



### ADULT HISTORY FORM

To help us serve you better, please complete the following information. We look forward to coaching you to build better health for you and your family.

#### PERSONAL INFORMATION:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ City/State/ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Work #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_ Cell #: (\_\_\_\_)\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_.com Would you like to receive our Free Wellness E-Newsletter? Yes No

Male: \_\_\_ Female: \_\_\_ Status: Single/ Married/ Divorced/ Widowed S/S #: \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Name And Address: \_\_\_\_\_ Occupation: \_\_\_\_\_

Children, Names and Ages:  
(Child #1, Age) \_\_\_\_\_ (Child #2, Age) \_\_\_\_\_ (Child #3, Age) \_\_\_\_\_

Reason for consulting our office? Wellness Evaluation: \_\_\_\_\_ or Chief Complaint: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

### Your WELLNESS Profile



and wellness is **NOW**.  
Place an "O" on the diagram indicating where you would **LIKE** your health and wellness to be.

### Your HEALTH Profile

What brings you into our office? Please briefly describe your chief concern, including the impact it has it had on your life. If you have no symptoms or complaints and are here for Wellness Services, please skip to the "General History" page.

Rate Severity 1 = mild 10= worst imaginable  
Are symptoms Constant or Intermittent?

When did this start?  
Did problem begin with injury?

#### Health Concerns:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Since the problem started, it is: \_\_\_ The Same \_\_\_ Getting Better \_\_\_ Getting Worse

What makes the problem worse? \_\_\_\_\_

What, if anything makes it feel better? \_\_\_\_\_

Does this interfere with your: \_\_\_ Work \_\_\_ Leisure \_\_\_ Sleep \_\_\_ Sports

\_\_\_ Other: \_\_\_\_\_

Have you seen other doctors for this condition? \_\_\_ Chiropractor \_\_\_ Medical Dr. \_\_\_ Other

Name/ Address: \_\_\_\_\_

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

What was the diagnosis? \_\_\_\_\_

Name/ Address: \_\_\_\_\_

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

What was the diagnosis? \_\_\_\_\_

## Your General History

List all *Medications* you are taking and why: (Prescription and non-prescription)

\_\_\_\_\_  
\_\_\_\_\_

List all *Supplements* you are taking and why:

\_\_\_\_\_  
\_\_\_\_\_

Primary Care Physician and Location: \_\_\_\_\_

Have you had any *Surgeries or Hospitalizations*? (Please include all surgeries)

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

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

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

What do you do for a living? \_\_\_\_\_

Have you ever had any work related injuries? \_\_\_\_\_

Have you ever had any slips, falls or auto accidents? \_\_\_\_\_

On a scale of 1-10 describe your Psychological/Emotional stress levels:

(1= none/ 10=extreme)

Home: \_\_\_\_\_

Work: \_\_\_\_\_

Financial: \_\_\_\_\_

On a scale of 1-10, (1 being very poor and 10 being excellent) describe your:

Eating habits: \_\_\_\_\_

Exercise habits: \_\_\_\_\_

Sleep: \_\_\_\_\_

Mind-set: \_\_\_\_\_

Please answer the following *Life Style Habits*:

Sleeping Position: \_\_\_ Back \_\_\_ Side \_\_\_ Stomach (# of pillows used under head: \_\_\_\_\_)

How many hours per night? \_\_\_\_\_

How old is your mattress? \_\_\_\_\_

Do you smoke? \_\_\_ (If Yes, how many per day \_\_\_\_\_)

How Many 8oz glasses per day of the following do you drink:

\_\_\_ Water

\_\_\_ Soda

\_\_\_ Coffee

\_\_\_ Juice

\_\_\_ Milk

\_\_\_ Tea

\_\_\_ Alcohol

# Symptom Review

NAME \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

AGE \_\_\_\_\_ SEX M \_\_\_ F \_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

**INSTRUCTIONS:** Number the boxes which apply to you with either a 1, 2, or 3  
 (1) for **MILD** symptoms  
 (2) for **MODERATE** symptoms  
 (3) for **SEVERE** symptoms  
 Leave the box **BLANK** if it does not apply to you!

