(Patient Data Sheet/Consent to Treat

First Name_________________ Middle Initial ____ Last Name ___________________

Address ___________________________ City ______________________ State _____

Zip ___________ Home Phone __________________ Work Phone_________________

Cell Phone____________________ E-Mail____________________________________

Sex ______ Birth date _________________ Social Security _______________________

Marital Status ___________ Race (circle) Black White Asian Hispanic Other_______

Ethnicity (circle) Hispanic Non-Hispanic Unknown Preferred Language______________

Emergency Contact_________________________ Phone Number __________________

Smoking Status (circle) Current (how many per day ____) Former Never

Method of Payment: Cash Check Charge

How did you hear about our office? ________________________________

Please read the following and sign at the bottom

I recognize that I am responsible for, and agree to pay all fees incurred at this office. I understand that any insurance benefits, which I may have, are a contracted arrangement between my insurance company and myself. This office will be responsible for preparing notes, billing receipts and informational reports as needed to aid in insurance payment/reimburses. I realize that this office is not responsible to negotiate disputed benefits for me.

I am choosing to be treated for today and all my future visits at this office, through the various types of chiropractic manipulations, acupuncture, acupressure, kinesiology, nutrition and homeopathy. I realize my insurance may pay for a portion of the chiropractic part of the visit only, but we cannot guarantee benefits. The first visit fee is $160.00 and subsequent visits are $70.00. I agree to pay the difference between the amount of what my insurance pays and the remainder of the bill.

My signature below signifies that I completely understand and agree to all of the above statements and give my consent for treatment.

Signature _______________________________________ Today's Date _________

Witnessed by ___________________________________ Date _________________

Insurance Data Sheet

Patient's full name ____

Social Security # ______________________ Birthday ____________________

Relationship to the PRIMARY INSURED: Patient is:

___ Self ___ wife ___ husband ___ child __ other

PRIMARY INSURED'S INFORMATION

Insured's Full Name ____

Address ____

Phone # ______________________________ Birthdate ____________________

Social Security # ____

Employer's (Company) Name ______________________________________

Insurance Company Name ____

ID Number ______________________________ Group # __________________

Insurance Claims Phone # ____

Send claims to address: ____

SECONDARY INSURED'S INFORMATION

Insured's Full Name ____

Address ____

Phone # ______________________________ Birthdate ____________________

Social Security # ____

Employer's (Company) Name ______________________________________

Insurance Company Name ____

ID Number ______________________________ Group # __________________

Insurance Claims Phone # ____

Send claims to address: ____

Complete Wellness Center
Cheryl Shea, DC
Patient Acknowledgement and Consent Form:

Authorization for Chiropractic Treatment:
I, undersigned, a patient in this office hereby authorize Dr. Cheryl Shea, DC, or her associates, and whomever they may designate as their assistants to administer such treatment as is necessary, and to perform therapy, exams and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

I hereby certify that I have read and fully understand the above authorization for treatment, the reasons why the treatment is necessary, its advantages and possible complications, if any, as well as possible alternative modes of treatment, which were explained to me by Dr. Cheryl Shea, DC, or one of her associates and whomever they may designate as their assistance. I also certify that no guarantee, cure or assurance has been made as to the results that may be obtained.

Signature____Witness_________________________________Date_________

Acknowledgement of Receipt of the Notice of Health Information Practices:
I, undersigned, acknowledge that I have been offered the Notification of Protected Health Information Practices (HIPPA). I understand that I may receive additional information at my request.

Signature____Witness_________________________________Date_________

Authorization to Treatment of Minor Child:
I hereby authorize Dr. Cheryl Shea, DC, or her associates, and whomever they may designate as their assistants, to administer such treatment as is necessary, and to perform the following therapy, exams, and manipulation and such additional therapy or procedures as are considered therapeutically necessary on the basis of findings during the course of said treatment.

