

**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](http://www.HQChiro.com)

Welcome!

Thank you for choosing Health Quest as part of your health care team! The following information will help you understand how our process works.

**STEP 1:**

During your initial consultation, your doctor at Health Quest will review your health history and make recommendations for lab tests that are appropriate for your specific health issues.

**STEP 2:**

Once you have completed your lab tests, your doctor will explain the meaning of your test results to you in a follow up consultation. He/she will create an individualized therapeutic program for you that may include diet changes and nutritional supplements, plus exercise, lifestyle and stress management advice.

**STEP 3:**

Subsequent consults are scheduled to monitor your progress. Your doctor will also design an on-going wellness program to be reviewed and updated with our staff every six months.

We invite you to contact us via phone or email should you have any questions during the course of your treatment. We may be reached at 410-356-9939 or [ContactUs@HQChiro.com](mailto:ContactUs@HQChiro.com). Office hours are Monday through Friday 8:30am-7:00pm and Saturday 9:00am-1:00pm.

We look forward to assisting you in achieving your wellness goals, and to guiding you in maintaining wellness throughout your life.

Yours in Good Health,

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

**hHealth Quest**  
*Chiropractic & Physical Therapy*  
 with **ADVANCED WEIGHT LOSS**  
**NUTRITION & FUNCTIONAL MEDICINE**

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:

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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:

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

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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?

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16. How do you deal with your stress?

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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:

Do you feel nauseous?	Do you have abdominal/intestinal pain?
Do you have bloating?	Do you get bloated after meals?
Do you get heartburn?	Do you have diarrhea?
Do you have constipation?	Do you travel outside of the U.S.?
Do you have gas?	Are your stools compact/hard to pass?
Do you belch following meals?	Do you have gurgles in your stomach?
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?

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

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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:

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29. Hospitalizations:

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30. Briefly describe where you have lived since childhood:

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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.

<b>Is your life:</b>	<b>Do you often:</b>
Now Past Satisfactory	Now Past Feel depressed
Now Past Boring	Now Past Have anxiety
Now Past Demanding	<b>Do you often:</b>
Now Past Unsatisfactory	Now Past Have irrational fears
<b>Do you worry over:</b>	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	<b>Have you:</b>
Now Past Money problems	Now Past Seriously considered suicide
	Now Past Attempted suicide

