Patient Information

Name: ____ ________
Last First MI

Email address: ____

Mailing Address: ____________________ City: ____________ State: ______ Zip: ________

Phone # (Cell)______________ (Home) ______________ (Other) ____________

Date of Birth: ____________ Sex: ❑ Male ❑ Female **SS#:** ______________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Minor

Race ❑ Caucasian ❑ African American ❑ Asian ❑ Native American ❑ Latin American ❑ Other ____

Occupation: ______________________

Employer: ______________________

How did you hear about our practice? ______________________________

Emergency contact: Name: ______________ Relation: __________ Phone #: ____________

Accident Information

Is this visit due to an accident? ❑ Yes ❑ No If yes, what type? ❑ Auto ❑ Work ❑ Other ______

Has it been reported? ❑ Yes ❑ No If yes, to whom? ______________________

Claim #: ______________________ Date of Injury: ______________________

Health or Auto Insurance Information

Do you have health insurance? ❑ Yes ❑ No Name of Carrier: ______________________

Do you have secondary insurance? ❑ Yes ❑ No Name of Carrier: ______________________

Policy Holder Name: ______________________________ D.O.B. :____________________

Relationship to patient (if other than self): ________________ Phone # ________________

PLEASE PROVIDE THIS OFFICE WITH A COPY OF YOUR DRIVER'S LICENSE AND INSURANCE CARD(S)

Assignment and Release (insured patients)

I certify that I (or my dependent) have insurance coverage with ________________ and I AUTHORIZE, REQUEST AND ASSIGN MY INSURANCE COMPANY TO PAY DIRECTLY TO THE PRACTICE, INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary, including the diagnosis and the records of any exam or treatment rendered to me, in order to secure the payment of benefits. I authorize the use of this signature on all insurance claims, including electronic submissions.

SIGNATURE (X) ______________________________ **DATE** 1/9/2023

Patient Name: Chart#: Date:

Health History

Who is your primary care physician? (doctor and/or practice) ______________________________

Please check to indicate if you are currently experiencing any of the following conditions:

❑ Low Back Pain (L/R) ❑ Elbow Pain (L/R) ❑ Blurred Vision ❑ Sudden Weight Loss
❑ Mid Back Pain (L/R) ❑ Hip Pain (L/R) ❑ Headaches ❑ Pins/Needles in Legs
❑ Neck Pain (L/R) ❑ Leg/Knee Pain (L/R) ❑ Nervousness ❑ Pins/Needles in Arms
❑ Wrist Pain (L/R) ❑ Ankle Pain (L/R) ❑ Tension/Stress ❑ Pins/Needles in Hands
❑ Hand Pain (L/R) ❑ Foot Pain (L/R) ❑ Night Pain ❑ Cold Feet
❑ Arm Pain (L/R) ❑ Fatigue ❑ Allergies ❑ Fever
❑ Shoulder Pain (L/R) ❑ Dizziness ❑ Jaw Problems ❑ Sleeping Difficulties

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV ❑ Cataracts ❑ Gout ❑ Migraines ❑ Stroke
❑ Allergy Shots ❑ Chemical Dependency ❑ Hair Loss ❑ Multiple Sclerosis ❑ Thyroid Problems
❑ Anorexia ❑ Diabetes ❑ Hernia ❑ Osteoporosis ❑ Ulcers
❑ Arthritis ❑ Difficulty Weight Loss ❑ Herniated Disc ❑ Parkinson's Disease ❑ Water Retention
❑ Bleeding Disorders ❑ Food Cravings ❑ High Cholesterol ❑ Polio ❑ Weight Gain
❑ Brittle Nails ❑ Fractures ❑ Hyperactivity ❑ Prosthesis
❑ Bulimia ❑ Glaucoma ❑ Kidney Disease ❑ Restlessness
❑ Cancer ❑ Goiter ❑ Liver Disease ❑ Rheumatoid Arthritis
❑ Other ______________________________

Are you currently under medical care? ❑ Yes ❑ No If yes, explain ______________________________

Please list any medications you are currently taking (**Be sure to include dosage and frequency**)______________________________

____

Please list any surgeries and/or hospitalizations you have had (**type & date**): ______________________________

____

____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

Is there a family history of any of the following conditions? (**Indicate family member including parents, grandparents & siblings**)

❑ Heart Disease ______________ ❑ Diabetes ______________
❑ Cancer ______________ ❑ Arthritis ______________ ❑ Other ______________________________

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Do your work activities mostly involve: ❑ Sitting ❑ Standing ❑ Light Labor ❑ Heavy Labor

What is your daily/weekly intake of the following:

Caffeine __________ cups/day Alcohol ________ drinks/week Cigarettes ______ packs/day

- I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE (X) ______________________________ **DATE 1/9/2023**

Reviewed by SIGNATURE (X) ______________________________ **DATE 1/9/2023**

Patient Name: Chart#: Date:

MODESTO
PHYSICAL MEDICINE

ADRENAL ASSESSMENT

Mark the symptoms that apply to you as of right now.