### GROUP 1

- 1  Acid foods upset
- 2  Get chilled, often
- 3  "Lump" in throat
- 4  Dry mouth-eyes-nose
- 5  Pulse speeds after meals
- 6  Keyed up - fail to calm
- 7  Cuts heal slowly
- 8  Gag easily
- 9  Unable to relax; startles easily
- 10  Extremities cold, clammy
- 11  Strong light imitates
- 12  Urine amount reduced
- 13  Heart pounds after retiring
- 14  "Nervous" stomach
- 15  Appetite reduced
- 16  Cold sweats often
- 17  Fever easily raised
- 18  Neuralgia-like pains
- 19  Staring, blinks little
- 20  Sour stomach frequent

### GROUP 2

- 21  Joint stiffness after arising
- 22  Muscle-leg-toe cramps at night
- 23  "Butterfly" stomach, cramps
- 24  Eyes or nose watery
- 25  Eyes blink often
- 26  Eyelids swollen, puffy
- 27  Indigestion soon after meals
- 28  Always seems hungry; feel "lightheaded" often
- 29  Digestion rapid
- 30  Vomiting frequent
- 31  Hoarseness frequent
- 32  Breathing irregular
- 33  Pulse slow; feels "irregular"
- 34  Gagging reflex slow
- 35  Difficulty swallowing
- 36  Constipation, diarrhea alternating
- 37  "Slow starter"
- 38  Get "chilled" infrequently
- 39  Perspire easily
- 40  Circulation poor, sensitive to cold
- 41  Subject to colds, asthma, bronchitis

### GROUP 3

- 42  Eat when nervous
- 43  Excessive appetite
- 44  Hungry between meals
- 45  Irritable before meals
- 46  Get "shaky" if hungry
- 47  Fatigue, eating relieves
- 48  "Lightheaded" if meals delayed
- 49  Heart palpitates if meals missed or delayed
- 50  Afternoon headaches
- 51  Overeating sweets upsets
- 52  Awaken after few hours sleeps - hard to get back to sleep
- 53  Crave candy or coffee in afternoons
- 54  Moods of depression - "blues" or melancholy
- 55  Abnormal craving for sweets or snacks

### GROUP 4

- 56  Hands and feet go to sleep easily, numbness
- 57  Sigh frequently, "air hunger"
- 58  Aware of "breathing heavily"
- 59  High altitude discomfort
- 60  Opens windows in closed room
- 61  Susceptible to colds and fevers
- 62  Afternoon "yawner"
- 63  Get "drowsy" often
- 64  Swollen ankles worse at night
- 65  Muscle cramps, worse during exercise; get "charley horses"
- 66  Shortness of breath on exertion
- 67  Dull pain in chest or radiating into left arm, worse on exertion
- 68  Bruise easily, "black/blue" spots
- 69  Tendency to anemia
- 70  "Nose bleeds" frequent
- 71  Noises in head or "ringing in ears"
- 72  Tension under the breastbone, or feeling of "tightness", worse on exertion

### GROUP 5

- 73  Dizziness
- 74  Dry Skin
- 75  Burning feet
- 76  Blurred vision
- 77  Itching skin and feet
- 78  Excessive falling hair
- 79  Frequent skin rashes
- 80  Bitter, metallic taste in mouth in mornings
- 81  Bowel movement painful or difficult
- 82  Worries, feels insecure
- 83  Feeling queasy; headache over eyes
- 84  Greasy foods upset
- 85  Stools light-colored
- 86  Skin peels on foot soles
- 87  Pain between shoulder blades
- 88  Use laxatives
- 89  Stools alternate from soft to watery
- 90  History of gallbladder attacks or gallstones
- 91  Sneezing attacks
- 92  Dreaming, nightmare type bad dreams
- 93  Bad breath (halitosis)
- 94  Milk products cause distress
- 95  Sensitive to hot weather
- 96  Burning or itching anus
- 97  Crave sweets

# Symptom Review

## GROUP 6

- 98  Loss of taste for meat
- 99  Lower bowel gas several hours after eating
- 100  Burning stomach sensations, eating relieves
- 101  Coated tongue
- 102  Pass large amounts of foul-smelling gas
- 103  Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hrs.
- 104  Mucus colitis or "irritable bowel"
- 105  Gas shortly after eating
- 106  Stomach "bloating" after eating

## GROUP 7

### (A)

- 107  Insomnia
- 108  Nervousness
- 109  Can't gain weight
- 110  Intolerance to heat
- 111  Highly emotional
- 112  Flush easily
- 113  Night sweats
- 114  Thin, moist skin
- 115  Inward trembling
- 116  Heart palpitates
- 117  Increased appetite without weight gain
- 118  Pulse fast at rest
- 119  Eyelids and face twitch
- 120  Irritable and restless
- 121  Can't work under pressure

