HeartsongHealth
EVIDENCE-BASED AND INTUITIVE MEDICINE

CONFIDENTIAL PATIENT RECORD

NAME: _____ AGE: _____ DOB: _____

CURRENT GENDER IDENTITY: _____ SEX ASSIGNED AT BIRTH: _____ PRONOUNS: _____

ADDRESS: _____ CITY/STATE: _____ ZIP:_____

PHONE: _____ EMAIL: _____

OCCUPATION:_____EMPLOYER:_____

DOMESTIC STATUS (CIRCLE): MARRIED/PARTNERED - SINGLE - DIVORCED - WIDOWED

DO YOU HAVE CHILDREN? Y N AGES: _____ CURRENTLY PREGNANT? Y N DUE DATE: _____

HAVE YOU ENTERED MENOPAUSE? Y N DATE OF LAST PERIOD: _____ HORMONE REPLACEMENT? Y N

EMERGENCY CONTACT:_____PHONE: _____RELATIONSHIP: _____

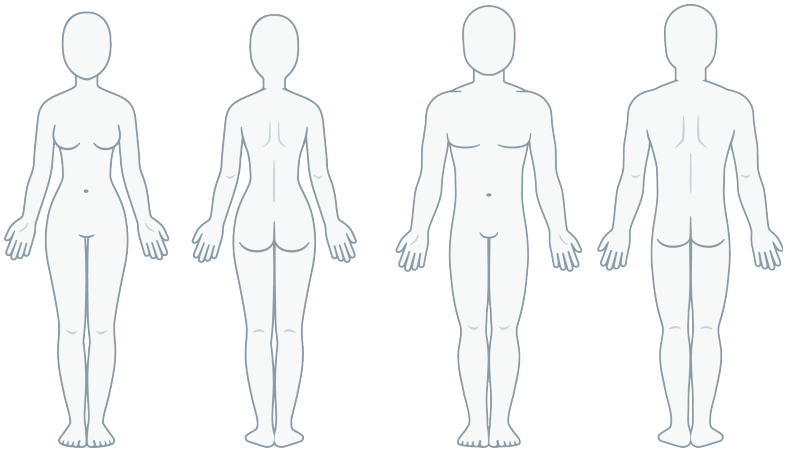
PREVIOUS CHIROPRACTIC TREATMENT? Y N FOR WHAT CONDITION? _____

HOW DID YOU HEAR ABOUT US? _____

HEALTH GOALS | LIST IN ORDER OF PRIORITY

1. _____
2. _____
3. _____
4. _____
5. _____

PAIN DIAGRAM | MARK AREAS OF PAIN / TENSION



LIFESTYLE

LIST THE 3 **HEALTHIEST** FOODS YOU EAT ON A TYPICAL DAY: _____, _____, _____

LIST THE 3 **LEAST HEALTHY** FOODS YOU EAT ON A TYPICAL DAY: _____, _____, _____

NUMBER OF MEALS/SNACKS YOU EAT ON A TYPICAL DAY: _____ VEGETARIAN/VEGAN? Y N

HOW MUCH DO YOU CONSUME **PER DAY** OR **PER WEEK**:

VEGETABLES: _____ MEAT: _____ FRUIT: _____

BREAD/PASTA: _____ CEREAL/PASTRY: _____ DESSERTS/CANDY: _____

FRUIT JUICE: _____ COFFEE: _____ ALCOHOL: _____

SOFT DRINKS: _____ FAST FOOD: _____ ARTIFICIAL SWEETENERS: _____

WHAT % OF MEALS ARE ORGANIC? _____ WHAT % OF MEALS ARE COOKED AT HOME? _____

DESCRIBE YOUR **SLEEP**: RESTFUL - DIFFICULTY FALLING ASLEEP - WAKE UP OFTEN - WAKE UP GROGGY

TYPICAL BEDTIME: _____ TYPICAL WAKE UP: _____ PAIN THAT WAKES YOU UP AT NIGHT? Y N

BOWEL MOVEMENTS PER DAY / PER WEEK: _____ TEND TOWARDS: CONSTIPATION - DIARRHEA - NEITHER

DESCRIBE YOUR **EXERCISE** HABITS:

DAYS/WEEK_____ WHAT TYPE(S)?_____ INTENSITY: MILD - MODERATE - HEAVY - ELITE

CURRENT **STRESS** LEVELS: 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 - OFF THE CHARTS!

RESPONSE TO STRESS: PAIN/TENSION - ILLNESS - FATIGUE - IRRITATION - DEPRESSION - ANXIETY - OTHER: _____

WORK SCHEDULE: _____ WHAT % AT HOME? _____ LENGTH OF COMMUTE? _____

HOURS PER DAY COMPUTER: _____ PHONE/TABLET: _____ TV: _____ PHONE IN BEDROOM? Y N

LIST ANY SUPPLEMENTS (VITAMINS, MINERALS, OILS, HERBS, HOMEOPATHY) YOU ARE CURRENTLY TAKING:

_____

MEDICATIONS | PLEASE CIRCLE ANY MEDICATIONS YOU ARE CURRENTLY TAKING, OR HAVE TAKEN IN THE PAST

Antacids
Antihistamines
Blood Pressure Meds
Antibiotics
Antidepressants
Anti-inflammatories
Birth Control Pills
Cardiac/Heart Meds
Cholesterol Med
Diuretics
Muscle Relaxers
Pain Killers
Parasite Meds
Yeast/Fungal Meds
Steroids *(prednisone, anabolics, cortisone)*
Hormones (*estrogen, progesterone, DHEA, testosterone, thyroid)*
Other: _____

ALLERGIES | PLEASE LIST ANY KNOWN ALLERGIES, INCLUDING FOOD, ENVIRONMENTAL, DRUG, ETC.

_____

TREATMENT FOR CURRENT CONDITIONS | ARE YOU CURRENTLY UNDER CARE OF ANOTHER HEALTHCARE PROVIDER?

MEDICAL HISTORY | HAVE YOU HAD ANY OF THE FOLLOWING PROCEDURES?

Appendectomy
Tonsils/Adenoids
Gall bladder removal
Organ transplant
Thyroid irradiation

Joint replacement
Implant
Cosmetic surgery
Tooth extraction
Orthodontia

Eye surgery
Biopsy
Mastectomy
C-Section
D&Cs

Terminated Pregnancy
Gastric Bypass
Gender Reassignment
Other:

DO YOU WEAR ORTHODONTIC EQUIPMENT (BRACES, NIGHT GUARD, INVISALIGN)? Y N _____

HAVE YOU EVER BEEN IN A TRAUMATIC ACCIDENT? (CAR ACCIDENT, FALL, ETC.)? Y N _____

HAVE YOU EVER HAD A FRACTURE, SPRAIN OR JOINT DISLOCATION? Y N _____

HAVE YOU EVER HAD A CONCUSSION OR HEAD TRAUMA? Y N _____

HAVE YOU EXPERIENCED ANY OTHER MAJOR TRAUMA? Y N _____

FAMILY HISTORY | INDICATE "SELF" OR WHICH FAMILY MEMBER

ADD/ADHD_____
Alcoholism_____
Allergies_____
Alzheimer's_____
Anemia_____
Arthritis_____
Asthma_____
Blood Disorders_____
Blood Pressure: High_____
Blood Pressure: Low_____
Cancer_____
Cataracts_____
Celiac Disease_____

Cholesterol: High/Low_____
Dementia_____
Depression_____
Diabetes_____
Emphysema/COPD_____
Epilepsy/Seizures_____
Glaucoma_____
Gout_____
Heart Disease_____
Hepatitis_____
HIV/AIDS_____
Liver Disease_____
Mental Disease_____

Migraines_____
Miscarriages/Infertility_____
Multiple Sclerosis_____
Muscular Dystrophy_____
Osteoporosis_____
Parkinson's_____
Polio_____
Rheumatoid Arthritis_____
Stroke_____
Thyroid Disease_____
Tuberculosis_____
Other: _____

□ I DO NOT KNOW MY FAMILY MEDICAL HISTORY

REVIEW OF SYSTEMS | IN THE PAST YEAR, HAVE YOU EXPERIENCED ANY OF THE FOLLOWING

Weight loss/gain >10 lbs
Pain that wakes you up at night
Dizziness/Fainting/Blacking Out
Numbness/Tingling/Weakness
Loss of balance / coordination
Phantom pains

Light Sensitivity
Chest pain
Palpitations
Persistent cough / wheezing
Ankle swelling

Calf pain
Blood in Urine/Stool
Acid reflux / ulcers
Vomiting/Nausea
Incontinence
GI/Urinary infection

Nosebleeds
Bleeding gums
Rash
Persistent illness
Headache *worse than ever experienced*

TREATMENT EXPECTATIONS

ARE YOU WILLING TO MAKE DIET AND LIFESTYLE CHANGES TO IMPROVE YOUR HEALTH? Y N UNSURE

ARE YOU WILLING TO COMMIT TO 3 VISITS IN ORDER TO DETERMINE BENEFIT OF TREATMENT? Y N UNSURE

ARE YOU WILLING TO TAKE NUTRITIONAL SUPPLEMENTS APPROPRIATE FOR YOUR GOALS? Y N UNSURE

DO YOU HAVE PREFERENCES REGARDING STYLE OF CHIROPRACTIC TREATMENT? Y N UNSURE

ARE YOU WILLING TO EXPERIENCE SETBACKS THAT MAY OCCUR AS PART OF THE HEALING PROCESS?