- ☐ I have low blood pressure.
- ☐ I feel dizzy when I stand up.
- ☐ I have hypoglycemia (low blood sugar).
- ☐ I crave salt.
- ☐ I crave sweets.
- ☐ I have dark circles under my eyes.
- ☐ I have sleep problems (either falling asleep or staying asleep).
- ☐ I have nonrestorative sleep (don’t feel energized).
- ☐ I have mental fogginess or trouble concentrating.
- ☐ I have headaches.
- ☐ I have frequent infections (catch cold easily).
- ☐ I don’t tolerate exercise well and feel completely exhausted after.
- ☐ I feel stressed most of the time.
- ☐ I feel tired but wired.
- ☐ I retain water.
- ☐ I have panic attacks or am easily startled.
- ☐ I have heart palpitations.
- ☐ I need to start the day with caffeine.
- ☐ I have poor tolerance to alcohol, caffeine, and other drugs.
- ☐ I feel weak and shaky.
- ☐ I have sweaty palms and feet when nervous.
- ☐ I feel fatigued.
- ☐ I felt worse shortly after taking thyroid medications.
- ☐ Fasting makes me feel worse.
- ☐ My muscles are weak.

Total number of symptoms: _____

< 3: Low risk
3-6: Intermediate risk
>7: High risk

Patient Name: Chart#: Date:

Gut Health Assessment

Mark which symptoms apply to you.

□ I have an autoimmune condition.
□ I have gas.
□ I have food sensitivities.
□ I have irritable bowel syndrome.
□ I have fewer than one bowel movement per day.
□ I have hard-to-pass stools.
□ I have diarrhea.
□ I have constipation.
□ I have stomach cramps.
□ I tend to have undigested food in my stools.
□ I need to take laxatives to have bowel movements.
□ I have taken antacids (Pepto-Bismol, Maalox, Tums, and so on) more than once in the past year.
□ I have taken acid-blocking medications like Pepcid, famotidine, Prevacid, omeprazole, Zantac, Nexium, or Prilosec in the last five years.
□ I have taken antibiotics for more than two weeks.
□ I have taken more than three courses of antibiotics in the last ten years before my symptoms started.
□ I have taken a steroid medication like prednisone for more than two weeks in the last ten years before my symptoms started.
□ I have taken the birth control pill.
□ I take over-the-counter pain relievers like ibuprofen, Aleve, Advil, or naproxen on a regular basis.
□ I have skin rashes, acne, or hives.
□ I have seasonal or environmental allergies.
□ I have a swollen, patchy, or coated tongue.
□ I feel bloated after eating or experiencing gas or belching.
□ I have anal itching.
□ I feel nausea after eating.
□ I have foul-smelling stools.
□ I have cravings for sweets, alcohol, or carbs.
□ I drink coffee or alcohol on a daily basis.
□ I frequently eat out.
□ I have taken antibiotics for more than two weeks.
□ I like to eat sushi and meat that is undercooked.

Total number of symptoms: _____

Patient Name: Chart#: Date:

MODESTO
PHYSICAL MEDICINE

Liver Assessment

Mark which symptoms apply to you.

□ Acne	□ Anger, irritability, aggressiveness	□ Anxiety, fear, nervousness
□ Apathy, lethargy	□ Arthritis	□ Asthma, bronchitis
□ Bags or dark circles under eyes		□ Bad breath
□ Belching or passing gas	□ Binge eating or drinking	□ Bloating
□ Blurred or tunnel vision	□ Brain fog	□ Canker sores
□ Chest congestion	□ Chest pain	□ Chronic coughing
□ Compulsive eating	□ Confusion, poor comprehension	□ Constipation
□ Craving certain foods	□ Depression	□ Depression
□ Diarrhea	□ Difficulty breathing	□ Difficulty in making decisions
□ Digestive problems	□ Dizziness	
□ Drainage from ear	□ Earaches, ear infections	□ Eczema
□ Emotional dysregulation	□ Excessive mucus formation	□ Excessive sweating
□ Excessive weight	□ Faintness	□ Fatigue, sluggishness
□ Feeling of weakness or tiredness		□ Food sensitivities
□ Flushing or hot flashes	□ Frequent illness	□ Frequent/urgent urination
□ Gagging, frequent need to clear throat		□ Genital itch or discharge
□ Hair loss	□ Hay fever	□ Headaches
□ Heartburn	□ Hives, rashes, or dry skin	□ Hormonal imbalances
□ Hyperactivity	□ Insomnia	□ Intestinal or stomach pain
□ Irregular/skipped heartbeat		□ Itchy ears
□ Learning disabilities	□ Mood swings	□ Multiple chemical
□ Nausea or vomiting	□ Near or farsightedness	□ One or more autoimmune conditions
□ Pain or aches in joints	□ Pain or aches in muscles	
□ Poor concentration	□ Poor memory	□ Poor physical coordination
□ Rapid or pounding heartbeat		□ Restlessness
□ Ringing in ears, hearing loss	□ Sensitivity to medications and supplements	
□ Shortness of breath	□ Sinus problems	□ Slurred speech
□ Sneezing attacks	□ Sore throat, hoarseness, loss of voice	
□ Stiffness or limitation of movement		□ Stuffy nose
□ Stuttering or stammering	□ Swollen, reddened, or sticky eyelids	
□ Swollen or discolored tongue, gum, lips		□ Underweight
□ Unexplained weakness	□ Water retention	□ Watery or itchy eyes