**Body Injury Sheet**  
 [PLEASE LABEL AND WRITE CLEARLY]

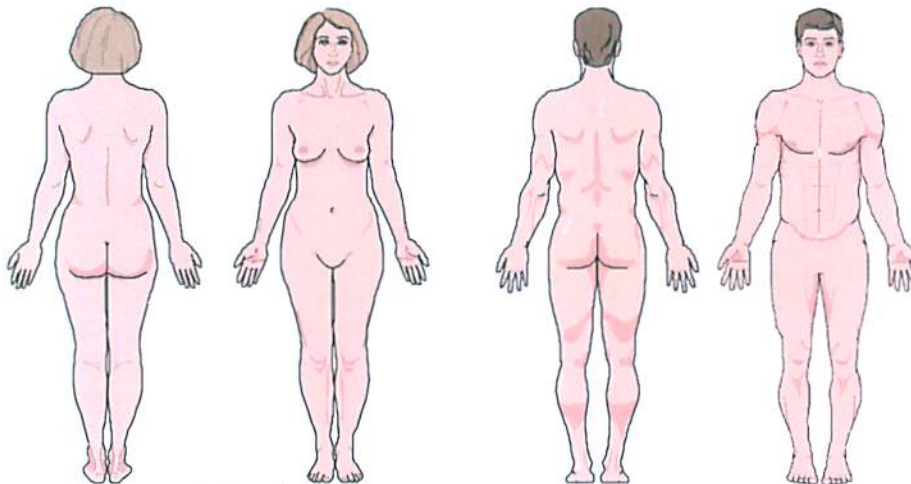
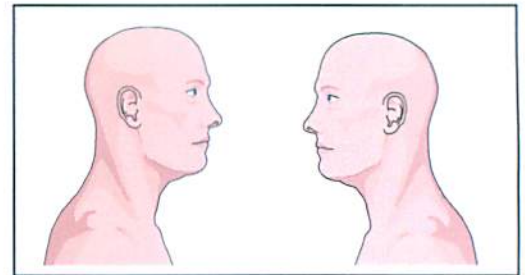
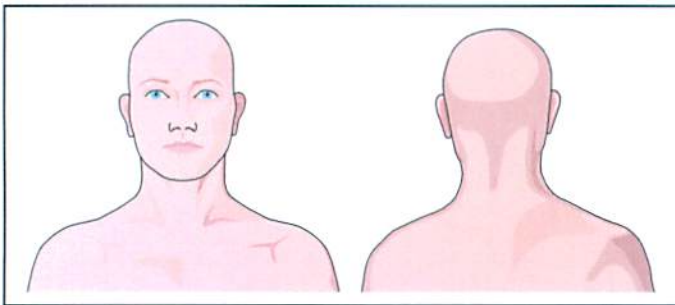
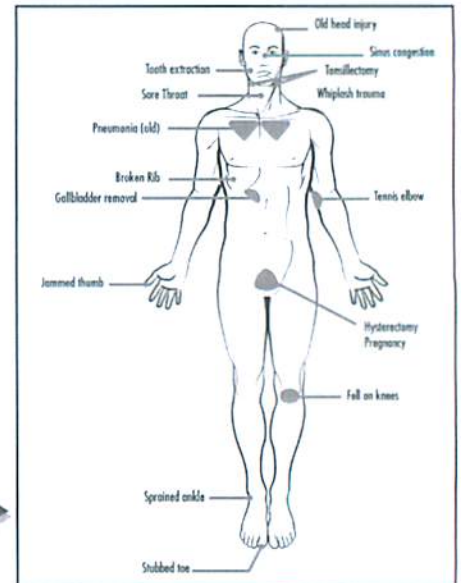
Name: \_\_\_\_\_ Date: \_\_\_\_\_

**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: \_\_\_\_\_

I clearly understand and agree that all services rendered to me are charged directly to me and that I am responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable. I authorize Health Quest to release my personal medical information to me.

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## POLICIES AND PROCEDURES

### Fee Schedule

New Patient consultation: \$300. (45 minutes - 1 hour)  
1 hour: (\$300)  
45 minutes: (\$230)  
30 minutes: (\$150)  
15 minutes: (\$80)

- ☞ Payment is due at time of consultation
- ☞ Methods of payment are: Cash, Check, Visa, MasterCard, Discover, American Express or a pre-arranged payment plan.
- ☞ All consultations are timed from the time the appointment begins; you will only be billed for the actual time used.

### Appointments

- ☞ Follow-up consults may be scheduled in 15, 30, 45, or 60-minute blocks of time.
- ☞ We encourage you to book your appointments 2 weeks in advance.
- ☞ As a courtesy to you, our office will send you a text or email message to confirm your appointment one day in advance.

### Lab Tests

- ☞ The results of your lab test(s) will be sent to Health Quest 2 to 4 weeks after mailing your specimens to the lab.
- ☞ Your doctor will evaluate the results. After his/her evaluation, you will be contacted to schedule a follow-up appointment.

**Cancellations**

- ↪ If you are unable to keep your scheduled appointment, you must notify our office a minimum of 24 hours before your scheduled time or you will be charged for that appointment.

**Returned Products**

- ↪ PRE-APPROVAL is REQUIRED on ALL RETURNS!!
- ↪ Refrigerated items CANNOT be returned
- ↪ No supplement returns will be accepted after 30 days on all regularly stocked items. Special orders CANNOT be returned!

**Important Notes**

- ↪ The doctors at Health Quest are not medical doctors; they do not service medical emergencies. If you have a medical emergency, you must contact your primary care physician or dial 911!
- ↪ Please contact our office if you are not clear on any of our policies or procedures.

I (please print name) \_\_\_\_\_ have read and understood Health Quest's Policies and Procedures.

Date \_\_\_\_\_

Signature \_\_\_\_\_

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