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Get Well & Stay Well

PERSONAL HISTORY

Please complete this paperwork as thoroughly as possible so we may best serve you.

Name _____ **DOB** _____ **Age** ____ **Gender** ☐ **M** ☐ **F**

Address_____ **City** _____ **State** ____ **Zip** _____

Email _____ **Cell** _____ **Work Phone**_____

Employer _____ **Type of Work** _____ **SSN** _____

Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Names & Ages of Children _____

How did you hear about us? ☐Google/Internet ☐TV ☐Mail ☐Facebook/Instagram
☐Newspaper ☐ Doctor ☐ Friend/Family _____ ☐ Other _____

Name & Phone of Person Responsible for Payment_____

Name & Phone of Emergency Contact Person _____

Current Health Concerns

What do you hope to achieve with your care here?

_____

What is your primary health concern?

_____

List 3-5 areas of your life this is hindering. Circle your top 1 or 2 priorities.

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

List 3-5 areas your life would improve if/when your health concern improves. Circle your top 1 or 2 priorities.

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

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Quality of Life Questionnaire

Name: _____ DOB: _____ Date: _____

Please take several minutes to answer these questions so we can help you get better.
(Please check all that apply)

01 How have you taken care of your health in the past?

- ☐ Medications
- ☐ Routine Medical
- ☐ Exercise
- ☐ Vitamins
- ☐ Emergency Room
- ☐ Chiropractic
- ☐ Holistic Care
- ☐ Nutrition/Diet
- ☐ Other: _____

02 How did the previous method(s) work out for you?

- ☐ Bad Results
- ☐ Great Results
- ☐ Still Trying
- ☐ Did Not Get Worse
- ☐ Some Results
- ☐ Nothing Changed
- ☐ Confused
- ☐ Did Not Work Very Long

03 How have others been affected by your health condition?

- ☐ No One Is Affected
- ☐ They Tell me To Do Something
- ☐ Haven't Noticed Any Problem
- ☐ People Avoid Me

04 What are you afraid this might be (or beginning) to affect (or will affect)?

- ☐ Job
- ☐ Marriage
- ☐ Time
- ☐ Kids
- ☐ Self-Esteem
- ☐ Finances
- ☐ Future Ability
- ☐ Sleep
- ☐ Freedom

05 Are there health conditions you are afraid this might turn into?

- ☐ Family Health Problems
- ☐ Heart Disease
- ☐ Cancer
- ☐ Arthritis
- ☐ Fibromyalgia
- ☐ Depression
- ☐ Chronic Fatigue
- ☐ Need Surgery

06 How has your health condition affected your job, relationships, finances, family, or other activities? Please give examples:

_____

_____

07 What has that cost you? (time, money, happiness, freedom, sleep, promotion, etc.). Give 3 examples:

1. _____
2. _____
3. _____

08 What are you most concerned with regarding your problem?

_____

09 Where do you picture yourself being in the next 1-3 years if this problem is not taken care of? Please be specific.

_____

_____

10 What would be different/better without this problem? Please be specific.

_____

11 What do you desire most to get from working with us?

_____

12 What would that mean to you?

_____

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CANDIDA QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Add up the points for the answer to each question below. Once you have your total, read the key below to better understand your current candida overgrowth situation.

Questions:		YES	NO
01	Have you taken repeated or prolonged courses of antibacterial drugs?	4	0
02	Have you been bothered by recurrent vagina, prostate or urinary infections?	3	0
03	Do you feel "sick all over," yet the cause hasn't been found?	2	0
04	Are you bothered by hormone disturbances? (including PMS, menstrual irregularities, sexual dysfunction, sugar craving, low body temperature, or fatigue)	2	0
05	Are you unusually sensitive to tobacco smoke, perfumes, and other chemical odors?	2	0
06	Are you bothered by memory or concentration problems?	2	0
07	Have you taken prolonged courses of prednisone or other steroids?	1	0
08	Have you taken birth control for more than 3 years?	1	0
09	Do you suffer with constipation, diarrhea, bloating or abdominal pain?	1	0
10	Does your skin itch, tingle or burn, is it unusually dry; or are you bothered by rashes?	1	0
11	When you wake up, do you have a white coating on your tongue?	1	0

TOTAL: _____

WOMEN

A score of 10 or greater indicates that your health problems may be connected to a Candida overgrowth. A score of 13 or higher suggests that your symptoms are very likely to be related to Candida.