Total number of symptoms __________

<3:	Optimal
3-12:	Mild toxicity
13-24:	Moderate toxicity
>25:	Severe toxicity

Patient Name: Chart#: Date:

FUNCTIONAL MEDICINE SYMPTOM ASSESSMENT

Which of the following symptoms do you have?
Please rate your symptoms: 1 means you do not experience the symptom at all and 10 means it drastically effects your lifestyle.

Symptom	Rating
Fatigue/Drowsiness	1 2 3 4 5 6 7 8 9 10
Hair Loss	1 2 3 4 5 6 7 8 9 10
Cold Intolerance	1 2 3 4 5 6 7 8 9 10
Inability to lose weight	1 2 3 4 5 6 7 8 9 10
Sadness/Depression	1 2 3 4 5 6 7 8 9 10
Mental Fog/Forgetfulness	1 2 3 4 5 6 7 8 9 10
Joint Pain	1 2 3 4 5 6 7 8 9 10
Acne	1 2 3 4 5 6 7 8 9 10
Puffy Face	1 2 3 4 5 6 7 8 9 10
Acid Reflux	1 2 3 4 5 6 7 8 9 10
Stomach Pain	1 2 3 4 5 6 7 8 9 10
Morning Fatigue	1 2 3 4 5 6 7 8 9 10
Irritability	1 2 3 4 5 6 7 8 9 10
Palpitations	1 2 3 4 5 6 7 8 9 10
Night Sweats	1 2 3 4 5 6 7 8 9 10
Emotional Lability	1 2 3 4 5 6 7 8 9 10
Weight Loss	1 2 3 4 5 6 7 8 9 10
Nervousness	1 2 3 4 5 6 7 8 9 10
Anxiety	1 2 3 4 5 6 7 8 9 10
Feeling Hot	1 2 3 4 5 6 7 8 9 10
Trouble Sleeping	1 2 3 4 5 6 7 8 9 10
Apathy/Feeling Numb	1 2 3 4 5 6 7 8 9 10
Vertigo	1 2 3 4 5 6 7 8 9 10
Nausea	1 2 3 4 5 6 7 8 9 10

What have you done to resolve these issues? ____

Name: Natasha Caffey-Laidlaw FILE#: 100861

Patient Name: Chart#: Date:

B/P: ______________________
Pulse: ______________________

How did they hear about us? __________________________

Consultation History Form

Chief complaint(s): ____

____

____

History: ____

When at its worst it feels like: ____

____

What have you done to try and handle: ____

____

Medications: ____

List any accidents or injuries you have had in your life (i.e. falls, MVAs, motorcycle, sports or work related)

____

____

How has your pain affected your life? ____

How has it affected your work/home life: ____

Recommendations for Care

Chiropractic DRX (Lumbar Cervical BOT) Visits: 6 12 18 24 25

Therapy: C. Traction Vibration W. Chair Rebuilder Shockwave: Treatments: 1 4 6 8 10

Trigenics: _____ visits Region(s): ____

Stem Cell with PRP: Region(s): ____

Hair Restoration: Treatments: 1 2 3 4 5 Micro Needling: Treatments: 1 2 3 4 5

IV Therapy: Treatments: 1 2 3 4 5 TPIs: Treatments: 1 2 3 4 5

DME: LSO Cervical Traction Stroops Band Lumbar Traction Knee Brace Ankle Brace

Front Desk

Today's Visit

X-rays taken here: **FB Special** **Radio**
No X-rays taken
X-ray or MRI brought in with patient
X-rays taken - $0 charge
DRX Demo Trigenics Shockwave
Stem Cell PRP TPIs

Scheduled for procedure
Referred out for other imaging
Demo therapy scheduled

IV Therapy Other: ______________________________
Today's Visit: $ ______________________________

Reschedule for:

Financial DRX Demo
Adjustment Trigenics
Stem Cell Inj. PRP Inj.
Hair Rest. IV Therapy
Micro Needl. Other: _____

Patient Name: Chart#: Date: