

# Coniglio Chiropractic L.L.C.

## INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other professional procedures, including various modes of physio-therapy, acupuncture and diagnostic services, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic and/or any other licensed professionals who now or in the future treat me while employed by, working or associated with, or serving as backup for the doctor named below, including those working at the office.

Chiropractic treatment involves the science, philosophy, and art of locating and correcting spinal misalignments and as such, is oriented toward improvement of spinal function relative to range of motion, muscular and neurological aspects. There has been no promise, implied or otherwise, of a cure for any symptom, disease or condition as a result of treatment in this clinic. I understand that the chiropractor will use their hands or a mechanical device upon my body to adjust a joint, which may cause an audible "pop" or "click". It is my intention to rely on the doctor to exercise professional judgment during the course of any procedures, which they feel at the time to be in my best interest. Neither the practice of chiropractic or medicine is an exact science, but relies upon information related by the patient, information gathered during examination, and the doctor's interpretation thereof, as well as the doctor's judgment and expertise in working with like cases.

This office includes nutritional recommendations in the treatment of patients. The goal of nutrition is to support the body to improve its overall health and not to treat a specific disease or symptom. All medication changes must be made by my medical physician. I understand nutritional supplements have been proven to be extremely safe when taken as directed. There is always a chance for an adverse reaction from any product. If I feel I am having a reaction to a product, I will stop using the product until I can discuss the matter. The products are sold retail and there is a NO refund policy.

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, and treatment, and any plans for future care or treatment. I understand that this information serves as a basis for planning my care and treatment; a means of communication among other health professionals who may contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; and a means by which a third-party payer can verify that services billed were actually provided.

I have had the opportunity to discuss with the doctor and/or with other office personnel the nature and purpose of chiropractic adjustments and other procedures. I understand and am informed that, as in the practice of medicine, in the practice of chiropractic, there are some risks of treatment including, but not limited to, fractures, disc injuries, strokes, dislocations and sprains. It is not reasonable to expect the doctor to be able to anticipate and explain all risks and complications of a given procedure on any particular visit, and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to the use of my health information for directory purposes. 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 Practice 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 Practice has already taken action in reliance thereon.

I have read, or have had read to me, the Informed Consent to Professional Care. I have also had an opportunity to ask questions about its consent, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

---

Name (printed)

---

Date Signed

---

Signature: Patient or Legal Representative (Attorney, Guardian, Parent)

# NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Coniglio Chiropractic L.L.C.  
1144 Mantua Pike  
Mantua, NJ 08051

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice Of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

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

---

## OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
-------	-----------	---------

Name: \_\_\_\_\_ Patient #: \_\_\_\_\_ Date: \_\_\_\_\_  
 Age \_\_\_\_\_  Male  Female  Single  Married  Divorced  Widowed # of Children \_\_\_\_\_  
 Occupation \_\_\_\_\_  
 Reason for consulting our office? \_\_\_\_\_

## YOUR HEALTH PROFILE

### WHY THIS FORM IS IMPORTANT

As a full spectrum Chiropractic office, we focus on your ability to be healthy. Our goals are, first, to address the issues that brought you to this office, and second, to offer you the opportunity of improved health potential and wellness services in the future. On a daily basis we experience physical, chemical and emotional stresses that can accumulate and result in serious loss of health potential. Most times the effects are gradual: not even felt until they become serious. Answering the following questions will give us a profile of the specific stresses you have faced in your lifetime, allowing us to better assess the challenges to your health potential.

### THE BEGINNING YEARS

Research is showing that many of the health challenges that occur later in life have their origins during the development years, some starting at birth. Please answer the following questions to the best of your ability.

### YOUR CHILDHOOD YEARS

	YES	NO	UNSURE	COMMENTS
Did you have any childhood illnesses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any serious falls as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you play youth sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you take / use any drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you have any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you fallen / jumped from a height over three feet? (i.e. – crib, bunk bed, trees)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you involved in any car accidents as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Was there any prolonged use of medicine such as antibiotics or an inhaler?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Did you suffer any other traumas (physical or emotional)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Were you vaccinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
As a child, were you under regular Chiropractic care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

### ADULT – (18 to present)

Do / did you smoke?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you been in any accidents?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Have you had any surgery?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you play any adult sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Do / did you participate in extreme sports?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

