HAGER HEALTH
& natural wellness center LLC

Health questionnaire

Please complete this form to the best of your knowledge. Your answers will allow us to determine how we can help you. If we do not sincerely believe your condition will respond satisfactorily, we will make the appropriate referral. THANK YOU.

PERSONAL INFORMATION

Name:______________________________________ Date: _____________________

Address: _______________________City:______________ State:_____ Zip:_________

Home Phone: _________________________ Work Phone:_________________________

Cell Phone:________________________ Age: ________ Date of Birth: _____________

E-mail:____

REFERRED BY: _____________________________________

May this office use your full name when we thank above mentioned person? _______

Marital Status (please circle): M S D W Number of Children: ______________

Your Spouse's Name:____

Your Occupation: ____

Employed by: ____

Address: ____

Name of person to contact in case of emergency:________________________________

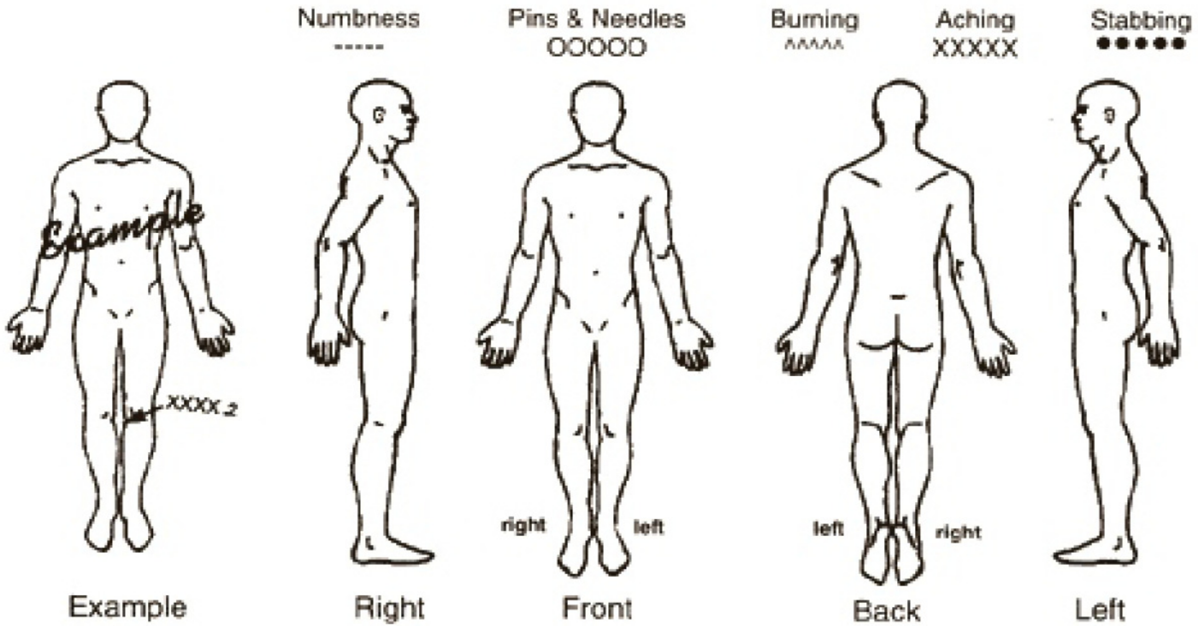
Relationship: _________________________ Phone Number(s):____________________

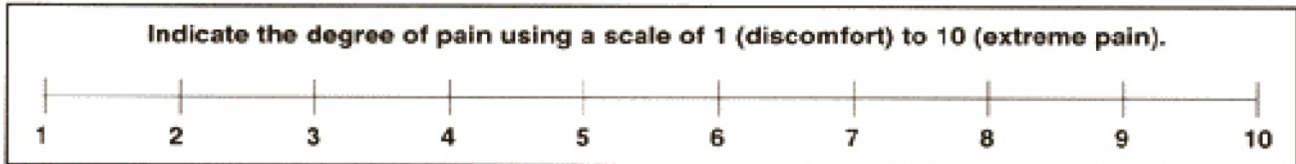
Referring Physician/Primary Care Physician:____________________________________

Primary Care Physician Contact Information____________________________________

CHIEF COMPLAINT(S)

Please mark **area(s)** of injury or discomfort on the diagrams below.





Please describe your current primary complaint?

____

____

Difficulty in: _____Standing,_____ Sitting, _____Bending, _____Walking, ____ Reaching

Cannot lift: _____ Light, _____Moderate, _____Heavy, _____Repetitive

Currently your pain is aggravated by:____Coughing, ____Sneezing, ____Straining at stool

Since your symptoms began, have you noticed a change in:____Bowel function, ____Bladder function, ____Ability to maintain an erection.

How long have you suffered from your current complaint? _________________

Have you ever suffered from this complaint previously_____________________

Have you received any treatment for your current condition? Yes ____ No _____

If Yes, When & Where? ____

Since the time this (these) complaint(s) began, what, if anything, have you tried to alleviate the symptoms that **did not** work? ____

____

Has the problem interrupted your sleep? Yes / No How:_____________________________

MEDICAL HISTORY

GENERAL
1) ___ Fever
2) ___ Chills
3) ___ Night Sweats
4) ___ Loss of Sleep
5) ___ Fatigue
6) ___ Nervousness
7) ___ Weight Loss or Gain
8) ___ Allergies
9) ___ Bleeding Problem
10) ___ Anemia
11) ___ Diabetes
12) ___ Cancer
13) ___ Thyroid Disease/Goiter
14) ___ Alcoholism
15) ___ Drug Abuse

RESPIRATORY
45) ___ Difficulty Breathing
46) ___ Chronic Cough
47) ___ Spitting Phlegm
48) ___ Spitting Blood
49) ___ Wheezing/Asthma
50) ___ Pneumonia
51) ___ Tuberculosis

NEUROLOGIC
82) ___ Weakness
83) ___ Twitching
84) ___ Tremors
85) ___ Headache
86) ___ Fainting
87) ___ Dizziness
88) ___ Convulsions
89) ___ Epilepsy
90) ___ Numbness/Tingling
91) ___ Arm/Leg Pain
92) ___ Mental Disorder

EYE EAR NOSE THROAT
16) ___ Poor Vision
17) ___ Pain in Eye(s)
18) ___ Deafness/Difficulty Hearing
19) ___ Nosebleeds
20) ___ Nose Problems
21) ___ Sinus Trouble
22) ___ Dental Problems
23) ___ Hoarseness
24) Tonsillectomy

CARDIOVASCULAR
52) ___ Irregular Heartbeat
53) ___ High Blood Pressure
54) ___ Pain over Heart
55) ___ Previous Heart Trouble
56) ___ Ankle Swelling
57) ___ Varicose Veins
58) ___ Rheumatic Fever
59) ___ Stroke

MUSCULOSKELETAL
93) ___ Neck Stiffness/Pain
94) ___ Pain Between Shoulders
95) ___ Low Back Pain
96) ___ Swollen Joints
97) ___ Painful Joints
98) ___ Muscle Aches/Soreness
99) ___ Spinal Curvature
100) ___ Arthritis

GASTROINTESTINAL
25) ___ Poor Appetite
26) ___ Poor Digestion
27) ___ Difficulty Swallowing
28) ___ Belching or Gas
29) ___ Frequent Nausea
30) ___ Vomiting
31) ___ Vomiting Blood
32) ___ Pain over Abdomen
33) ___ Ulcer
34) ___ Black or Bloody Stools
35) ___ Liver Problems
36) ___ Gall Bladder Problems
37) ___ Jaundice
38) ___ Hernia
39) ___ Diarrhea
40) ___ Constipation
41) ___ Hemorrhoids
42) ___ Appendicitis

GENITOURINARY
60) ___ Frequent Urination
61) ___ Painful Urination
62) ___ Blood in Urine
63) ___ Kidney Disease
64) ___ Urinary Infection
65) Inability to Control Urination
66) ___ Difficulty Starting Urine Flow
67) ___ Get Up ___ Times per Night to Urinate
68) ___ Breast Lump or Pain
69) ___ Venereal Infection
70) ___ Sexual Difficulties

HABITS
101) Smoking ____ Packs/Day
102) ___ Drinking
103) ___ Recreational Drug Use

SKIN
71) Itching
72) ___ Bruising Easily
73) ___ Change in Mole(s)
74) Skin Cancer

EXERCISE
104) None
105) ___ 1-2 Times/Week
106) ___ 3-5 Times/Week
107) 6-7 Times/Week

MEN ONLY
43) ___ Testicular Swelling/Pain
44) ___ Prostate Problems

WOMEN ONLY
75) ___ Painful Periods
76) ___ Excessive Flow
77) ___ Irregular Cycles
78) ___ Vaginal Burning/Itching
79) ___ Hot Flashes
80) ____________ Date Last Period Began
81) ____________ Date of Last PAP Test

FAMILY HISTORY
Include information on brothers, sisters, parents and grandparents.