Signature of parent/guardian____Relationship___________________________

Child's name____________________________________Witness_________________________________Date__________

Notice of Financial Responsibility:
I, the undersigned accept full financial responsibility for the treatment performed by Complete Wellness Center. Insurance forms will be completed as a courtesy for the above named patient, however payment to Complete Wellness Center is expected at the time services are rendered, unless other arrangements have been approved. I understand that I am personally responsible for any and all co-payments, co-insurance, and deductibles, and that I am responsible for non-covered services. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself and that I am personally responsible for payment of any and all covered and/or non-covered services. I also understand that if I suspend or terminate my care of treatment, any fees for professional services rendered me will be immediately due and payable. Should the services of an outside agency be requited for collection of this account, I agree to pay cost of collection including but not limited to collection agency fees, attorney's fees, interest and court costs.

Signature____Witness_________________________________Date_________

Notice of Patient Responsibility:
I, the undersigned, accept full responsibility for acupuncture, consultations, Asyra testing, outside bloodwork and/or labs, and/or nutritional supplements provided by Complete Wellness Center. I understand that the cost of acupuncture, consultations, Asyra testing, outside bloodwork and/or labs, and/or nutritional supplements may not be covered by my insurance provider. I understand that Complete Wellness Center is not required to accept the write-off limitations of my insurance provider, when I am notified prior to the service. I assume all financial responsibilities for these services performed at Complete Wellness Center and by Dr. Cheryl Shea, DC.

Signature____Witness_________________________________Date_________

Notice of Assignment:
I authorize the direct payment to Complete Wellness Center of any sum I now or hereafter owe Complete Wellness Center by my attorney out of the proceeds of any settlement of my case, and by any insurance company obligated to reimburse me for the charges for Complete Wellness Center or otherwise obligated to make payment to me or Complete Wellness Center based in whole or in part upon the charges made for your services.

Signature____Witness_________________________________Date_________

Notice of Missed Appointment Fees:
There will be a charge ($70) for an office visit missed without 24 hours cancellation notice. If you do not keep your appointment, other patients who need "same day" urgent care, or a different appointment, are being obliged to wait longer than necessary. Acute health problems, family crisis, and inclement weather are exceptions. The purpose of this fee is to encourage our patients to take their appointments as seriously as we do.

Signature____Witness________________________________Date__________

Authorization to Release Information:
You are hereby authorized to release information you deem appropriate concerning my medical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred for services rendered me by you or your associates or any member of your staff acting on your behalf.

Signature____Witness________________________________Date__________
I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy.

PATIENT HISTORY FORM

Name/ID ______________________________ Date ______________

Address ____

City ______________________ State ________ ZIP ____________

Phone ____

Sex ________ Age __________ Height __________ Weight __________

Occupation ____

Please complete the following questions. This survey will give us a detailed understanding of your present health condition. If you have any questions or do not understand any portion of it, we will be happy to assist you.

Chief Complaint - Primary reason you are seeking treatment:

____

____

Surgeries you have had and your age at time of surgery:

1. ____________________ age _____ 3. ____________________ age _____

2. ____________________ age _____ 4. ____________________ age _____

Prescription medications you are presently taking:

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Supplements or over-the-counter medications you are taking, such as vitamins or ibuprofen:

1. ____________________ 3. ____________________

2. ____________________ 4. ____________________

Habits (Please circle all that apply):

alcohol chocolate cigarettes coffee laxatives tea sugar or sugar substitutes

Do you consider yourself: overweight average underweight

Describe activity level: sedentary light moderate heavy

Are you primarily responsible for preparing your own meals? yes no

How many of your weekly meals do you eat out? ___________

How many glasses of water do you drink each day? ________

List any foods you crave:

____

____

List any foods you avoid:

____

____

List any special diet or dietary restrictions: ____________________________________

____

Are you following a dietary regimen (Weight Watchers, etc.)? yes no

Family history of conditions (please list or mark accordingly):

	MOTHER	FATHER	SIBLINGS
Allergies	______	______	
Asthma	______	______	______
Heart disease	______	______	______
Cancer	______	______	______
Arthritis	______	______	______
Kidney disease	______	______	______
Diabetes	______	______	______
Stomach disorders	______	______	______
Other (please list)	______	______	______

Metabolic Assessment Form

Name: ____ Age: _____ Sex: ____ Date: ___________

PART I: Please list the 5 major health concern in your order of importance:

1.____
2.____
3.____
4.____
5.____

PART II: Please circle the appropriate number "0 - 3" on all questions below.
0 as the least/never to 3 as the most/always.

Category I

Feeling that bowels do not empty completely	**0 1 2 3**
Lower abdominal pain relief by passing stool or gas	**0 1 2 3**
Alternating constipation and diarrhea	**0 1 2 3**
Diarrhea	**0 1 2 3**
Constipation	**0 1 2 3**
Hard dry or small stool	**0 1 2 3**
Coated tongue of "fuzzy" debris on tongue	**0 1 2 3**
Pass large amount of foul smelling gas	**0 1 2 3**
More than 3 bowel movements daily	**0 1 2 3**
Do you use laxatives frequently	**0 1 2 3**

Category II

Excessive belching burping or bloating	**0 1 2 3**
Gas immediately following a meal	**0 1 2 3**
Offensive breath	**0 1 2 3**
Difficult bowel movements	**0 1 2 3**
Sense of fullness during and after meals	**0 1 2 3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0 1 2 3**

Category III

Stomach pain, burning or aching 1- 4 hours after eating	**0 1 2 3**
Do you frequently use antacids	**0 1 2 3**
Feeling hungry an hour or two after eating	**0 1 2 3**
Heartburn when lying down or bending forward	**0 1 2 3**
Temporary relief from antacids, food, milk, carbonated beverages	**0 1 2 3**
Digestive problems subside with rest and relaxation	**0 1 2 3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	**0 1 2 3**

Category IV

Roughage and fiber cause constipation	**0 1 2 3**
Indigestion and fullness lasts 2-4 hours after eating	**0 1 2 3**
Pain, tenderness, soreness on left side under rib cage bloated	**0 1 2 3**
Excessive passage of gas	**0 1 2 3**
Nausea and/or vomiting	**0 1 2 3**
Excessive passage of gas	**0 1 2 3**
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	**0 1 2 3**
Frequent urination	**0 1 2 3**
Increased thirst and appetite	**0 1 2 3**
Difficulty losing weight	**0 1 2 3**

Category V

Greasy or high fat foods cause distress	**0 1 2 3**
Lower bowel gas and or bloating several hours after eating	**0 1 2 3**
Bitter metallic taste in mouth, especially in the morning	**0 1 2 3**
Unexplained itchy skin	**0 1 2 3**
Yellowish cast to eyes	**0 1 2 3**
Stool color alternates for clay colored to normal brown	**0 1 2 3**
Reddened skin, especially palms	**0 1 2 3**
Dry or flaky skin and/or hair	**0 1 2 3**
History of gallbladder attacks or stones	**0 1 2 3**
Have you had your gallbladder removed	**Yes No**

Category VI

Crave sweets during the day	**0 1 2 3**
Irritable if meals are missed	**0 1 2 3**
Depend on coffee to keep yourself going or started	**0 1 2 3**
Get lightheaded and if meals are missed	**0 1 2 3**
Eating relieves fatigue	**0 1 2 3**
Feel shaky, jittery, tremors	**0 1 2 3**
Agitated, easily upset, nervous	**0 1 2 3**
Poor memory, forgetful	**0 1 2 3**
Blurred vision	**0 1 2 3**

Category VII

Fatigue after meals	**0 1 2 3**
Crave sweets during the day	**0 1 2 3**
Eating sweets does not relieve cravings for sugar	**0 1 2 3**
Must have sweets after meals	**0 1 2 3**
Waist girth is equal or larger than hip girth	**0 1 2 3**
Frequent urination	**0 1 2 3**
Increased thirst & appetite	**0 1 2 3**
Difficulty losing weight	**0 1 2 3**

Category VIII

Cannot stay asleep	**0 1 2 3**
Crave salt	**0 1 2 3**
Slow starter in the morning	**0 1 2 3**
Afternoon fatigue	**0 1 2 3**
Dizziness when standing up quickly	**0 1 2 3**
Afternoon headaches	**0 1 2 3**
Headaches with exertion or stress	**0 1 2 3**
Weak nails	**0 1 2 3**

Category IX
Cannot fall asleep 0 1 2 3
Perspire easily 0 1 2 3
Under high amounts of stress 0 1 2 3
Weight gain when under stress 0 1 2 3
Wake up tired even after 6 or more hours of sleep 0 1 2 3
Excessive perspiration or perspiration with little or no activity 0 1 2 3