On a scale of 1 – 10 describe your stress level:  
 (1 = none / 10 = Extreme)

Occupational \_\_\_\_\_  
 Personal \_\_\_\_\_

On a scale of Poor, Good, Excellent describe your:

Diet \_\_\_\_\_ Exercise \_\_\_\_\_ Sleep \_\_\_\_\_ General Health \_\_\_\_\_

## Addressing The Issues That Brought You To The Office

If you have no symptoms or complaints, and are here for wellness services, please check (✓) here \_\_\_\_\_ **“Wish to have Chiropractic Wellness Services”** and skip to **“Family Health Profile.”** Others need to briefly describe the chief area of complaint, including the effect it has had on your life.

If you are experiencing pain, is it...

- Sharp                       Dull                       Comes and goes                       Travels                       Constant

Since the problem started, it is...  About the same                       Getting better                       Getting worse

What makes it worse: \_\_\_\_\_

Yes, it interferes with:     Work                       Sleep                       Walking                       Sitting                       Hobbies                       Leisure

Other Doctors seen for this problem (please list)

- Chiropractor \_\_\_\_\_  
 Medical Doctor \_\_\_\_\_  
 Other \_\_\_\_\_

Please check (✓) all symptoms you have ever had, even if they do not seem related to your current problem.

Are You Pregnant?                       YES     NO

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> Headaches                | <input type="checkbox"/> Pins and needles in legs | <input type="checkbox"/> Fainting               | <input type="checkbox"/> Neck pain       |
| <input type="checkbox"/> Pins and Needles in arms | <input type="checkbox"/> Loss of smell            | <input type="checkbox"/> Back Pain              | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Dizziness                | <input type="checkbox"/> Buzzing in Ears          | <input type="checkbox"/> Ringing in Ears        | <input type="checkbox"/> Nervousness     |
| <input type="checkbox"/> Numbness in fingers      | <input type="checkbox"/> Numbness in toes         | <input type="checkbox"/> Loss of taste          | <input type="checkbox"/> Stomach Upset   |
| <input type="checkbox"/> Fatigue                  | <input type="checkbox"/> Depression               | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Tension         |
| <input type="checkbox"/> Sleeping problems        | <input type="checkbox"/> Neck stiff               | <input type="checkbox"/> Cold Hands             | <input type="checkbox"/> Cold feet       |
| <input type="checkbox"/> Diarrhea                 | <input type="checkbox"/> Constipation             | <input type="checkbox"/> Fever                  | <input type="checkbox"/> Hot Flashes     |
| <input type="checkbox"/> Cold Sweats              | <input type="checkbox"/> Lights bother eyes       | <input type="checkbox"/> Problem Urinating      | <input type="checkbox"/> Heartburn       |
| <input type="checkbox"/> Mood swings              | <input type="checkbox"/> Menstrual Pain           | <input type="checkbox"/> Menstrual Irregularity | <input type="checkbox"/> Ulcers          |

List any medications you are taking \_\_\_\_\_  
\_\_\_\_\_

### Family Health Profile:

At our office we are not only interested in your health and well-being, but also the health and well-being of your family and loved ones. Please mention below any health conditions or concerns you may have about your:

Children \_\_\_\_\_  
Spouse \_\_\_\_\_  
Mother \_\_\_\_\_  
Father \_\_\_\_\_  
Brothers \_\_\_\_\_  
Sisters \_\_\_\_\_  
Others \_\_\_\_\_

Have you ever:

Bought bottled water:                       Yes                       No                      **When Last?** \_\_\_\_\_  
Belonged to a health club:                       Yes                       No                      **When Last?** \_\_\_\_\_  
Consumed vitamins or supplements:                       Yes                       No                      **When Last?** \_\_\_\_\_

**The statements made on this form are accurate to the best of my recollection and I agree to allow this office to examine me for further evaluation:**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

CONIGLIO CHIROPRACTIC & WELLNESS  
1144 MANTUA PIKE  
MANTUA, NJ 08051

**PATIENT REGISTRATION**

PATIENT'S NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_

CELL#: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

SS #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

IN CASE OF EMERGENCY: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
.....

LEGAL GUARDIAN (IF MINOR): \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(STREET) (CITY) (STATE) (ZIP)

SS #: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_  
.....