MEN

A score of 8 or greater indicates that your health problems may be connected to a Candida overgrowth.

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ADRENAL STRESS QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

Check all the boxes that apply to you. Add up the total and place in the box below.

- ☐ I am frequently tired.
- ☐ I feel tired even after 8 to 10 hours of sleep.
- ☐ I am chronically stressed.
- ☐ It is difficult for me to handle stress.
- ☐ I am a night-shift worker.
- ☐ I work long hours.
- ☐ I have little relaxation time during my days.
- ☐ I get headaches frequently.
- ☐ I don't exercise consistently.
- ☐ I am or have been an endurance athlete (or participate in CrossFit).
- ☐ I have erratic sleep patterns.
- ☐ I wake up in the middle of the night.
- ☐ I crave salt.
- ☐ I have high sugar intake.
- ☐ I have difficulty concentrating.
- ☐ I carry weight in my midsection (an apple-shape body).
- ☐ I have low blood sugar issues (hypoglycemia).
- ☐ I have irregular periods.
- ☐ I have a low libido.
- ☐ I have PMS or perimenopausal/menopausal symptoms.
- ☐ I get sick frequently.
- ☐ I have low blood pressure.
- ☐ I have muscle fatigue or weakness.
- ☐ I rely on caffeine for energy (coffee, energy shots, etc.).

TOTAL: _____

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SYMPTOM & INFLAMMATION CALCULATOR

Rate the following symptoms on a scale of 0 - 4: 0=None 1=Some 2=Mild 3=Moderate 4=Severe

HEAD Total:_____
____Headaches
____Faintness
____Migraines
____Dizziness
____Trouble Sleeping

MIND Total:_____
____Brain Fog
____Poor Memory
____Impaired Coordination
____Difficulty Deciding
____Slurred/Stuttered Speech
____Learning/Attention Deficit

EYES Total:_____
____Swollen, Red Eyes
____Dark Circles
____Puffy Eyes
____Poor Vision
____Watery, Itchy Eyes

NOSE Total:_____
____Nasal Congestion
____Excessive Mucus
____Stuffy/Runny Nose
____Sinus Problems
____Frequent Sneezing

EARS Total:_____
____Itchy Ears
____Earaches/Infections
____Drainage From Ear(s)
____Ringing, Hearing Loss

MOUTH/THROAT Total:___
____Chronic Cough
____Clear Throat Frequently
____Sore Throat
____Swollen Lips
____Canker Sores

HEART Total:_____
____Irregular Heartbeat
____Fast Heart Rate
____Chest Pain

LUNGS Total:_____
____Chest Congestion
____Asthma, Bronchitis
____Shortness of Breath
____Difficulty Breathing

SKIN Total:_____
____Acne
____Hives, Eczema, Dry Skin
____Hair Loss
____Hot Flashes
____Excessive Sweating

WEIGHT Total:_____
____Overweight
____Food Cravings
____Inability to Lose Weight
____Water Retention/Swelling
____Compulsive Eating
____Underweight

DIGESTION Total:_____
____Nausea/Vomiting
____Constipation
____Heartburn/Indigestion
____Belching/Passing Gas
____Intestinal/Stomach Pains
____Diarrhea ____Bloating

EMOTIONS Total:_____
____Anxiety
____Depression
____Mood Swings
____Nervousness
____Easily Irritated

ENERGY/ACTIVITY Total:__
____Fatigue
____Lethargy
____Hyperactivity
____Restlessness

JOINT/MUSCLES Total:___
____Pain/Aching Joints
____Muscle Stiffness
____Pain/Muscle Aches
____Weakness/Tiredness
____Arthritis

OTHER Total:_____
____Frequent Illness/Infections
____Frequent/Urgent Urination
____Genital Itching/Discharge

In the last 3 months, have your symptoms: ☐ Improved ☐ Worsened ☐ No Change

What makes your condition WORSE _____

What makes your condition BETTER _____

How would you describe the symptoms? Check ALL that apply:

☐ Aching Pain	☐ Tiredness	☐ Heavy Feeling	☐ Dead Feeling	☐ Tingling/Electric Shocks
☐ Stabbing Pain	☐ Numbness	☐ Hot Sensation	☐ Swelling	☐ Pins & Needles Pain
☐ Sharp Pain	☐ Cramping	☐ Throbbing Pain	☐ Burning	☐ Cold Hands/Feet

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Is this condition interfering with any of the following? Check ALL that apply:

☐ Sleep ☐ Walking ☐ Family Time ☐ Recreational Activities
☐ Work ☐ Standing ☐ Daily Activities

Do you smoke? ☐ Yes ☐ No If yes, how many cigarettes daily? _____

Do you drink? ☐ Yes ☐ No If yes, how many drinks per week? _____

Do you exercise? ☐ Yes ☐ No If yes, please describe type and how often:
_____

How would you rate your symptoms in the last week?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

If you had to accept some level of symptoms after completion of treatment, what would be an acceptable level?

NO PAIN 1 2 3 4 5 6 7 8 9 10 WORST POSSIBLE PAIN

Previous Health Conditions

Primary Health Provider Information:

Name _____ Phone _____

When were you last seen?_____ May we send them updates on your condition? ☐ Yes ☐ No

Please list ALL allergies/sensitivities to medication, food, and other items here:

Items you react to	Reaction

List the prescription drugs you are currently taking (or you may attach a list):

Name	Dose (mg or IU)	Time(s) Daily

List all nutritional supplements (vitamins, herbs, homeopathics, etc.) as above:

This is a confidential record of your medical history and pertinent health information. The Doctor reserves the right to discuss this information with medical and allied health professionals per the informed consent. Copies of this record can only be released by your written authorization, unless you sign here, indicating we can release copies by your verbal request.

Name _____ Signature_____ Date _____

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WELLNESS QUESTIONNAIRE

Name: _____ DOB: _____ Date: _____

In medicine today, leaky gut aka intestinal permeability, isn't typically diagnosed. However that doesn't mean it's not affecting your health. Many health issues related to gut health go undiagnosed, misdiagnosed, or are ignored by traditional medicine. Please complete this evaluation to help determine how we can help your condition.

Let's get started

Please check any that apply to you:

Sub-Clinical Symptoms Including:
- ☐ Headaches
- ☐ Migraines

Hormone Imbalance Including:
- ☐ PMS
- ☐ Emotional imbalance

Gastrointestinal Issues Including:
- ☐ Abdominal bloating, cramps or painful gas
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease and other intestinal disorders

Respiratory Conditions Including:
- ☐ Chronic sinusitis
- ☐ Asthma
- ☐ Allergies

Joint Conditions Including:
- ☐ Knee, Shoulder, or Spine

Autoimmune Conditions Including:
- ☐ Diabetes Mellitus
- ☐ Lupus
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia
- ☐ Chronic Fatigue

Thyroid Conditions Including:
- ☐ Hashimotos
- ☐ Hypothyroidism
- ☐ Hyperthyroidism

Developmental and Social Concerns Including:
- ☐ Autism
- ☐ ADD/ADHD

Skin Conditions Including:
- ☐ Eczema
- ☐ Skin rashes
- ☐ Hives

Circle the number that most closely fits, then add up your results.

	None	Mild	Mod	Severe
Constipation and/or diarrhea	0	1	2	3
Abdominal pain or bloating	0	1	2	3
Mucous or blood in stool	0	1	2	3
Joint pain or swelling, arthritis	0	1	2	3
Chronic or frequent fatigue or tiredness	0	1	2	3
Food allergies, sensitivities or intolerance	0	1	2	3
Sinus or nasal congestion	0	1	2	3
Chronic or frequent inflammations	0	1	2	3
Eczema, skin rashes or hives (urticaria)	0	1	2	3

	None	Mild	Mod	Severe
Asthma, Hayfever, or airborne allergies	0	1	2	3
Confusion, poor memory or mood swings	0	1	2	3
Use of NSAIDS (Aspirin, Tylenol, Motrin)	0	1	2	3
History of antibiotic use	0	1	2	3
Alcohol consumption makes you feel sick	0	1	2	3
Gluten sensitivity or Celiac's disease	0	1	2	3
Nausea	0	1	2	3
Weight issues	0	1	2	3

