

*h*Health Quest
Chiropractic & Physical Therapy
with *ADVANCED WEIGHT LOSS*

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!

Dr. Paul Ettlinger, DC
Dr. Nova Conetta, DC
and the rest of the Health Quest team

Client Case Record

Name: _____ Date: _____
 Cell phone: _____ Home Phone: _____ Work phone: _____
 Address: _____
 City: _____ State: _____ Zip: _____
 Age: _____ Birth date: _____ Sex: []Female []Male
 Occupation: _____ Email: _____
 How did you hear about us? _____

Please list your five top physical complaints in order of importance:

1. _____ When did this start? _____
 Office notes: _____

Intermittent / Constant
 Sharp / Dull / Achy
 Mild / Mod / Severe

2. _____ When did this start? _____
 Office notes: _____

Intermittent / Constant
 Sharp / Dull / Achy
 Mild / Mod / Severe

3. _____ When did it start? _____
 Office notes: _____

Intermittent / Constant
 Sharp / Dull / Achy
 Mild / Mod / Severe

4. _____ When did it start? _____
 Office notes: _____

Intermittent / Constant
 Sharp / Dull / Achy
 Mild / Mod / Severe

5. _____ When did it start? _____
 Office notes: _____

Intermittent / Constant
 Sharp / Dull / Achy
 Mild / Mod / Severe

Current medications you are taking:

Client Case Record (continued)

History of medical illnesses, surgeries, removed organs and treatments:

Social History:

- History of smoking? []No []Yes Amount: _____
- History of alcohol? []No []Yes Amount: _____
- Current dietary caffeine? []No []Yes Amount: _____
- Current dietary refined sugar? []No []Yes Amount: _____
- History of excessive grains (breads, pasta, etc.)? []No []Yes Amount: _____
- History of low calorie diets? []No [] Yes Detail: _____
- History of excessive salty foods? []No []Yes Amount: _____
- History of family illness or genetic issues? []No []Yes Explain: _____

Allergies / Sensitivities:

Current Physician Name /Phone Number:

The information on this sheet is, to the best of my knowledge, true and accurate.

Patient Signature/Date

Body Injury Sheet

[PLEASE LABEL AND WRITE CLEARLY]