WHO REFERRED YOU TO OUR OFFICE? \_\_\_\_\_

WOULD YOU BE INTERESTED IN REFERRING YOUR FAMILY MEMBERS? \_\_\_\_\_

**BILLING RESPONSIBILITIES:**

INSURANCE COMPANY: \_\_\_\_\_ PHONE #: \_\_\_\_\_

ID/CLAIM #: \_\_\_\_\_ GROUP #: \_\_\_\_\_

INSURED'S NAME: \_\_\_\_\_ SS #: \_\_\_\_\_

INSURED'S DATE OF BIRTH: \_\_\_\_\_  
.....

CHIROPRACTIC BENEFITS ARE QUOTED TO US BY YOUR INSURANCE CARRIER. THE BENEFITS ARE SUBJECT TO THE TERMS AND PROVISIONS OF YOUR PLAN AND ARE NOT NECESSARILY A GUARANTEE OF PAYMENT.

1. I authorize my insurance benefits to be paid directly to Coniglio Chiropractic & Wellness.
2. I am financially responsible for any non-covered services.
3. I authorize the facility to release medical information for billing.

\*SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**OFFICE POLICY REGARDING INSURANCE ASSIGNMENT,  
SELF-PAYING AND APPOINTMENT SCHEDULING**

Coniglio Chiropractic L.L.C. is pleased to accept your insurance assignment, as soon as the responsible party verifies your exact coverage. We will file forms to assist you in every way we can. It must be fully understood that the contract is between you and your insurance company. You are fully responsible for any amount that is not paid by your insurance.

1. You are required to sign an “Authorization to Pay Physician” form and any other assignment documents required by your insurance company on your first visit.
2. Our office does not guarantee that your insurance will pay. We will make every attempt, at the beginning of your health care, to receive verification of your policy and what it covers. However, if for some reason, your insurance claim is denied, you are responsible for the full amount.
3. Our office will **NOT** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation. If circumstance warrants, your insurance assignment may be withdrawn.
4. You are required to pay the percentage of your responsibility as you go along. (E.g. if your insurance pays 80% of your care, you pay 20% on each visit).
5. Any insurance balance over 60 days past due is subject to late payment penalties at 1.5% per month.
6. I agree to pay any collection and/or attorney fees that may arise as a result of any unpaid balance being forwarded to a collection agency and/or attorney to cause payment.
7. All returned checks are subject to a \$25 service fee and a late payment fee (see below).
8. A late payment fee will be assessed if payment on balance is not received by the 10<sup>th</sup> of the month.
9. Late Payment Fee: \$15 if the balance is \$0 - \$99; \$25 if the balance is \$100 - \$999.99; and \$35 if the balance is \$1000 or more. (Balance means Previous Balance on Statement that shows the Late Fee.)
10. A \$30.00 fee will be charged if an appointment is missed without prior rescheduling.
11. For your health this is a Smoke-Free property.
12. I have read and understand the above office policy and agree to its terms.

---

**SIGNATURE OF PATIENT/GUARDIAN**

---

**DATE**

# Metabolic Assessment Form

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

**Please list the 5 major health concerns in your order of importance:**

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

**Please circle the appropriate number “0 - 3” on all questions below. 0 as the least/never to 3 as the most/always.**

<b>Category I</b>			
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
Use laxatives frequently . . . . .	0	1	2 3
<b>Category II</b>			
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
<b>Category III</b>			
Stomach pain, burning, or aching 1- 4 hours after eating . . . . .	0	1	2 3
Use antacids . . . . .	0	1	2 3
Feel 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
<b>Category IV</b>			
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 . . . . .	0	1	2 3
Excessive passage of gas . . . . .	0	1	2 3
Nausea and/or vomiting . . . . .	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

<b>Category V</b>			
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 from 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	
<b>Category VI</b>			
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 if meals are missed . . . . .	0	1	2 3
Eating relieves fatigue . . . . .	0	1	2 3
Feel shaky, jittery, or have 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
<b>Category VII</b>			
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 and appetite . . . . .	0	1	2 3
Difficulty losing weight . . . . .	0	1	2 3
<b>Category VIII</b>			
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