YOUR TOTAL # _____

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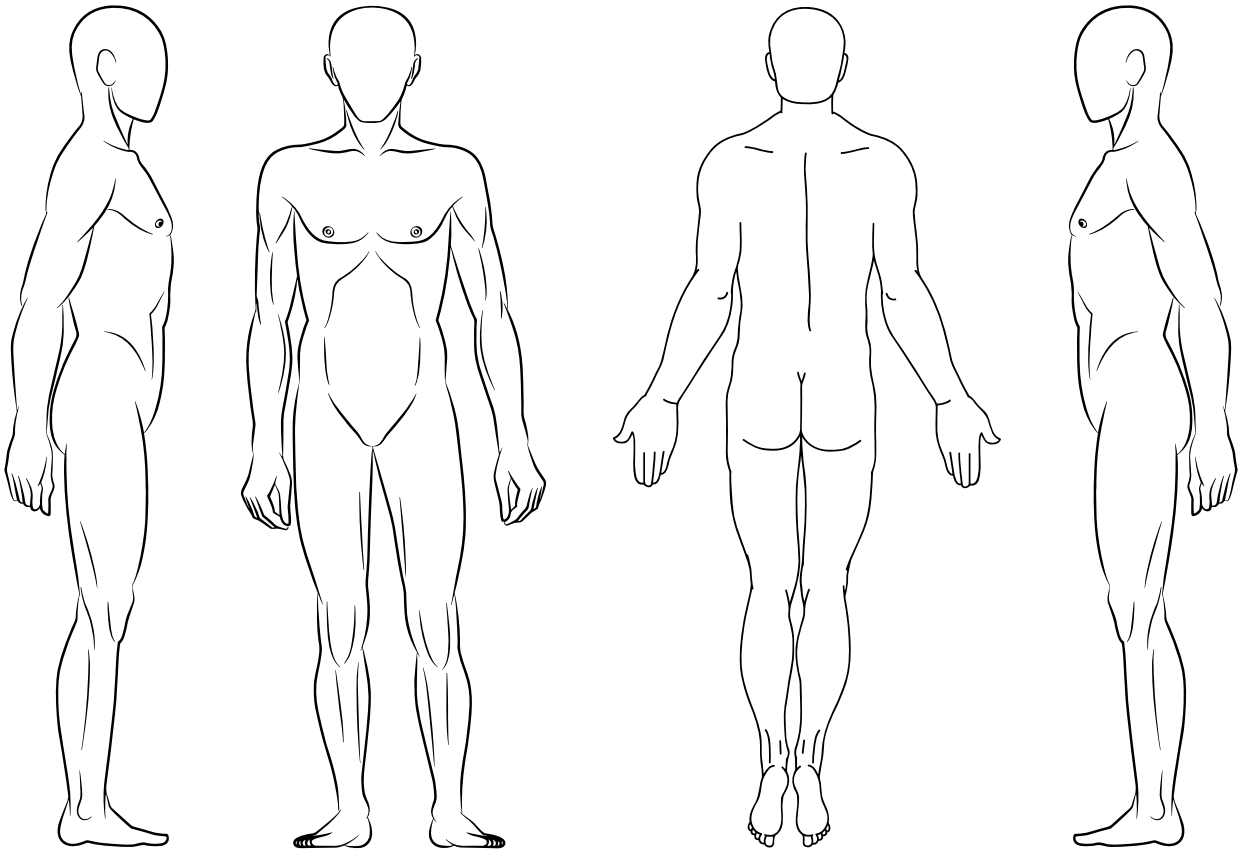
BODY DIAGRAM

Name: _____ DOB: _____ Date: _____

Please mark ALL SCARS, and INJURIES/SURGERIES – REGARDLESS OF SIZE and with as much detail as you can. Please write anywhere in the box.



Please write down any other history of medical imaging (less than 3 years old), bloodwork (within last 6 months), blood thinners, or chemo/radiation.

_____

_____

_____

_____

_____

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Notice of Privacy Practices

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Legacy Health - Dr. Adam Tomasetti has adopted the following privacy policies:

USES AND DISCLOSURES

Treatment Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the services provided, and the medical condition being treated.