### (B)

- 122  Increase in weight
- 123  Decrease in appetite
- 124  Fatigue easily
- 125  Ringing in ears
- 126  Sleepy during day
- 127  Sensitive to cold
- 128  Dry or scaly skin
- 129  Constipation
- 130  Metal sluggishness
- 131  Hair coarse, falls out
- 132  Headaches upon arising wear off during day
- 133  Slow pulse, below 65
- 134  Frequency of urination
- 135  Impaired hearing
- 136  Reduced initiative

## GROUP 7 (continued)

### (C)

- 137  Failing memory
- 138  Low blood pressure
- 139  Increased sex drive
- 140  Headaches, "splitting or rending" type
- 141  Decreased sugar tolerance

### (D)

- 142  Abnormal thirst
- 143  Bloating of abdomen
- 144  Weight gain around hips or waist
- 145  Sex drive reduced or lacking
- 146  Tendency to ulcers, colitis
- 147  Increased sugar tolerance
- 148  Women: menstrual disorders
- 149  Young girls: lack of menstrual function

### (E)

- 150  Dizziness
- 151  Headaches
- 152  Hot flashes
- 153  Increased blood pressure
- 154  Hair growth on face or body (female)
- 155  Sugar in urine (not diabetes)
- 156  Masculine tendencies (female)

### (F)

- 157  Weakness, dizziness
- 158  Chronic fatigue
- 159  Low blood pressure
- 160  Nails weak, ridged
- 161  Tendency to hives
- 162  Arthritic tendencies
- 163  Perspiration increase
- 164  Bowel disorders
- 165  Poor circulation
- 166  Swollen ankles
- 167  Crave salt
- 168  Brown spots or bronzing of skin
- 169  Allergies - tendency to asthma
- 170  Weakness after colds, influenza
- 171  Exhaustion - muscular and nervous
- 172  Respiratory disorders

## FEMALE ONLY

- 173  Very easily fatigued
- 174  Premenstrual tension
- 175  Painful menses
- 176  Depressed feeling before menstruation
- 177  Menstruation excessive and prolonged
- 178  Painful breasts
- 179  Menstruate too frequently
- 180  Vaginal discharge
- 181  Hysterectomy/ovaries removed
- 182  Menopausal hot flashes
- 183  Menses scanty or missed
- 184  Acne, worse at menses
- 185  Depression of long standing

## MALES ONLY

- 186  Prostate trouble
- 187  Urination difficult or dribbling
- 188  Night urination frequent
- 189  Depression
- 190  Pain on inside of legs or heels
- 191  Feeling of incomplete bowel evacuation
- 192  Lack of energy
- 193  Migrating aches and pains
- 194  Tire too easily
- 195  Avoid activity
- 196  Leg nervousness at night
- 197  Diminished sex drive

## IMPORTANT

TO THE PATIENT: Please list below the five main health complaints you have in order of their importance:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**YOUR WELLNESS GOALS:** At our office we concern ourselves with YOUR health and YOUR wellness goals. (Please list your goals for your health and wellness in the spaces provided).

Physical Goals:	Nutritional/Biochemical Goals:	Psychological/Emotional Goals:
Ex. Sleep Better	Ex. Lose Weight	Ex. Be More Organized

**Have**

**you ever:**

Bought bottled water:  Yes  No

Belonged to a health club:  Yes  No

Consumed vitamins or supplements  Yes  No

If there is a need for dietary changes would you like to know?  Yes  No

If there is a need for specific exercises would you like to know?  Yes  No

If there is a need for support in the psychological/mind/body/stress dimension of health would you like assistance?  Yes  No

Do you exercise  Yes  No

If Yes, What do you do and how often? \_\_\_\_\_

Food Diary for the past 2 full days:

Day 1—Breakfast	Day 2—Breakfast
Day 1—Lunch	Day 2—Lunch
Day 1—Dinner	Day 2—Dinner
Day 1—Snacks	Day 2—Snacks

I consent to a professional and complete Nutrition Response Testing examination. understand that any fee for service rendered is due at the time of service and cannot be deferred to a later date.