<b>Category IX</b>				
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
<b>Category X</b>				
Tired, sluggish . . . . .	0	1	2	3
Feel cold – hands, feet, 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
<b>Category XI</b>				
Heart palpitations . . . . .	0	1	2	3
Inward trembling . . . . .	0	1	2	3
Increased pulse even at rest . . . . .	0	1	2	3
Nervous and emotional . . . . .	0	1	2	3
Insomnia . . . . .	0	1	2	3
Night sweats . . . . .	0	1	2	3
Difficulty gaining weight . . . . .	0	1	2	3
<b>Category XII</b>				
Diminished sex drive . . . . .	0	1	2	3
Menstrual disorders or lack of menstruation . . . . .	0	1	2	3
Increased ability to eat sugars without symptoms . . . . .	0	1	2	3
<b>Category XIII</b>				
Increased sex drive . . . . .	0	1	2	3
Tolerance to sugars reduced . . . . .	0	1	2	3
“Splitting” type headaches . . . . .	0	1	2	3

<b>Category XIV (Males only)</b>				
Urination difficulty or dribbling . . . . .	0	1	2	3
Frequent urination . . . . .	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
<b>Category XV (Males only)</b>				
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 maintaining 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 than in the past . . . . .	0	1	2	3
<b>Category XVI (Menstruating Females Only)</b>				
Are you perimenopausal . . . . .	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 breakouts . . . . .	0	1	2	3
Facial hair growth . . . . .	0	1	2	3
Hair loss/thinning . . . . .	0	1	2	3
<b>Category XVII (Menopausal Females Only)</b>				
How many years have you been menopausal? _____				
Since menopause, do you ever have uterine bleeding? _____	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 breasts . . . . .	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

How many alcoholic beverages do you consume per week? \_\_\_\_\_

How many times do you eat out per week? \_\_\_\_\_

How many times a week do you eat fish? \_\_\_\_\_

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: \_\_\_\_\_

Rate your stress levels on a scale of 1-10 during the average week: \_\_\_\_\_

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

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

# Health Questionnaire (NTAF)

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_ Date: \_\_\_\_\_

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

## SECTION A

- Is your memory noticeably declining? 0 1 2 3
- Are you having a hard time remembering names and phone numbers? 0 1 2 3
- Is your ability to focus noticeably declining? 0 1 2 3
- Has it become harder for you to learn things? 0 1 2 3
- How often do you have a hard time remembering your appointments? 0 1 2 3
- Is your temperament getting worse in general? 0 1 2 3
- Are you losing your attention span endurance? 0 1 2 3
- How often do you find yourself down or sad? 0 1 2 3
- How often do you fatigue when driving compared to the past? 0 1 2 3
- How often do you fatigue when reading compared to the past? 0 1 2 3
- How often do you walk into rooms and forget why? 0 1 2 3
- How often do you pick up your cell phone and forget why? 0 1 2 3

## SECTION B

- How high is your stress level? 0 1 2 3
- How often do you feel that you have something that must be done? 0 1 2 3
- Do you feel you never have time for yourself? 0 1 2 3
- How often do you feel you are not getting enough sleep or rest? 0 1 2 3
- Do you find it difficult to get regular exercise? 0 1 2 3
- Do you feel uncared for by the people in your life? 0 1 2 3
- Do you feel you are not accomplishing your life's purpose? 0 1 2 3
- Is sharing your problems with someone difficult for you? 0 1 2 3

## SECTION C

### SECTION C1

- How often do you get irritable, shaky, or have lightheadedness between meals? 0 1 2 3
- How often do you feel energized after eating? 0 1 2 3
- How often do you have difficulty eating large meals in the morning? 0 1 2 3
- How often does your energy level drop in the afternoon? 0 1 2 3
- How often do you crave sugar and sweets in the afternoon? 0 1 2 3
- How often do you wake up in the middle of the night? 0 1 2 3
- How often do you have difficulty concentrating before eating? 0 1 2 3
- How often do you depend on coffee to keep yourself going? 0 1 2 3
- How often do you feel agitated, easily upset, and nervous between meals? 0 1 2 3

### SECTION C2

- Do you get fatigued after meals? 0 1 2 3
- Do you crave sugar and sweets after meals? 0 1 2 3
- Do you feel you need stimulants such as coffee after meals? 0 1 2 3
- Do you have difficulty losing weight? 0 1 2 3
- How much larger is your waist girth compared to your hip girth? 0 1 2 3
- How often do you urinate? 0 1 2 3
- Have your thirst and appetite been increased? 0 1 2 3
- Do you have weight gain when under stress? 0 1 2 3
- Do you have difficulty falling asleep? 0 1 2 3

## SECTION 1 - S

- Are you losing your pleasure in hobbies and interests? 0 1 2 3
- How often do you feel overwhelmed with ideas to manage? 0 1 2 3
- How often do you have feelings of inner rage (anger)? 0 1 2 3
- How often do you have feelings of paranoia? 0 1 2 3
- How often do you feel sad or down for no reason? 0 1 2 3
- How often do you feel like you are **not** enjoying life? 0 1 2 3

- How often do you feel you lack artistic appreciation? 0 1 2 3
- How often do you feel depressed in overcast weather? 0 1 2 3
- How much are you losing your enthusiasm for your favorite activities? 0 1 2 3
- How much are you losing enjoyment for your favorite foods? 0 1 2 3
- How much are you losing your enjoyment of friendships and relationships? 0 1 2 3
- How often do you have difficulty falling into deep restful sleep? 0 1 2 3
- How often do you have feelings of dependency on others? 0 1 2 3
- How often do you feel more susceptible to pain? 0 1 2 3
- How often do you have feelings of unprovoked anger? 0 1 2 3
- How much are you losing interest in life? 0 1 2 3

## SECTION 2 - D

- How often do you have feelings of hopelessness? 0 1 2 3
- How often do you have self-destructive thoughts? 0 1 2 3
- How often do you have an inability to handle stress? 0 1 2 3
- How often do you have anger and aggression while under stress? 0 1 2 3
- How often do you feel you are not rested even after long hours of sleep? 0 1 2 3
- How often do you prefer to isolate yourself from others? 0 1 2 3
- How often do you have unexplained lack of concern for family and friends? 0 1 2 3
- How easily are you distracted from your tasks? 0 1 2 3
- How often do you have an inability to finish tasks? 0 1 2 3
- How often do you feel the need to consume caffeine to stay alert? 0 1 2 3
- How often do you feel your libido has been decreased? 0 1 2 3
- How often do you lose your temper for minor reasons? 0 1 2 3
- How often do you have feelings of worthlessness? 0 1 2 3

## SECTION 3 - G

- How often do you feel anxious or panic for no reason? 0 1 2 3
- How often do you have feelings of dread or impending doom? 0 1 2 3
- How often do you feel knots in your stomach? 0 1 2 3
- How often do you have feelings of being overwhelmed for no reason? 0 1 2 3
- How often do you have feelings of guilt about everyday decisions? 0 1 2 3
- How often does your mind feel restless? 0 1 2 3
- How difficult is it to turn your mind off when you want to relax? 0 1 2 3
- How often do you have disorganized attention? 0 1 2 3
- How often do you worry about things you were not worried about before? 0 1 2 3
- How often do you have feelings of inner tension and inner excitability? 0 1 2 3

## SECTION 4 - ACH

- Do you feel your visual memory (shapes & images) is decreased? 0 1 2 3
- Do you feel your verbal memory is decreased? 0 1 2 3
- Do you have memory lapses? 0 1 2 3
- Has your creativity been decreased? 0 1 2 3
- Has your comprehension been diminished? 0 1 2 3
- Do you have difficulty calculating numbers? 0 1 2 3
- Do you have difficulty recognizing objects & faces? 0 1 2 3
- Do you feel like your opinion about yourself has changed? 0 1 2 3
- Are you experiencing excessive urination? 0 1 2 3
- Are you experiencing slower mental response? 0 1 2 3

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only.

# Medication History

Please circle any of the following medication you have been or are currently taking.