Healthcare Operations Your health information may be used as necessary to support the day-to-day activities and management of our office. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and comply with government mandated reporting.

Public health reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of the Information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION

Appointment reminders Your health information may be used by our staff to notify you of appointment reminders.

Information about treatments Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

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INDIVIDUAL RIGHTS

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your Protected Health Information.
2. The right to receive confidential Communications concerning your medical condition and treatment.
3. The right to inspect and copy your Protected Health Information.
4. The right to amend or submit corrections to your Protected Health Information.
5. The right to receive an accounting of how and to whom your Protected Health Information has been disclosed.
6. The right to receive a printed copy of this notice.

RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulation. Whatever the reason for these revisions, we wil provide you with a revised notice on your next office visit. The revised policies and practices will be applied to al protected health information that we maintain.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy Protected Health Information be submitted in writing. You may obtain a form to request access to your records by contacting our receptionist or your provider.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to your provider outlining your concerns at:

Legacy Health
Attn: Dr. Adam Tomasetti
3808 Market Street
Camp Hill, PA 17011

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person The name and address of the person you may contact for further information concerning our privacy practices is Dr. Adam Tomasetti at the address above.

** HIPAA (Health Insurance Portability and Accountability Act) was signed into law on August 21, 1996, Public Law, 104-191. This was designed to provide insurance portability, to improve the efficiency of health care by standardizing the exchange of administrative and financial data, and to protect the privacy, confidentiality and security of the healthcare information. It impacts all areas of the healthcare industry.

Please sign the "Signature Page" for our records. You may keep this copy for your records.

HIPAA-PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Legacy Health.

_____ _____

Signature *Date*

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Consent to Chiropractic Examination and Treatment

I, the undersigned, hereby authorize providers at Legacy Health to perform an appropriate physical examination and conduct necessary diagnostic procedures to establish a diagnosis and plan for care. I understand that the examination and any subsequent treatment plans will be discussed with me, and my questions will be answered, before proceeding with any treatments.

DESCRIPTION OF PROCEDURES

- Neurological, physical, and orthopedic examination based on standard chiropractic practices
- Diagnostic procedures as deemed necessary by the provider
- Chiropractic adjustments and manipulations
- Any additional treatments or therapies recommended by Legacy Health providers

ACKNOWLEDGMENT OF UNDERSTANDING

- I acknowledge that I have had the opportunity to discuss the nature and purpose of the examination and treatment(s) to my satisfaction.
- I understand that I have the right to refuse any or all parts of the examination or treatment and can withdraw my consent at any time.
- I am aware that, as with any health procedure, there may be potential risks and benefits, which will be explained to me prior to treatment.

Please sign the "Signature Page" for our records. You may keep this copy for your records.

CONSENT TO CHIROPRACTIC EXAMINATION AND TREATMENT

By signing below, I voluntarily consent to the examination and treatment provided by Dr. Adam Tomasetti and the Legacy Health team. I acknowledge that no guarantees have been made to me regarding the results of any treatment or examination.

_____ _____

Signature *Date*

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Signature Page

PLEASE READ THE FOLLOWING DOCUMENTS:

- Notice of Privacy Practices
- Consent to Chiropractic Examination and Treatment

Sign your agreement on this form which will be a part of your records. You may keep the consent and HIPAA documents for your reference.

Thank you!

CONSENT TO CHIROPRACTIC EXAMINATION / TREATMENT

I hereby authorize Dr. Adam Tomasetti and/or whomever is designated as assistants to administer chiropractic examination, treatment and/or x-rays as deemed necessary for my care.

_____ _____

Signature *Date*

HIPAA-PRIVACY

I understand and agree to the Privacy laws, policies and procedures of Legacy Health.

_____ _____

Signature *Date*

CONSENT TO CHIROPRACTIC EXAMINATION / TREATMENT OF A MINOR (if applicable)

I hereby authorize Legacy Health, Dr. Adam Tomasetti and/or whomever is designated as assistants to administer chiropractic examination, and treatment as deemed necessary to my child.

_____

Name of child

_____ _____

Signature of parent / guardian *Date*