Y N UNSURE

ARE YOU WILLING TO PROVIDE FEEDBACK ABOUT THE EFFECTS OF YOUR TREATMENT

SO THAT WE CAN BETTER UNDERSTAND YOUR BODY? Y N UNSURE

IS YOUR FAMILY WILLING TO COMPLY WITH APPROPRIATE LIFESTYLE CHANGES? Y N UNSURE

DO YOU BELIEVE THAT YOU CAN REACH YOUR HEALTH GOALS? Y N UNSURE

WHEN WAS THE LAST TIME YOU REMEMBER FEELING HEALTHY? _____

ADDITIONAL INFORMATION | PLEASE PROVIDE ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELEVANT

_____

_____

_____

_____

_____

_____

_____

_____

_____

FINANCIAL POLICIES

PAYMENT IN FULL IS DUE AT TIME OF SERVICE Accepted payment forms include cash, check, all major credit cards, as well as HSA or FSA cards. See below for information on insurance reimbursement. This policy applies to ALL patient visits, including personal injury claims.

CHECKS Please make checks payable to SUZIE LEE, D.C. Returned checks will be charged a $20 fee.

CANCELLATIONS In order to make appointment times available for patients in need, we request that all cancellations or appointment changes be made no later than **24 hours** prior to the beginning of your scheduled appointment time. Cancellations and changes made beyond that deadline, as well as "no-shows" will be charged a **MISSED APPOINTMENT FEE** in the amount of **50% of the appointment fee**, for the first occurrence. Subsequent occurrences will be charged the **full appointment fee.**

INSURANCE If your plan covers out-of-network chiropractic treatment, we will provide a SUPERBILL that you can submit to your insurance company for reimbursement. Please verify your deductible and out-of-network chiropractic benefits with your provider. Clinical Nutrition and Functional Medicine services are generally not covered by insurance, but may be eligible for HSA / FSA funds. Please consult your employer / accountant.

RETAIL As part of your treatment plan, we may recommend nutritional supplementation or orthotic equipment to aid in management or prevention of your condition. For your convenience, we keep many of these items in stock so that you are sure to have the proper item as quickly as possible at a reasonable price. In order to keep the prices as low as possible, we enforce the following return policies:

- **We do not accept returns on retail items**, unless otherwise noted by your doctor during your visit.
- Orthopedic items provided as a trial or loan must be returned within the designated time frame or you will be charged the full retail price of the items.
- There will be NO REFUNDS given on expired items, or those that have been opened or when protective seal has been broken
- Foot Levelers custom inserts can be returned for full refund for up to 1 year, following 45 days of wear

I HAVE READ AND UNDERSTOOD THE ABOVE FINANCIAL POLICIES. MY SIGNATURE BELOW INDICATES THAT I WILL ADHERE TO THE POLICIES OUTLINED IN THE ABOVE DOCUMENT.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR PATIENT): _____ **DATE:**_____

☐ I would like a SUPERBILL to submit to my insurance company for out-of-network chiropractic reimbursement

CONSENT TO TREATMENT | CHIROPRACTIC

I (**PRINT NAME**), _____, do hereby give my consent to Dr. Suzie Lee and/or Dr. David Lee (hereafter "HeartsongHEALTH") for the performance of conservative noninvasive treatment to the joints and soft tissues, including, but not limited to, chiropractic adjustments, soft tissue therapy and craniosacral therapy.

TREATMENT RISKS Although spinal manipulation/adjustment is considered to be one of the safest, most effective forms of therapy for musculoskeletal problems, I am aware that there are possible risks and complications associated with these procedures as follows:

- *Soreness*: Some patients may experience mild muscle soreness following treatment, similar to the discomfort felt after a physical training workout. I will contact HeartsongHEALTH in the case of excessive soreness.

- *Dizziness*: Temporary symptoms like dizziness and nausea can occur due to changes in nervous system signaling. These symptoms are rare. I will inform HeartsongHEALTH if I experience dizziness or nausea following treatment.

- *Fractures/Joint Injury*: In isolated cases underlying physical defects, deformities, or pathologies like weak bones from osteoporosis may render the patient susceptible to injury. When osteoporosis, degenerative disk, or other abnormality is detected, this office will proceed with extra caution. I will inform HeartsongHEALTH of any of the above conditions before proceeding with treatment.

