

***h*Health Quest**
Chiropractic & Physical Therapy
with *ADVANCED WEIGHT LOSS*
NUTRITION & FUNCTIONAL MEDICINE
7920 McDonogh Road, Suite 101
Owings Mills, MD 21117
410.356.9939 www.HQChiro.com

Welcome!

Congratulations!

You've just taken your first step toward creating a new life for yourself. And we will be here to help you every step of the way. To make this process go as smoothly as possible, please be aware of the following policies and procedures prior to coming in for your initial evaluation:

- Make sure you've eaten before your appointment and get a good night's rest the night before.
- Do not drink alcohol at least 24 hours prior to your appointment.
- Do not wear any lotions or perfumes to your appointment.
- We can be reached by phone at 410.356.9939 or email at ContactUs@HQChiro.com.
- Directions to the office can be found at www.HQChiro.com – or give us a call and we'll direct you.

Thank you in advance for your cooperation. We look forward to seeing you!

Yours in Good Health,

Dr. Paul Ettlinger, Dr. Stefanie Coforio,
and the rest of the team at Health Quest

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Please answer all questions honestly and to the best of your knowledge. All information is kept confidential.

Name:			Date:		
Address:				Country:	
City:		State:		Zip/Postal Code:	
Home Phone:		Work Phone:		Fax:	
E-mail:			Cell Phone:		
Please mark your preference for occasional follow up communication from our office: <input type="checkbox"/> Email <input type="checkbox"/> Phone					
Age:	Birth date:	Sex: M F	Status: M S W D	# of Children:	
Occupation:		Employer:		Years Employed:	
Spouse's Name:		Occupation:		Employer:	
Person responsible for this account:				Referred by:	
What is your major complaint?					
Other complaints?					
What are your overall health goals once your complaints are resolved?					
How long has it been since you really felt good?					

Weight _____ Height _____ Blood Pressure (if known) _____ % Body Fat (if known) _____

1. Are you presently taking any medications, nutritional supplements or vitamins? _____
 please list (attach sheet if necessary)

2. In the past, have you used birth control pills and/or antibiotics? _____
If yes, for how long? _____

3. If you have fillings, please list material(s) used: _____

4. Do you presently, or have you ever had any of these conditions? (circle)

Anemia	Frequent Headaches	Skin condition
Arthritis	Heartburn	Thyroid condition
Asthma	High blood pressure	Unexplained weight change
Chest pains	High cholesterol	Cancer:
Chronic cold/flu symptoms	Hypoglycemia	
Chronic fatigue	Kidney problems	
Depression	Liver problems	
Diabetes	Osteoporosis	

5. How much sleep do you get each night on average? _____

6. Do you have any food allergies, sensitivities or restrictions?

7. Do you smoke, drink alcohol or use recreational drugs? _____

a. How much, how often?

b. How often do you drink caffeinated beverages?

8. Please list foods you tend to overeat or crave (eg:, sweets, breads, fatty foods, meats, milk, etc.):

9. Are there foods that you eat on a daily or almost daily basis?

a. Do you "miss" these foods if you do not eat them? _____

10. Write briefly about your weight gain/loss history:

a. What do you feel triggered your weight fluctuation? (circle)
heredity stress eating habits boredom other: _____

b. Was your weight gain/loss: (circle) sudden gradual problem since childhood

11. Please list close relatives that have diabetes, heart disease or obesity and their relationship to you:

12. What methods have you tried to lose/gain weight:

13. How is your energy level? _____

a. Are there times in the day that you feel best? _____ Worst? _____

14. Are you happy in your life right now? _____

15. What are your main sources of stress?

16. How do you deal with your stress?

17. Please answer the following questions Yes or No:

a. If I'm feeling down, a snack makes me feel better. Yes _____ No _____

b. I sometimes have a hard time going to sleep without a bedtime snack. Yes _____ No _____

c. I get tired and/or hungry in the mid-afternoon. Yes _____ No _____

d. I get a sleepy, almost "drugged" feeling after eating a meal containing bread, pasta or dessert.
Yes _____ No _____

e. Now and then I think I am a secret eater. Yes _____ No _____

f. At a restaurant, I almost always eat too much bread before the meal is served. Yes _____ No _____

g. I have difficulty concentrating, or frequent fuzzy or spacey thinking patterns. Yes _____ No _____

h. I experience cravings for sugar, breads, pasta and baked goods. Yes _____ No _____

i. I feel shaky if I don't eat on time or if I don't snack. Yes _____ No _____

j. I often find myself irritable or angry. Yes _____ No _____

18. Check off any of the following that have applied to you within the last 30 days:

<input type="checkbox"/> Do you feel nauseous?	<input type="checkbox"/> Do you have abdominal/intestinal pain?
<input type="checkbox"/> Do you have bloating?	<input type="checkbox"/> Do you get bloated after meals?
<input type="checkbox"/> Do you get heartburn?	<input type="checkbox"/> Do you have diarrhea?
<input type="checkbox"/> Do you have constipation?	<input type="checkbox"/> Do you travel outside of the U.S.?
<input type="checkbox"/> Do you have gas?	<input type="checkbox"/> Are your stools compact/hard to pass?
<input type="checkbox"/> Do you belch following meals?	<input type="checkbox"/> Do you have gurgles in your stomach?
<input type="checkbox"/> Do your bowel movements alternate between constipation and diarrhea?	