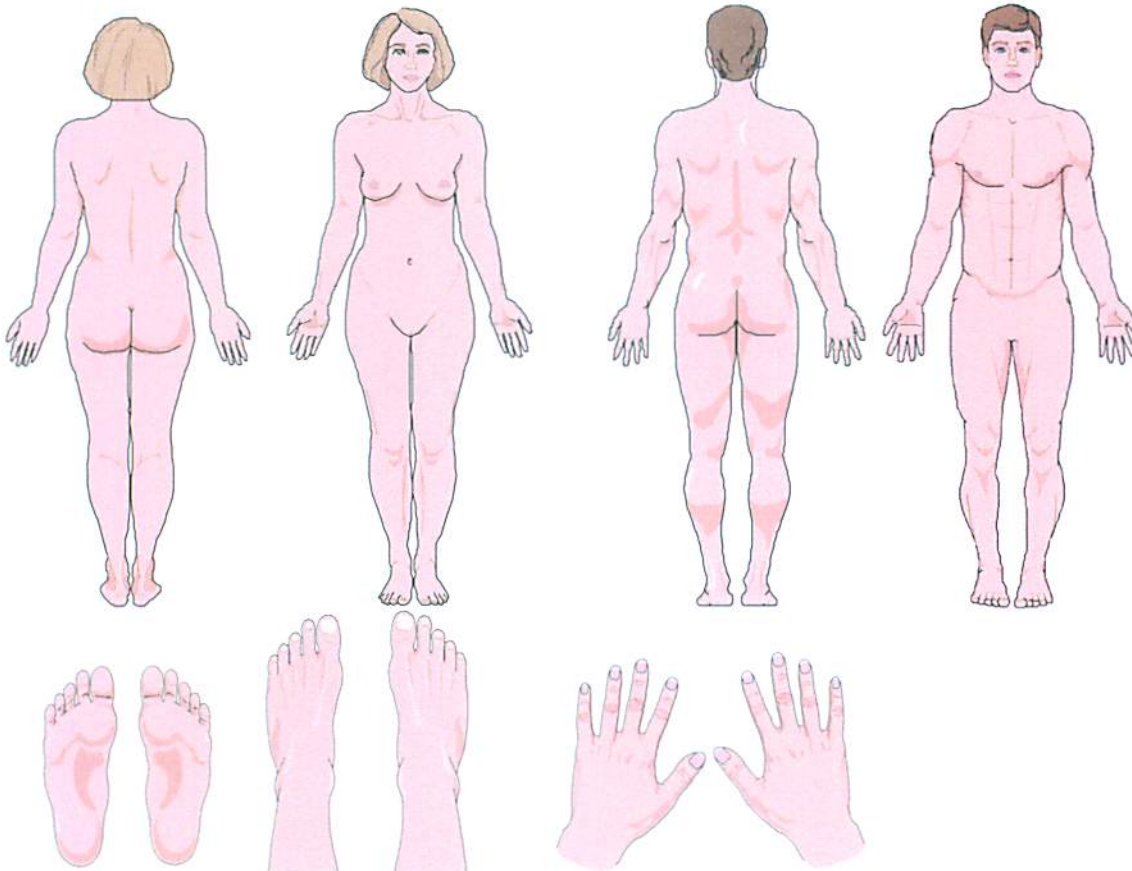
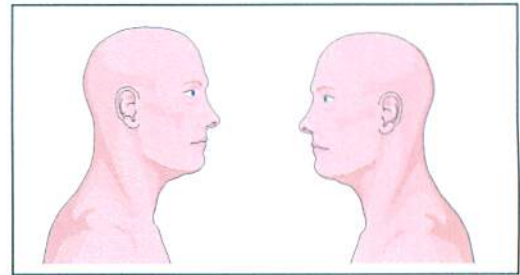
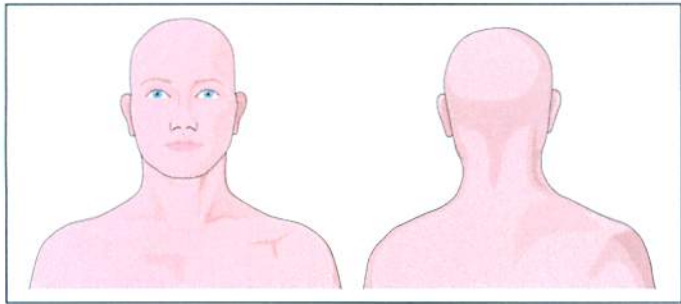
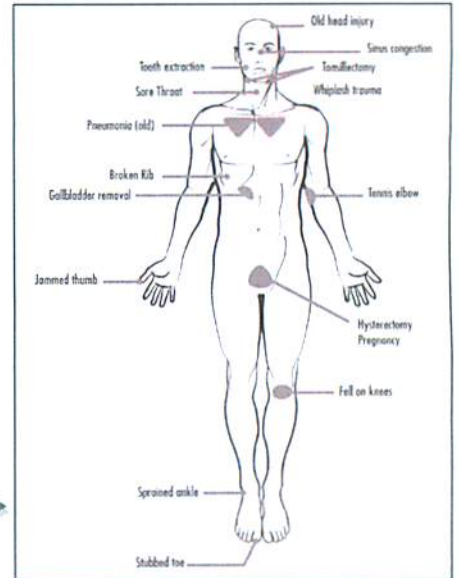
Name: _____ Date: _____

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: _____

Symptom Checklist

Please check off all that apply

Section 1

- Cravings for junk food
- Drinks wine in evenings
- Craves refined carbohydrates
- Frustrating stubborn weight
- History of low-calorie diets
- History of up and down weight
- Fluid retention
- History of birth control pills
- History of Hormone Replacement Therapy
- High protein diets don't work
- Poor willpower
- Can't lose weight despite exercise
- History of blood sugar problems

Section 2

- Out of breath when walking up stairs
- Dizziness
- Excessive facial hair (female)
- Perspiring after getting out of shower
- Fatigue during the day
- Difficulty getting out of bed in morning
- Waking up in the middle of the night
- Difficulty falling asleep
- Afternoon headaches
- Arthritis or stiff and painful joints
- Bursitis
- Tendonitis
- Twitch under eye lid
- Heel spurs
- Low back weakness or pain
- Itchiness or hives
- Nervousness
- Fluid retention
- Dehydrated despite amount of fluid consumed
- Swollen ankles
- Craving salty foods
- Enlarged abdomen
- Enlarged bump in upper back/lower neck
- Hands and feet go to sleep easily
- Chest pain
- Muscle cramps, worse during exercise
- Dull pain in chest or radiating in left arm

Section 3 (female only)

- PMS
- Irregular periods
- Depression during menstruation
- Bloating and cramping during menstruation
- Weight gain during menstruation
- Weight gain during ovulation
- Difficulty losing weight after pregnancy
- Heavy bleeding during menstruation
- Enlarged swollen breasts during menstruation
- Hot flashes
- Night Sweats
- Vaginal Dryness
- Leaky bladder
- Frequent urination at night

NOTES:

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 _____