Category X
Tired, sluggish 0 1 2 3
Feel cold – hands, feel, all over . 0 1 2 3
Require excessive amounts of sleep to function properly 0 1 2 3
Increase in weight gain even with low-calorie diet 0 1 2 3
Gain weight easily 0 1 2 3
Difficult, infrequent bowel movements 0 1 2 3
Depression, lack of motivation 0 1 2 3
Morning headaches that wear off as the day progresses 0 1 2 3
Outer third of eyebrow thins 0 1 2 3
Thinning of hair on scalp, face or genitals or excessive falling hair 0 1 2 3
Dryness of skin and/or scalp 0 1 2 3
Mental sluggishness 0 1 2 3

Category XI
Heart palpations 0 1 2 3
Inward trembling 0 1 2 3
Increased pulse even at rest 0 1 2 3
Nervousness and emotional 0 1 2 3
Insomnia 0 1 2 3
Night sweats 0 1 2 3
Difficulty gaining weight 0 1 2 3

Category XII
Diminished sex drive 0 1 2 3
Menstrual disorders of lack of menstruation 0 1 2 3
Increased ability to eat sugars without symptoms 0 1 2 3

Category XIII
Increased sex drive 0 1 2 3
Tolerance to sugars reduced 0 1 2 3
"Splitting" type headaches 0 1 2 3

Category XIV (Male Only)
Urination difficulty or dribbling 0 1 2 3
Urination frequent 0 1 2 3
Pain inside of legs or heels 0 1 2 3
Feeling of incomplete bowel evacuation 0 1 2 3
Leg nervousness at night 0 1 2 3

Category XV (Males Only)
Decrease in libido 0 1 2 3
Decrease in spontaneous morning erections 0 1 2 3
Decrease in fullness of erections 0 1 2 3
Difficulty in maintain morning erections 0 1 2 3
Spells of mental fatigue 0 1 2 3
Inability to concentrate 0 1 2 3
Episodes of depression 0 1 2 3
Muscle soreness 0 1 2 3
Decrease in physical stamina 0 1 2 3
Unexplained weight gain 0 1 2 3
Increase in fat distribution around chest and hips 0 1 2 3
Sweating attacks 0 1 2 3
More emotional then in the past 0 1 2 3

Category XVI (Menstruating Females Only)
Are you a menopausal **Yes** **No**
Alternating menstrual cycle lengths **Yes** **No**
Extended menstrual cycle, greater than 32 days **Yes** **No**
Shortened menses, less than every 24 days **Yes** **No**
Pain and cramping during periods 0 1 2 3
Scanty blood flow 0 1 2 3
Heavy blood flow 0 1 2 3
Breast pain and swelling during menses 0 1 2 3
Pelvic pain during menses 0 1 2 3
Irritable and depressed during menses 0 1 2 3
Acne break outs 0 1 2 3
Facial hair growth 0 1 2 3
Hair loss/thinning 0 1 2 3

Category XVII (Menopausal Females only)
How many years have you been menopausal? ________
Do you ever have uterine bleeding since menopause? **Yes** **No**
Hot flashes 0 1 2 3
Mental fogginess 0 1 2 3
Disinterest in sex 0 1 2 3
Mood swings 0 1 2 3
Depression 0 1 2 3
Painful intercourse 0 1 2 3
Shrinking breast 0 1 2 3
Facial hair growth 0 1 2 3
Acne 0 1 2 3
Increased vaginal, pain, dryness or itching 0 1 2 3

PART III: Foods

- How many alcohol beverages they consume per week? ___________
- How many caffeinated beverages do you consume per day? __________
- How many times do you eat out per week? ___________
- List the three worst foods you eat during the average week?
- _____________________, ______________________, _____________________
- List the three healthiest foods you eat during the average week?
- _____________________, ____________________, ___________________
- Do you smoke?_______ If yes, how many times a day ____________ , a week ____________.
- Rate your stress levels on a scale of 1-10 during the average week. __________________
- How many times a week do you eat raw nuts or seeds? _____________
- How many times a week do you eat fish? ___________
- How many times a week do you workout? ____________

Please list any medications you currently take and for what conditions:

____

Please list any natural supplements you currently take and for what conditions:

____