24. In your estimation, how physically fit are you right now?

Unfit _____ Below average _____ Average _____ Above average _____ Very fit _____

25. How often do you exercise? _____

a. What is your regimen?

26. If you do not currently exercise, what types of exercise have you enjoyed doing in the past?

27. What are your fitness goals? (circle all that apply)

<input type="checkbox"/> General fitness endurance	<input type="checkbox"/> Muscle toning
<input type="checkbox"/> Weight loss/maintain weight	<input type="checkbox"/> Muscle strengthening
<input type="checkbox"/> Osteoporosis prevention	<input type="checkbox"/> Muscular coordination/balance
<input type="checkbox"/> Specific sport enhancement	Other _____
<input type="checkbox"/> Flexibility	

28. Surgeries, starting with most recent:

29. Hospitalizations:

30. Briefly describe where you have lived since childhood:

31. What is your heritage? (Irish, German, Spanish, etc.) _____

32. Circle "Now" or "Past" for only those items with which you identify. Ignore anything that does not apply to you.

Is your life:	Do you often:
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	Do you often:
Now Past Unsatisfactory	Now Past Have irrational fears
Do you worry over:	Now Past Feel upset
Now Past Home life	Now Past Feel things go wrong
Now Past Marriage	Now Past Feel shy
Now Past Children	Now Past Cry
Now Past Job	Now Past Feel inferior
Now Past Income	Have you:
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide

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Body Injury Sheet

[PLEASE LABEL AND WRITE CLEARLY]

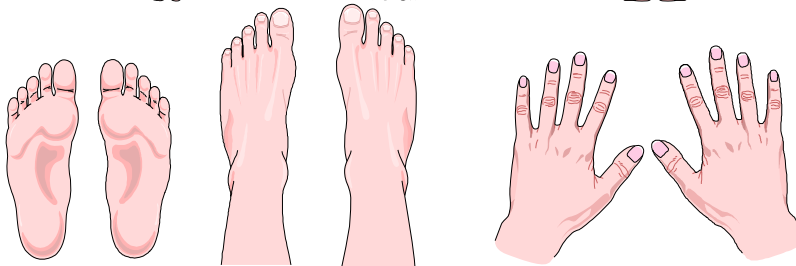
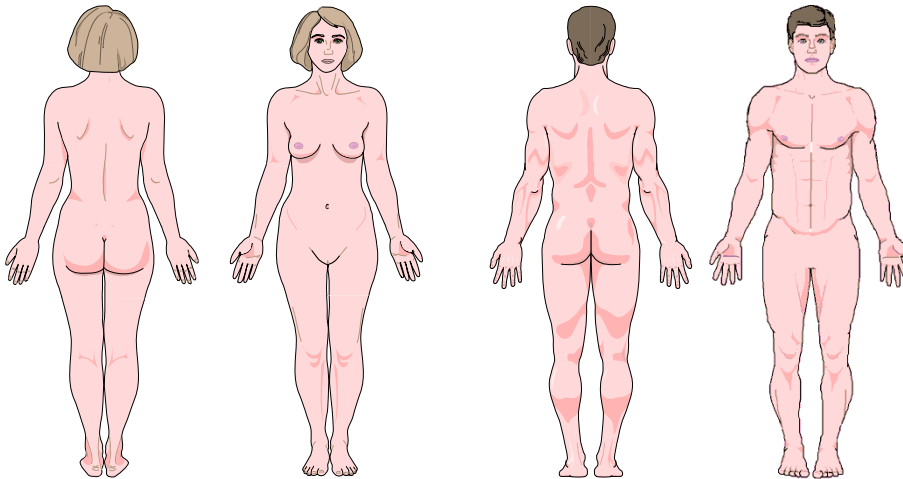
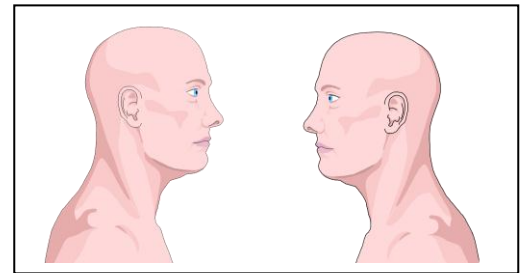
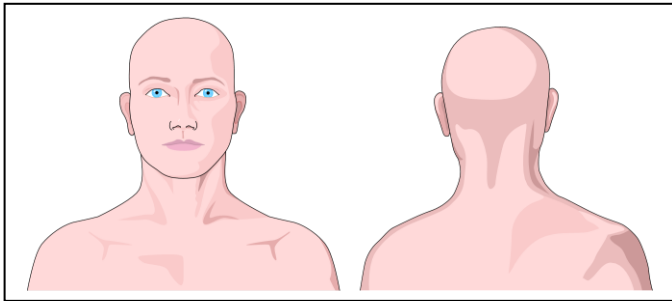
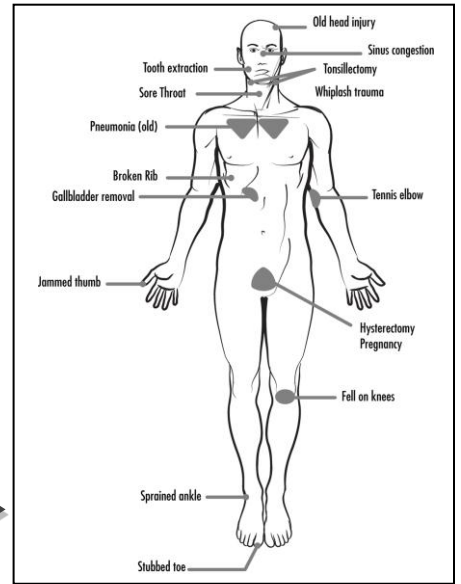
Name: _____ Date: _____

LABEL AREAS of old injuries and past infections

Injury Examples: scars, injuries from auto accident, head injury, falls or hits, surgeries, broken bones, muscle/tendon/ligament tears, organs removed, etc.

Infection Examples: sore throat, tonsils swollen, ear infections, lung infection, bronchial infections, bladder infections, sinus infection, appendicitis, etc.

SEE EXAMPLE TO THE RIGHT



Patient Signature: _____

Advanced Weight Loss Informed Consent for Care

Print Full Name _____

Date _____

1. Acupressure is a service delivered at Health Quest. It is a simple, safe, non-invasive and natural method of normalizing the transmission of energy flows in the body and or stress reduction. This is not a method for preventing, diagnosing, treating, healing, relieving or curing symptoms, disease or medical conditions of any kind. I understand that should I receive acupressure, exercise advice, exercise therapy, diet advice, or nutritional advice, there may be temporary side-effects such as fatigue, flu-like symptoms and possible aggravation of the symptoms presented after a treatment. _____ **Initials**

2. I agree not to wear perfumes or scented deodorants at Health Quest due to the potential of other client sensitivities. I also understand that being well fed and hydrated is necessary to facilitate benefits from services delivered and it is my responsibility to see that I have adequate nourishment each day. _____ **Initials**

3. I understand the practitioners are Chiropractors, Chiropractic Assistants, Massage Therapists and/or Personal Trainers. No cures are guaranteed. I understand that the initial visit includes a history, exam and testing as directed in order to evaluate if the services of Health Quest are right for me and determine if I am eligible for Health Quest services. _____ **Initials**

4. I understand that once nutritional supplements are purchased from and leave the office, they may not be returned, exchanged, refunded or credited unless Health Quest determines that the order was filled incorrectly. _____ **Initials**

5. I understand that changes in my weight and health as a result of this program can affect the need for or dosage of any medications I may currently be taking. I understand I need to closely monitor my use of these medications with my prescribing physician. _____ **Initials**

6. **Administrative Fees:** I understand that the following fees may apply: _____ **Initials**

- Bounced Check Fee per incident (Two max. then cash only): \$35.00
- Records Copy Fee: \$20.00/request (issued to client only, not sent to 3rd party)

7. I understand that Health Quest does no 3rd party or insurance billing, reporting, coding, processing, or annual expense reporting of any kind whatsoever with regard to the Advanced Weight Loss Program (this includes Doctor reports, records to insurance companies, insurance report forms, etc.) _____ **Initials**

I have read and understand the above terms of service.

Patient Signature _____

Date _____

CONSENT TO TREAT A MINOR (Under 18 years old)

I, _____, do hereby request this center evaluate and perform services for my child named _____, age _____, and consent to the above terms of service on his/her behalf. I am the legal guardian of this child. I understand that while this child is at Health Quest, he/she is to be with me at all times and may not be left unsupervised or in the care of staff or other clients.

Guardian Signature _____ Date _____

Please complete this form if you would like us to share information about your progress with another person.

Authorization to Release Medical Information

To: (practitioner or clinic name here) _____

Address: (address here) _____

I, _____ request the following information:

- Test results
- History
- Records
- Diagnosis
- Treatment
- Reports
- Progress

Concerning my:

- Accident
- Injury
- Illness
- Other _____

To be released to: _____

(Name of Practitioner, Doctor, family member etc.)

Address: _____

Fax: _____

For the purpose of: _____

(Specify)

Signed: _____ Date: _____

Patient Spouse Parent Guardian