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

Thank you for filling out this form. It is your first step to Optimal Health!  
Return this to our staff along with your Driver's License

## Informed Consent for Nutrition Response Testing

### PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at the Quantum Chiropractic to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

# Privacy Notice

## TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS.

I, \_\_\_\_\_, hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Quantum Chiropractic will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for Quantum Chiropractic to provide treatment to me, and also necessary for Quantum Chiropractic to obtain payment for that treatment and to carry out its health care operations. Bruce Steinberg, DC and/or Shari Trombley has further explained my right to obtain a copy of this Privacy Notice prior to signing this Consent, and has encouraged me to read this Privacy Notice prior to my signing this Consent.
2. Quantum Chiropractic reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.
3. I understand that, and consent to, the following appointment reminders or communications that will be used by Quantum Chiropractic.
  - a.) a text message to the cellular number provided by me; and
  - b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.
4. Quantum Chiropractic may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for Quantum Chiropractic to conduct its specific health care operations.
5. I understand that I have a right to request that Quantum Chiropractic restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Quantum Chiropractic is not required to agree to any restrictions that I have requested. If Quantum Chiropractic agrees to a requested restriction, then the restriction is binding.
6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that Quantum Chiropractic has already taken action in reliance on this consent.
7. I understand that if I revoke this Consent at any time, Quantum Chiropractic has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above in this Privacy Notice and contained in the enclosed Releases, then Quantum Chiropractic will not treat me.

**I have read and understand the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.**

Name of Individual (Printed) Signature of Individual \_\_\_\_\_

Signature of Legal Guardian/if a minor Relationship \_\_\_\_\_

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_

Witness: \_\_\_\_\_

## Releases

I hereby request and consent to receive nutrition response testing, for me (or for the patient named below, for whom I am legally responsible) by any Clinical Nutritionist or coach who now or in the future treat me while employed by, working with, are associated with, or providing coverage services for this office (collectively known as the "Treating Doctor(s)"), including those working at any office associated with the Treating Doctor(s) (collectively known as the "Staff".) I authorize the Treating Doctor(s) and Staff to request medical records as needed from any source.

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

I clearly understand that all services rendered me are charged directly to me and that I am personally responsible for payment. I authorize and assign any benefits to be paid directly to the Doctor's Office. Any payments will be immediately credited to my account upon receipt. I also understand that if I suspend or terminate my care and treatment, any fees for professional service rendered me will be immediately due and payable.

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

In consideration of services rendered, I hereby assign to the provider of the services and his assignees so much of my third party insurer, first party no-fault automobile or Worker's Compensation insurance benefits and rights, attendant thereto, as shall equal the full amount of the bill for such services and the provider or his assign may secure in my name.

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

Kindly furnish my doctors, insurance company, attorney and any other involved parties or their representatives all information you may have regarding my condition while under your treatment or observation, including but not limited to the history obtained, X-ray, testing, physical findings, diagnosis and prognosis.

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

I have had the opportunity to review and understand a Privacy Notice. I understand that I have the right to review the complete policy prior to signing this consent. I understand that the organization reserves the right to change their notice and practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. There are no restrictions, unless explicitly noted here.

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

---

I have read and understood the above information:

Patient /Guardian Name: \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# Financial Policy & Profile

## PAYMENT IS DUE AS SERVICES ARE RENDERED

Our office is a cash practice, all services are due when rendered, unless other arrangements have been made prior to treatment.

Method of Payment:

Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Credit Card: \_\_\_\_\_ HAS: \_\_\_\_\_ Insurance: \_\_\_\_\_

### Group Insurance

Patients are responsible for payment at the time of their visit. Nutrition response testing is a non-covered service a

### Medicare

The doctor is a non-participating Medicare provider. Medicare patients are required to pay cash as services are rendered and we will submit your claims as a courtesy to you. Medicare patients must present their Medicare card at the onset of treatment. The only treatment Medicare covers is acute care.

### Workers Compensation and Personal Injury

We are a cash practice, if you have been injured; you are still required to pay at the time of service. You will be reimbursed by your insurance carrier.

### My Certification (Assignment & Release)

I certify that the above information is correct and I request services. I certify that I, and/or my dependant(s), assign directly to Dr. Bruce P. Steinberg all insurance benefits, if any, otherwise payable to me for services rendered. I understand that any services rendered, including Nutrition Response Testing deemed "not medically necessary" or "maintenance care" may not be covered by my insurance company and ***I understand that I am financially responsible for all charges whether or not they are covered and/or paid for by insurance.*** I understand that as of the date of this release the fee for visit is \$40.00 and is subject to change. I accept full financial responsibility for all services rendered. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Date