108) ___ Diabetes
109) ___ Thyroid Disease/Goiter
110) ___ Tuberculosis
111) ___ Kidney Disease
112) ___ High Blood Pressure
113) ___ Heart Disease
114) ___ Cancer
115) ___ Muscle, Bone or Nerve
116) Other

Have you ever had surgery? Yes ____ No ____ If so, please state the type of surgery, and estimated date of surgery: ____

Have you been hospitalized in the past 5 years? Yes____ No____

Details:____

Are you allergic to any medication? Please list: _____________________________________

Are you taking any medications? Please list: _______________________________________

Do you wear Orthotics (shoe inserts)? Yes ___ No ____

If yes, what type & how old are they? __________________________________

On average, how many hours of restful sleep do you get per night? __________

Do you take vitamins/supplements? If yes, please list: ________________________________

____

Please circle your current emotional stress level: mild moderate excessive

Women:

Are you pregnant? Yes ____No ____Due date:___________________________

Are you under the regular care of an Ob-Gyn/Midwife?_____________________

To the best of my knowledge, the above information is accurate. I will notify this office immediately if any of the information changes.

____ __________________

Signature Date

HAGER HEALTH
& natural wellness center LLC
(203) 858-7582
drhager@hagerhealth.com ■ www.hagerhealth.com

INFORMED CONSENT TO CHIROPRACTIC CARE:

You understand that the chiropractic adjustment is used to correct dysfunctions of the spine involving the joints, muscles and nerves that is called a subluxation.

You consent to the performance of a spinal examination in which the doctor uses their hands to feel the muscles and joints of the spine or other body parts (palpation), performs a visual inspection of your posture, checks the ability to move through a normal range of motion for spinal or other body parts, and performs any further orthopedic or neurological tests. X-rays or other imaging may be ordered by the chiropractor.

The tests and spinal adjustments are standard and commonly used. They involve very little risk and serious side effects are rare. Some patients may have muscle soreness after chiropractic adjustments or after performing standard physical exam tests.

Spinal adjustments have been used routinely in the management of patients with a variety of symptoms and/or disorders, including those without symptoms who want to improve overall health. Chiropractic is considered part of a wellness lifestyle. I have read and understand this informed consent and I consent to chiropractic examination and care.

____________________________ ______________________
Signature of Patient Date

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING:

I specifically authorize the natural health practitioners at Hager Health and Natural Wellness Center, LLC to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, infections, or other medical conditions and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing. This permission form applies to subsequent visits and consultations.

____________________________ ______________________
Signature of Patient Date

HAGER HEALTH
& natural wellness center LLC

Dr. Loren M. Hager (203) 858-7582

This notice describes how chiropractic and medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

In the course of your care as a patient at this office we may use or disclose personal and health related information about you in the following ways:

- Your personal health information, including your clinical records, may be disclosed to another health care provider or hospital if it is necessary to refer you for further diagnosis, assessment or treatment.
- Your health care records as well as your billing records may be disclosed to another party, such as an insurance carrier, an HMO, a PPO or your employer, if they are or may be responsible for the payment of your services.
- Your name, address, phone number and your healthcare records may be used to contact you regarding appointment reminders, information about alternatives to your present care or other health related information that may be if interest to you.

If you are not at home to receive an appointment reminder, a message may be left on your answering machine. Further, you have the right to inspect or obtain a copy of the information we will use for these purposes. You also have the right to refuse to provide authorization for this office to contact you regarding these matters. If you do not provide us with this authorization it will not affect the care provided to you or the reimbursement avenues associated with your care.

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

- If we are providing health care services to you based on the orders of another health care provider.
- If we provide health care services to you in an emergency.
- If we are required by law to provide care to you and we are unable to obtain your consent after attempting to do so.
- If there are substantial barriers to communicating with you, but in our professional judgment we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information, other than as outlined above, will only be made upon your written authorization.

We normally provide information about your health to you in person at the time you receive chiropractic care from us. We may also mail information to you regarding your health care or about the status of your account. If you would like to receive this information at an address other than your home or if you would like the information in a different form please advise us in writing as to your preferences.

You have the right to inspect and/or copy your health information for seven years from the date that the record was created or as long as the information remains in our files. In addition you have the right to request an amendment to your health information. Requests to inspect, copy or amend you health related information should be provided to us in writing.

We are required by state and federal law to maintain the privacy of your patient file and the protected health information therein. We are also required to provide you with this notice of

our privacy practices with respect to your health information.

We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice we will notify you in writing as soon as possible following the changes. Any change in our privacy notice will apply for all of your health information in our files.

Information that we use or disclose based on this privacy notice may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

If you have a complaint regarding our privacy notice, our privacy practices or any aspect of our privacy activities you should direct your complaint to Dr. Loren M. Hager immediately.

If you would like further information about our privacy policies and practices please contact Dr. Loren M. Hager.

This notice is effective as of April 1, 2003. This notice, and any alterations or amendments made hereto will expire seven years after the date upon which the record was created. My signature acknowledges that I have received a copy of this notice.

_____________________________ ________________________________ ____________

Name (print) Signature Date

Or if you are a minor, or if you are being represented by another party

_____________________________ ________________________________ ____________

Personal Representative (print) Signature Date

____

Description of the authority to act on behalf of the patient.