- *Stroke*: Although strokes happen with some frequency in our world, strokes from chiropractic adjustments are extremely rare. Nerve or brain damage, including stroke, is reported to occur once in one million to once in ten million treatments. If I have any questions or concerns about the risk of stroke, I will address them with HeartsongHEALTH

TREATMENT BENEFITS I also understand that there are beneficial effects associated with these treatment procedures including decreased pain, improved mobility and function, and reduced muscle spasm. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, as well as chiropractic, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

MENTAL HEALTH I further understand that mental and emotional stressors may impact my physical health, and that HeartsongHEALTH may, in the course of regular treatment, directly or indirectly address these stressors. I understand that this treatment is not a substitute for psychological or psychiatric care. I understand that HeartsongHEALTH makes no claims as to the nature of any memories or insights that may unfold in the course of regular treatment.

I HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTOOD THE ABOVE EXPLANATION OF CHIROPRACTIC TREATMENT. I HAVE MADE MY DECISION TO BEGIN TREATMENT VOLUNTARILY AND FREELY. THE HEALTH HISTORY I HAVE PROVIDED IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE. TO ATTEST TO MY CONSENT TO THESE EXAMINATION AND TREATMENT PROCEDURES, I HEREBY AFFIX MY SIGNATURE TO THIS INFORMED CONSENT DOCUMENT.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR PATIENT): _____ **DATE**:_____

CONSENT TO TREATMENT | CLINICAL NUTRITION

I (**PRINT NAME**), _____, do hereby give my consent to Dr. Suzie Lee and/or Dr. David Lee (hereafter "HeartsongHEALTH") for the performance of supportive clinical nutrition measures, including, but not limited to, diet and lifestyle recommendations, and implementation of nutritional and herbal supplement protocol.

I acknowledge that HeartsongHEALTH does not claim to "treat" my health condition, but only to support the functional systems of my body so that resolution of health concerns may occur, independently or in conjunction with conventional medical treatment. I further acknowledge that HeartsongHEALTH does not seek to "diagnose" or "cure" my illness, and is not a substitute for appropriate conventional medical care.

TREATMENT RISKS Although clinical nutrition measures carry a very low risk of side effects, I am aware that there are possible risks and complications associated with any supportive interventions. Some of these risks include:

- *Interaction with prescribed medications*: I understand that it is my responsibility to inform HeartsongHEALTH of any prescribed or OTC medications I am taking, or any changes or additions to my medications, so that they can assess the safety of combining those medications with herbs and supplements.

- *Digestive Upset / Rash*: Some patients may experience mild to moderate digestive disturbances or skin rash with the introduction of new foods or supplements to which the body is not adapted. I will inform HeartsongHEALTH if I experience digestive or skin symptoms, so that appropriate recommendations can be made to minimize this risk.

- *Fatigue / Headache / Sleep disturbance / Mood alteration*: Mild symptoms may occur as a result of biochemical alterations that occur as a result of changing the diet or adding certain supplements. I will inform HeartsongHEALTH if I experience these or any other general symptoms, so that appropriate recommendations can be made to minimize this risk.

Treatment Benefits: I also understand that there are beneficial effects associated with these supportive measures, including including improved sleep, balanced mood, increased energy, and resolution of chronic disease or illness. However, I appreciate there is no certainty that I will achieve these benefits. I realize that the practice of medicine, as well as clinical nutrition, is not an exact science and I acknowledge that no guarantee has been made to me regarding the outcome of these procedures.

I HAVE READ (OR HAVE HAD READ TO ME) AND UNDERSTOOD THE ABOVE EXPLANATION OF CLINICAL NUTRITION. I HAVE MADE MY DECISION TO BEGIN TREATMENT VOLUNTARILY AND FREELY. THE HEALTH HISTORY I HAVE PROVIDED IS COMPLETE AND ACCURATE, TO THE BEST OF MY KNOWLEDGE. TO ATTEST TO MY CONSENT TO THESE EXAMINATION AND TREATMENT PROCEDURES, I HEREBY AFFIX MY SIGNATURE TO THIS INFORMED CONSENT DOCUMENT.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR PATIENT): _____ **DATE**:_____

Privacy Policy

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 with Dr. Suzie Lee and/or Dr. David Lee (hereafter "HeartsongHEALTH), they 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 responsible for the payment of your services.)
· Your name, address, phone number, and your health care records may be used to contact you regarding appointment reminders, to provide information about alternatives to your present care, or to provide other health related information that may be of 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 or disclose your health information without your consent or authorization in the 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 that 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 described in the examples outlined above, will only be made upon your written authorization. We normally provide information about your health care 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 for 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 your 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 health 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.

I have read and understood the above Privacy Policy.

SIGNATURE OF PATIENT (OR GUARDIAN OF MINOR PATIENT): _____ **DATE**:_____