



CONFIDENTIAL HEALTH HISTORY QUESTIONNAIRE
Chiropractic

Patient Name: (Last) (First) (Middle) Date:

*Natural medical healthcare is possible only when the physician completely understands the patient's physical, mental and emotional condition. The information you provide helps the doctor understand your needs and how to help you reach your health goals. Please answer each question completely. Print all information and mark anything you have a question about.

Address: STREET/ PO Box, CITY, STATE, ZIP
Phone: HOME, MOBILE, WORK WITH EXTENSION
Best Reached At: (circle one) Home Mobile Work
SSN
Email
Date of Birth Age
Gender you identify with:
Gender on your birth certificate
Occupation
Emergency Contact: NAME, PHONE NUMBER, RELATIONSHIP
How many children do you have?
Marital Status: Single, Married, Separated, Divorced, Other
With whom do you live?: Spouse, Friends, Parents, Alone, Children, Other

What are your concerns for which you are seeking health care? (List Primary concern first)
1. Date of onset:
2. Date of onset:
3. Date of onset:
4. Date of onset:
Are you seeking primary care from Bloom Natural Healthcare?
If no, who is your primary health care physician?
NAME PHONE (IF KNOWN)
For what concern did you last receive medical healthcare?
Date of care:

How did you hear about Bloom Natural Healthcare?

Signature - Patient (or Guardian - if a minor) Date

Relationship to Patient (if other than self):

PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

All information will be kept strictly confidential. Your responses will help determine if chiropractic treatment will benefit you. Unless we sincerely feel that your condition will respond satisfactorily, we will not recommend treatment.

Please check the degree of all conditions you currently have or have had. To be responsible for your case, we need your complete health history.

O = Occasional F = Frequent C = Constant

<p>O F C</p> <p>Muscle / Joint</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bursitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Foot trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low back pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neck pain, stiffness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain between shoulders</p> <p>General</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chills</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Convulsions</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Headache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nervousness, depression</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Neuralgia</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sweats</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tremors</p> <p>Cardiovascular</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hardening of arteries</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over heart</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Rapid heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Slow heartbeat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swelling of ankles</p> <p>Genitourinary</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bed-wetting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lack of kidney control</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Kidney infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful urination</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Prostate trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pus in urine</p>	<p>O F C</p> <p>Eye, Ear, Nose and Throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Deafness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dental decay</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Earache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Ear noise</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged glands</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Enlarged thyroid</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Eye pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Failing vision</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Far sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gum trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nasal obstruction</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Near sightedness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sinus infection</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Tonsillitis</p> <p>Gastrointestinal</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Belching or gas</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colitis</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Colon trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult digestion</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bloating abdomen</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Gallbladder trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Intestinal worms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Jaundice</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Liver trouble</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Pain over stomach</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor appetite</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vomiting of blood</p>	<p>O F C</p> <p>Skin</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Boils</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Dryness</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hives or allergy</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Itching</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Skin eruptions (rash)</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Varicose veins</p> <p>Pain or numbness in</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Shoulders</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Arms</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Elbows</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hand</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Knees</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Feet</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful tailbone</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Poor posture</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Sciatica</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spinal curvature</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Swollen joints</p> <p>Respiratory</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Chronic cough</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Difficult breathing</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up blood</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spitting up phlegm</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Wheezing</p> <p>Women only</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Congested breasts</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Cramps or backache</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Excess menstrual flow</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Irregular cycle</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Lumps in breast</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Painful menstruation</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Vaginal discharge</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many months? _____ How many children do you have _____</p>	<p><i>Check any of the following conditions you currently have or have had:</i></p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arteriosclerosis</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Chicken pox</p> <p><input type="checkbox"/> Cholera</p> <p><input type="checkbox"/> Cold sores</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Diphtheria</p> <p><input type="checkbox"/> Eczema</p> <p><input type="checkbox"/> Edema</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Fever blisters</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart disease</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Influenza</p> <p><input type="checkbox"/> Lumbago</p> <p><input type="checkbox"/> Malaria</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Multiple sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pleurisy</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p> <p><input type="checkbox"/> Rheumatic fever</p> <p><input type="checkbox"/> Scarlet fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Venereal disease</p> <p><input type="checkbox"/> Whooping cough</p>
--	---	--	--

Describe chiropractic problem: _____

How long have you had this condition?	Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does it bother you (check appropriate box): <input type="checkbox"/> Work <input type="checkbox"/> Sleep <input type="checkbox"/> Other (please specify)	
What seemed to be the initial cause?	
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how long ago? _____
For what reason?	
Are you under the care of a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for what reason?

PERSONAL HEALTH HISTORY

Patient's Name _____ DOB _____ Date _____

Intern _____ Clinician _____

Have you been hospitalized in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, for major surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No for serious injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you had any mental or emotional disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Indicate the drugs do you now take? <input type="checkbox"/> Birth control pills <input type="checkbox"/> Tranquilizers <input type="checkbox"/> Pain Killers <input type="checkbox"/> Other (specify)	
Do you wear: <input type="checkbox"/> heel lifts? <input type="checkbox"/> sole lifts? <input type="checkbox"/> inner soles? <input type="checkbox"/> area supports? <input type="checkbox"/> negative heels? <input type="checkbox"/> platform shoes?	
What is the age of your mattress? _____ Is it <input type="checkbox"/> comfortable? <input type="checkbox"/> uncomfortable? Do you use a bedboard? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How is most of your day spent? <input type="checkbox"/> standing <input type="checkbox"/> sitting <input type="checkbox"/> walking <input type="checkbox"/> other (specify)	

Have you ever:	Yes	No	If yes, briefly explain.
- had a broken bone?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	
- had strains or sprains?	<input type="checkbox"/>	<input type="checkbox"/>	
- used a cane, crutch or other support?	<input type="checkbox"/>	<input type="checkbox"/>	
- been struck unconscious?	<input type="checkbox"/>	<input type="checkbox"/>	
- been hospitalized for other than surgery?	<input type="checkbox"/>	<input type="checkbox"/>	

Do you:	Yes	No
- take minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- think you need minerals, herbs or vitamins?	<input type="checkbox"/>	<input type="checkbox"/>
- have any drug allergy?	<input type="checkbox"/>	<input type="checkbox"/>

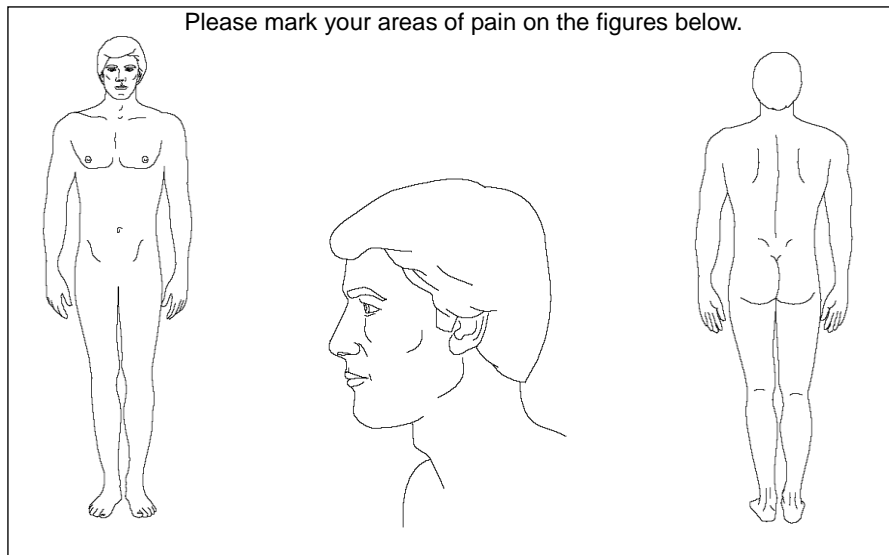
When did you last have:	Never	0-6 mos.	6 -18 mos.	longer
- spinal x-ray?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- spinal examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- physical examination?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HABITS	None	Light	Mod	Heavy
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drugs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Appetite	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Soft Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Salty Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Sweeteners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please list any other health conditions you have been treated for, or surgery you have had in the last ten years.

FAMILY HEALTH HISTORY: Information about your immediate family members, brothers, sisters, parents, and grandparents will give us a better understanding of your total health picture.

RELATIONSHIP	PRESENT AND PAST HEALTH PROBLEMS



INFORMED CONSENT

The purpose of this form is to present risks & benefits of the therapies offered with **Bloom Natural Healthcare**.

This must be signed before treatment is rendered.

Ask your practitioner about any questions or concerns at any time.

NATUROPATHIC MEDICINE

Naturopathy combines safe and effective traditional therapies with the most current advances in modern medicine by attempting to find the underlying cause rather than focusing on symptomatic treatment. The doctors in our clinic treat a variety of conditions including womens' health, stress, pain, organ dysfunction, infections, and much more. There is risk of pharmaceutical/supplement interaction, so inform your ND of current medications. Your ND may suggest hydrotherapy, which encourages circulation, enhanced immune function and relaxation. Side effects are minimal, but may include dizziness, fatigues, detoxification reactions and irritated skin.

ACUPUNCTURE

Acupuncture involves using very thin needles and/or pressure to stimulate special points on the body that affect different organ systems. Our acupuncturists are gentle and effective and combine traditional Chinese bodywork and other techniques to aid in energy flow. Uncommon side effects may be bruising, minor bleeding, fainting and discomfort. More commonly, relaxation and pain relief are experienced. Your acupuncturist may use acupressure and Chinese bodywork, which stimulates or sedates the points by hand.

MANIPULATION

Manipulation is an effective therapy that aims to restore joint motion and neurological function. A proper screening is required and performed to ensure you do not have risks or contraindications to adjustments. Different techniques are used depending on the individual. Uncommon risks include fracture, sprain, and cerebral vascular accidents. More commonly, pain relief, increased range of motion, and alignment correction are experienced.

EXERCISES (GYROTONIC®, GYROKINESIS®), STRETCHING, MASSAGE, TRIGGER POINT THERAPY

It is possible that in the process of learning new movements/exercises that your muscles may become sore or achey. More commonly, pain relief, increased range of motion and alignment correction are experienced.

The goal of massage/soft tissue therapy is to decrease the tension and tenderness, while increasing blood/lymph flow. Your problem may be caused by poor mechanics/repetitive stress, in which case, exercises or stretches may be indicated. Deep tissue work, overstretching and over-exercise may cause discomfort or injury. Massage may cause initial soreness, bruising or lightheadedness, but usually pain relief, increased motion, and relaxation are experienced.

SUPPLEMENTS, HERBALS, HOMEOPATHICS, ORTHOPEDIC EQUIPMENT

These are products that can aid in healing by nutritional, energetic, and mechanical support; They can be effective for many conditions. Be sure to inform your practitioner about all medications you currently take to minimize drug/supplement interactions. Some side effects may be gas, bloating, and less commonly allergic reaction. If biomechanical support is needed, back braces, cervical pillows, cervical traction, orthotics may be suggested for your particular case.

IMAGING, REFERRALS

Further lab work (X-rays, MRI, blood work, urine analysis, etc.) may be necessary. When co-management or referral is indicated, a prompt referral to another specialist for evaluation or alternative therapy will be suggested. The following are examples: medical management, physical therapy, vestibular testing, psychological evaluation, injection therapy, surgery, naturopathic, chiropractic, acupuncture, massage, etc.

We will inform you of alternatives to the therapies offered within or external to Bloom Natural Healthcare. Our first concern is your health/well being.

Please inform your practitioner of any changes in symptoms, medications, diagnoses by other doctors and if there is a chance of pregnancy at any time during your care.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Signature (Patient or Guardian if a minor)

Date



INFORMED CONSENT

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT and HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Bloom Natural Healthcare for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Bloom Natural Healthcare. I understand that diagnosis or treatment of me by my physician(s) at Bloom Natural Healthcare may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Bloom Natural Healthcare is not required to agree to the restrictions that I may request. However, if Bloom Natural Healthcare agrees to a restriction that I request, the restriction is binding on Bloom Natural Healthcare and my physician(s) at Bloom Natural Healthcare.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physician(s) at Bloom Natural Healthcare has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Bloom Natural Healthcare uses Office Ally as its insurance billing clearinghouse; I understand this and do hereby give my consent to have my insurance information processed by this company.

I understand I have a right to review Bloom Natural Healthcare's Notice of Privacy Practices prior to signing this document. Bloom Natural Healthcare's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Bloom Natural Healthcare. This Notice of Privacy Practices also describes my rights and Bloom Natural Healthcare's duties with respect to my protected health information.

Bloom Natural Healthcare reserves the right to change the privacy practices that are described in The Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I, _____ have had the opportunity to read this form and my questions are answered to my satisfaction. I hereby consent to the treatments above.

Patient Name (Please Print)

Signature - Patient (or Guardian - if a minor)

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)



INSURANCE INFORMATION, BUSINESS AGREEMENT and PAYMENT POLICY FORM

BUSINESS AGREEMENT

1. I understand that all responsibility for Naturopathic, Exercise Therapy and/or Acupuncture services provided in this office for myself or my dependents is entirely mine, due and payable at the time services are rendered unless other arrangements have been made with Bloom Natural Healthcare. In the event that payments are not paid in full within 30 days of the treatment date, I understand that a 1.5% service charge (*i.e.* 18% per annum) shall be added to my account. I further understand that any dishonored checks will be assessed a statutory handling and collection fee of \$25.00 and any related bank fee incurred.
2. I have signed and understand the authorized consent form given by Bloom Natural Healthcare for the modalities used within the office.
3. If I am a female using oral contraceptives, I understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Therefore, I understand that I will need to use some additional form of birth control during the use of antibiotics and for one complete cycle of birth control pills after the antibiotics are completed.
4. I acknowledge that no guarantee, warranty or assurance has been given by anyone as to the treatment results that may be obtained.
5. I grant my permission to Bloom Natural Healthcare agents to telephone me at my home or at my workplace to discuss matters related to this consent, my treatment, or my account.
6. I hereby authorize Bloom Natural Healthcare to release any information necessary to process my family's medical claims.
7. I understand that the "courtesy notice" for cancellations and/or rescheduling of my appointments is 48 hours. I acknowledge that I will give at least 24 hours notice for cancellation of appointments and that I will be charged a late fee for all broken appointments, no shows and short notice cancellations. I understand that if I break an appointment for a third time that I will not be rescheduled and will be provided with medical care for 30 days only, to allow time to find another health care practitioner.
8. The Fee Schedule is based on "Time Of Service" payments, and varies according to the complexity of visit and/or treatment length.

**Prices are subject to change.*
9. Insurance Companies are billed according to the total amount of code fees (associated with services provided, and type of office visit) that are considered "usual and customary" for practitioners in the local area. These fees may be different than the "Time of Service" fee schedule.
- 10.

Patient Name (Please Print)

Signature - Patient (or Guardian - if a minor)

Date

PAYMENT POLICY

By signing below, I understand that full payment for all services and products I receive from Bloom Natural Healthcare and its practitioners is required at the time of service, except that portion billed to my insurance company. Further, I understand that Bloom Natural Healthcare may submit my bill to my insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.

Signature - Patient (or Guardian - if a minor)

Date