## Acetylcholine Receptor Antagonist – Antimuscarinic Agents

Atropine, Ipratropium, Scopolamine, Tiotropium

## Acetylcholine Receptor Antagonist - Ganglionic Blockers

Mecamylamine, Hexamethonium, Nicotine (high doses), Trimethaphan

## Acetylcholinesterase Reactivators

Pralidoxime

## Acetylcholine Receptor Antagonist - Neuromuscular Blockers

Atracurium, Cisatracurium, Doxacurium, Metocurine, Mivacurium, Pancuronium, Rocuronium, Uccinylcholine, Tubocurarine, Vecuronium, Hemicholine

## Agonist Modulator of GABA Receptor (benzodiazepines)

Xanax, Lexotanil, Lexotan, Librium, Klonopin, Valium, ProSon, Rohypnol, Dalmane, Ativan, Loramet, Sedoxil, Dormicum, Megadon, Serax, Restoril, Halcion

## Agonist Modulator of GABA Receptors (nonbenzodiazepines)

Ambien, Sonata, Lunesta, Imovane

## Cholinesterase Inhibitors (irreversible)

Echotiophate, Isoflurophate, Organophosphate Insecticides, Organophosphate-containing nerve agents

## Cholinesterase Inhibitors (reversible)

Donepezil, Galatamine, Rivastigmine, Tacrine, THC, Erophonium, Neostigmine, Phystigimine, Pyridostigmine, Carbamate Insecticides

## Dopamine Reuptake Inhibitors

Wellbutrin (Bupropion)

## Dopamine Receptor Agonists

Mirapex, Sifrol, Requip

## D2 Dopamine Receptor Blockers (antipsychotics)

Thorazine, Prolixin, Trilafon, Compazine, Mellaril, Stelazine, Vesprin, Nozinan, Depixol, Navane, Iuanxol, Clopixol, Acuphase, Haldol, Orap, Clozaril, Zyprexa, Zydis, Seroquel, Geodon, Solian, Invega, Abilify

## GABA Antagonist Competitive binder

Flumazenil

## Monoamine Oxidase Inhibitor (MAOI)

Marplan, Aurorix, Maneric, Moclodura, Nardil, Adlegiine, Elepryl, Azilect, Marsilid, Iprozid, Ipronid, Rivivol, Popilniazida, Zyvox, Zyvoxid

## Noradrenergic and Specific Sertonegic Antidepressants (NaSSaa)

Remeron, Zispin, Avanza, Norset, Remergil, Axit

## Selective Serotonin Reuptake Inhibitor

Paxil, Zoloft, Prozac, Celexa, Lexapro, Luvox, Cipramil, Emocal, Serpam, Seropram, Cipralex, Esteria, Fontex, Seromex, Seronil, Sarafem, Fluctin, Faverin, Seroxat, Aropax, Deroxat, Rexetin, Xentor, Paroxat, Lustral, Serlain, Dapoxetine

## Selective Serotonin Reuptake Enhancers

Stablon, Coaxil, Tatinol

## Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs)

Effexor, Pristiq, Meridia, Serzone, Dalcipran, Despramine, Duloxetine

## Tricyclic Antidepressants (TCAs)

Elavil, Endep, Tryptanol, Trepiline, Asendin, Asendis, Defanyl, Demolox, Moxadil, Anafranil, Norpramin, Pertofrane, Prothiadin, Thanden, Adapin, Sinequan, Trofranil, Janamine, Gamanil, Aventyl, Pamelor, Opipramol, Vivactil, Rhotrimine, Surmontil

**\*Please refer to prescribing physician for nutritional interactions with any medications you maybe taking.**

## **Coniglio Chiropractic Wellness Center**

Board Certified Chiropractic Orthopedist and Sports Physician

1144 Mantua Pike, Mantua, NJ 08051

Phone (856) 468-4200 Fax (856) 468-2233

Name: \_\_\_\_\_

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

Please take several minutes to answer these questions so the Doctors can help you get better faster. **(Please circle as many that apply)**

1. How have you taken care of this condition in the past?

Medications

Routine Medical

Nutrition/Diet

Vitamins

Other (please specify): \_\_\_\_\_

Emergency Room

Exercise

Holistic Care

Chiropractic

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

Bad results

Some results

Nothing changed

Still trying

Great results

Did not get worse

Did not work very long

Confused

3. How have others been affected by your health condition?

No one is affected

Haven't noticed any problem

They tell me to do something

People avoid me

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

Job

Kids

Marriage

Time

Freedom

Sleep

Future ability

Self-esteem

Finances

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

Family health problems  
Cancer  
Arthritis  
Depression  
Need surgery

Heart disease  
Diabetes  
Fibromyalgia  
Chronic Fatigue

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

What are you most concerned with regarding your problem? \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

What would be different/better without this problem? Please be specific \_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

What is that worth to you? \_\_\_\_\_

\_\_\_\_\_