating	0 1 2 3

Category III

Intolerance to smells Intolerance to jewelry	0 1 2 3
Intolerance to shampoo, lotion, detergents, etc	0 1 2 3
Multiple smell and chemical sensitivities	0 1 2 3
Constant skin outbreaks	0 1 2 3

Category IV

Excessive belching, burping, or bloating	0 1 2 3
Gas immediately following a meal	0 1 2 3
Offensive breath	0 1 2 3
Difficult bowel movements	0 1 2 3
Sense of fullness during and after meals	0 1 2 3
Difficulty digesting proteins and meats; undigested food found in stools	0 1 2 3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0 1 2 3
Use of antacids	0 1 2 3
Feel hungry an hour or two after eating	0 1 2 3
Heartburn when lying down or bending forward	0 1 2 3
Temporary relief by using antacids, food, milk, or carbonated beverages	0 1 2 3
Digestive problems subside with rest and relaxation	0 1 2 3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0 1 2 3

Category VI

Difficulty digesting roughage and fiber	0 1 2 3
Indigestion and fullness last 2-4 hours after eating	0 1 2 3
Pain, tenderness, soreness on left side under rib cage	0 1 2 3
Excessive passage of gas	0 1 2 3
Nausea and/or vomiting	0 1 2 3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0 1 2 3
Frequent loss of appetite	0 1 2 3

Category VII

Abdominal distention after consumption of fiber, starches, and sugar	0 1 2 3
Abdominal distention after certain probiotic or natural supplements	0 1 2 3
Decreased gastrointestinal motility, constipation	0 1 2 3
Increased gastrointestinal motility, diarrhea	0 1 2 3
Alternating constipation and diarrhea	0 1 2 3
Suspicion of nutritional malabsorption	0 1 2 3
Frequent use of antacid medication	0 1 2 3

Category VIII

Greasy or high-fat foods cause distress	0 1 2 3
Lower bowel gas or bloating several hours after eating	0 1 2 3
Bitter metallic taste in mouth, especially in the morning	0 1 2 3
Burpy, fishy taste after consuming fish oils	0 1 2 3
Unexplained itchy skin	0 1 2 3
Yellowish cast to eyes	0 1 2 3
Stool color alternates from clay colored to normal brown	0 1 2 3
Reddened skin, especially palms	0 1 2 3
Dry or flaky skin and/or hair	0 1 2 3
History of gallbladder attacks or stones	0 1 2 3
Have you had your gallbladder removed?	*YES NO*

Category IX

Acne and unhealthy skin	0 1 2 3
Excessive hair loss	0 1 2 3
Overall sense of bloating	0 1 2 3
Bodily swelling for no reason	0 1 2 3
Hormone imbalances	0 1 2 3
Weight gain	0 1 2 3
Poor bowel function	0 1 2 3
Excessively foul-smelling sweat	0 1 2 3

Category X

Crave sweets during the day	0 1 2 3
Irritable if meals are missed	0 1 2 3
Depend on coffee to keep going/get started	0 1 2 3
Get light-headed if meals are missed	0 1 2 3
Eating relieves fatigue	0 1 2 3
Feel shaky, jittery, or have tremors	0 1 2 3
Agitated, easily upset, nervous	0 1 2 3
Poor memory, forgetful between meals	0 1 2 3
Blurred vision	0 1 2 3

Category XI

Fatigue after meals	0 1 2 3
Crave sweets during the day	0 1 2 3
Eating sweets does not relieve cravings for sugar	0 1 2 3
Must have sweets after meals	0 1 2 3
Waist girth is equal or larger than hip girth	0 1 2 3
Frequent urination	0 1 2 3

Increased thirst and appetite 0 1 2 3
Difficulty losing weight 0 1 2 3

Category XII

Cannot stay asleep 0 1 2 3
Crave salt 0 1 2 3
Slow starter in the morning 0 1 2 3
Afternoon fatigue 0 1 2 3
Dizziness when standing up quickly 0 1 2 3
Afternoon headaches 0 1 2 3
Headaches with exertion or stress 0 1 2 3
Weak nails 0 1 2 3

Category XIII

Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under a high amount of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep 0 1 2 3
Excessive perspiration or perspiration with little or no activity 0 1 2 3

Category XIV

Edema and swelling in ankles and wrists 0 1 2 3
Muscle cramping 0 1 2 3
Poor muscle endurance 0 1 2 3
Frequent urination 0 1 2 3
Frequent thirst 0 1 2 3
Crave salt 0 1 2 3
Abnormal sweating from minimal activity 0 1 2 3
Alteration in bowel regularity 0 1 2 3
Inability to hold breath for long periods 0 1 2 3
Shallow, rapid breathing 0 1 2 3

Category XV

Tired/sluggish 0 1 2 3
Feel cold—hands, feet, all over 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression/lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face, or genitals, or excessive hair loss 0 1 2 3
Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XVI

Heart palpitations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervous and emotional Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XVII (Males Only)

Urination difficulty or dribbling 0 1 2 3
Frequent urination 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel emptying 0 1 2 3
Leg twitching at night 0 1 2 3

Category XVIII (Males Only)

Decreased libido 0 1 2 3
Decreased number of spontaneous morning erections 0 1 2 3
Decreased fullness of erections 0 1 2 3
Difficulty maintaining morning erections 0 1 2 3
Spells of mental fatigue Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decreased physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional than in the past 0 1 2 3

Category XIX (Menstruating Females Only)

Perimenopausal 0 1 2 3
Alternating menstrual cycle lengths 0 1 2 3
Extended menstrual cycle (greater than 32 days) 0 1 2 3
Shortened menstrual cycle (less than 24 days) 0 1 2 3
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XX (Menopausal Females Only)

How many years have you been menopausal? _____ *Years*
Since menopause, do you ever have uterine bleeding? *YES NO*
Hot flashes 0 1 2 3
Mental fogginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breasts 0 1 2 3
Facial hair growth 0 1 2 3
Acne 0 1 2 3
Increased vaginal pain, dryness, or itching 0 1 2 3

Name_____ **DOB**: _____

Clinical Care Release

_____ has been accepted as a patient to be seen at Innovative Health and Wellness Group.

The patient and/or his/her guardian(s), or legally responsible person(s) desire to be examined by the licensed practitioners and the clinical staff. You the patient, upon signature, give permission/consent to any clinically appropriate examination and therapeutic procedures, as determined by the clinical staff and consented to.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that providers of many disciplines may be in attendance or participate in this clinical evaluation and care process. These individuals will potentially observe all examination and treatment procedures.

Clinical staff: (Please take the time to understand the staff, their roles, and feel free to ask about scope of practice with each one). We have a multi-disciplinary staff to accommodate you.

Staff:

Dr. Elizabeth Seymour, MD

- Medical Doctor
- Clinical Director

Dr. Erin Van Veldhuizen, MSN, FNP-C, DC, DACNB, DCBCN, DCN, CCCN, CCTT

- Family Nurse Practitioner- Certified (Delegation with Elizabeth Seymour, MD)
- Chiropractor
- Diplomat, American Chiropractic Neurology Board
- Diplomat, Chiropractic Board of Clinical Nutrition
- Diplomat, Clinical Nutrition from American Association of Integrative Medicine
- Nutritional Therapy
- Certified Camera Thermographer, International Association of Camera Thermographers

Dr. Nisreen Tayebjee, DC

- Chiropractor
- Nutrition Therapy

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that there are risks associated with all diagnostic and therapeutic procedures, including those used at Innovative Health and Wellness Group. The procedures ordered by the staff clinicians are recommended because the potential benefits are greater than the potential risks.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that NO promise or guarantee of a cure or outcome has been given. While the Innovative Health and Wellness Group staff will attempt to work with any patient we feel we can assist in recovery or improvement, we also reserve the right to deny or suspend care should the patient's condition warrant it.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that neither the patient or any assigns will hold Innovative Health and Wellness Group, its staff, or its volunteers liable for any actions, non-actions, or outcomes associated with the diagnosis, treatment, and recommendations of the staff.

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Statement of Patient Financial Responsibility

Name: _____ DOB:_____

Innovative Health and Wellness Group appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies complete financial responsibility on your part.

The financial responsibility obligates you to ensure payment in full of our fees and the costs of all testing, including laboratory and other outside tests. We expect these payments at time of service.

The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that at no time will IHWG be obligated to communicate or bill any insurance company. We will provide you with a detailed statement of services provided should you wish to seek reimbursement independently.

While your specific treatment plan is determined by the clinical staff. The patient and/or his/her guardian(s), or legally responsible person(s) acknowledge and agree that all costs specific to transportation, lodging, and travel expenses are to be borne by the patient and/or his/her guardian(s), or legally responsible person(s).

I have read the above policy regarding my financial responsibility to Innovative Health and Wellness Group, for providing services to myself or the above-named patient. I certify the information is, to the best of my knowledge, true and accurate. Payment in full and the entire amount of bill incurred by me or the above-named patient is due prior to service rendered.

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Authorization to Release Information

I authorize Innovative Health and Wellness Group to release to appropriate agencies or persons, any information acquired in the course of my or the above-named patient's examination and treatment. This information may be stored and transmitted electronically using appropriate safeguards and/or data encryption.

For more information, please see the HIPAA authorization form and privacy notice, or feel free to ask a member of staff should you need clarification.

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Cancellation/No Show Policy

We acknowledge there may be times when you miss an appointment due to emergencies or obligations to work or family; however, we urge you to call 24 hours prior to canceling your appointment.

Our opportunities to treat patients are limited by our treatment regime, therefore the patient and/or his/her guardian(s), or legally responsible person(s) also acknowledge that if the patient No Shows for more than two appointments that they may be dismissed from care. The Practice will notify you if you are discharged from care.

I have read and acknowledge the above policy, and I agree to the terms described.

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

Video and Photography Consent

Occasionally Innovative Health and Wellness Group will conduct filming and/or photography for promotional materials as well as for training purposes. The patient and/or their legal guardian is responsible for ensuring they are not incidentally recorded should they refuse this consent. The staff at this facility will never attempt to employ hidden or covert means to record any patient without their knowledge.

Educational Usage

In consideration that Innovative Health and Wellness Group partners with educational organizations, we request your consent to film or record various aspects of your treatment. We also request your consent to use information related to your condition or care in the training of staff and/or students. Any protected health information (PHI) will be removed or redacted from any documents used in this manner.

Promotional Usage

While relatively uncommon, we will ask to record patients for testimonials or photograph for promotional materials. General information may be shared such as a brief description of your condition, your first name and/or initials and statements you may wish to make. Should you be asked and agree to provide a testimonial, there will be no reimbursement and the product, including the rights to use your likeness, will become the sole property of IHWG.

You are free to refuse your consent to be recorded or photographed with **NO EFFECT** on your care.

I have read the above policies and wish to give my consent to:

__ Both educational and promotional usage.
__ Only educational usage.
__ None of the above.

_____ _____ Date _____/_____/_____
Signature of patient Printed name

_____ _____
Signature of Guardian, if patient is a minor or dependent Relationship to patient

Experimental Therapy Statement

Some of the devices and therapies used at Innovative Health and Wellness Group are proprietary and/or are in the process of gaining regulatory approval. While they are thought by our clinical staff and medical advisory board to have a positive effect, no claim is made that any of the devices listed below diagnose or treat any condition unless specifically evaluated and approved by the Food and Drug Administration for that usage.

- Qi5 scanning and therapy
- PTL II laser therapy
- Compounded infusion formulas for the treatment of specific conditions.
- Various compounded medications and nutritional and dietary and supplemental usage combined with conventional medical care.

Additionally, the nutraceuticals and supplements offered may contain elements that have not been assessed by the Food and Drug Administration. While none of these, in the opinion of the clinical staff, pose an unbalanced risk or are

Inherently unsafe, we as healthcare providers feel you should be made aware that they may not have been proven effective in treating your specific condition.

I have read and acknowledge the above statement.

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient

HIPAA Authorization Form

_____ _____/_____/_____ _____

Patient's full name Date of birth Telephone number

_____ _____

Name of legal guardian/representative (if patient is under 18) Relationship to patient

I authorize Innovative Health and Wellness Group to access, use or disclose my protected health information in the manner described below.

1) IHWG may request and be provided with a copy of prior health records, including protected health information from your current or previous healthcare provider(s).
2) IHWG may communicate with your current or previous healthcare provider(s) in reference to your diagnosis, treatment and care.
3) IHWG staff may communicate internally regarding your case.
4) You have the right to authorize or disallow communication with outside non-clinical personnel (such as a family member) regarding your diagnosis, treatment or care of IWHG.

The following information may be disclosed to, from, or between outside medical personnel and IHWG as it is relevant to your care:

*Medical Records *All treatment records

*Records regarding communicable diseases *Chiropractic records

*Alcohol/Drug abuse treatment records *Any other information relating to your condition

*Mental Health records

All past, present and future periods of healthcare information may be shared for the period of this authorization.

The purpose of the use or disclosure of this information is to facilitate effective and accurate diagnosis and treatment at IHWG, and to comply with state and federal laws.

This authorization is valid beginning on _____/_____/_____ (today's date) and expires one year after the end of your care received at or from IHWG, including any follow-up care and consultations.

I acknowledge that the information used or disclosed under this authorization may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form; however, if I refuse to sign the staff of IHWG may refuse service if they are unable to gain access to previous medical records. If signed, I have the right to revoke this authorization, in writing, at any time. I acknowledge that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. Please see the HIPAA privacy notice for a more detailed outline of our privacy policy.

In the event I cannot be reached, IHWG may use the following methods to communicate important health information:

___ e-mail provide the email address: _____

___ voicemail at the following number (be aware work voicemails may not be secure): _____

___ standard mail at the following address: _____

Name of any person(s) allowed to communicate with IHWG and relation to patient:

_____

_____ _____ Date _____/_____/_____

Signature of patient Printed name

_____ _____

Signature of Guardian, if patient is a minor or dependent Relationship to patient