

Confidential Patient Information

Today's Date

Last Name _____ First Name _____ M.I. _____

What name would you like the staff to call you? _____ Social Security No. _____

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip Code _____ Marital **M S W D** Sex: **M F**

Home Phone No. _____ Work Phone No. _____ Height _____ Weight _____

E-mail? Yes No If Yes, Address? _____

List Physical Demands of Job _____

Occupation _____

Employer or School Currently Attending _____

Name of spouse (use last name only if different) _____

Spouse's Employer _____

Spouse's Work Phone No. _____ Date of Birth _____

Children's names and ages:

How did you hear about this office? Check all below that apply:

- Friend Name _____
- Co-worker Name _____
- Relative Name _____
- Yellow pages
- Lecture Location/Subject of Talk: _____
- Newspaper Ad
- Clinic Sign
- Referred from Doctor or other health professional Name: _____

Name(s) of Family Physician(s)

Name of Nearest Friend/Relative: _____

Address: _____ Phone No: _____

Check here if there is any possibility that this injury occurred as a result of a work-related injury or a personal injury (car accident)

By signing below, I authorize payment of benefits to Berglund Health & Wellness Center for all services provided, and authorize the release of any records or information necessary to process this claim. I understand that health and accident insurance policies are an arrangement between myself and my insurance company and that I am ultimately responsible for payment in full unless other arrangements are made and put in writing. I agree to pay for my portion of payment on the day services are rendered. I understand that most orthopedic devices and nutritional supplements and some lab tests are not covered services/products and you will be asked to pay for them on each visit.

Acceptable forms of payment:

- Personal check
- Cash
- Money Order
- Debit Card
- Credit Card

Signature _____

Date _____

Comprehensive Health & Wellness Questionnaire

Patient name _____ Birth date _____ Today's Date _____ Age _____

Conditions you would like the doctor to evaluate _____

Have you had these conditions evaluated before? YES NO

If yes, by whom and what did they find? _____

When did you first notice these symptoms? _____

Are these symptoms getting progressively worse? _____

Which symptoms are constant? _____

Which symptoms come & go? _____

| |
|---|
| Prior professional seen for this condition? |
| <input type="checkbox"/> MEDICAL DOCTOR |
| <input type="checkbox"/> CHIROPRACTOR |
| <input type="checkbox"/> PHYSICAL THERAPIST |
| <input type="checkbox"/> ACUPUNCTURIST |
| <input type="checkbox"/> MASSAGE THERAPIST |
| <input type="checkbox"/> OTHER _____ |

| Do they interfere with | Symptoms worse in: | Painful/difficult activities? |
|--|--|---|
| <input type="checkbox"/> WORK | <input type="checkbox"/> MORNING | <input type="checkbox"/> WALKING |
| <input type="checkbox"/> SLEEP | <input type="checkbox"/> MIDDAY | <input type="checkbox"/> BENDING |
| <input type="checkbox"/> DAILY ROUTINE | <input type="checkbox"/> NIGHT | <input type="checkbox"/> LYING DOWN |
| <input type="checkbox"/> RECREATION | <input type="checkbox"/> COLD and/or RAINY WEATHER | <input type="checkbox"/> LIFTING <input type="checkbox"/> SITTING |

What happens? _____

Your occupation and primary physical duties: _____

Have you ever been to a chiropractor before? YES NO If Yes, for what symptoms: _____

Name of chiropractor(s) _____ Were the chiropractic treatments effective? YES NO How long ago? _____

Are you taking drugs for your current problem? YES NO Name of drugs: _____

Do you sleep on your: BACK SIDE STOMACH ALL POSITIONS Rate your bed's support: FIRM GOOD FAIR POOR

Type of pillow: THICK MEDIUM THIN NONE CERVICAL PILLOW Type of mattress: WATERBED AIR SPRING

| Date of Last: | Date of Last: | Date of Last: | Date of Last: |
|--|---|--|--|
| Physical Exam _____ Doctor's Name _____ Routine? YES NO If not a routine physical, what was the Dr. looking for? _____ _____ | X-rays: _____ X-ray facility? _____ Of what body part? NECK BACK HEAD ARM HAND CHEST HIP KNEE FOOT | Blood Tests: _____ Urine Tests: _____ Ordered by Dr. _____ Routine? YES NO If not routine, what is your Dr. monitoring? _____ _____ | Other tests ordered? MRI CT Scan EKG/Stress test EEG Other test(s) _____ _____ |

Vitamins, minerals, herbs: (Please list any below that you may be taking)

The following sheets deal with your general health. As you will see, the list of questions is quite extensive and thorough. It is important to circle all those things that apply. Do not skim through. Providing complete and accurate information will aid the doctor in keying in on aspects of your health, diet, lifestyle or genetics that may be aggravating or predisposing factors in your health. Properly answering these questions may provide the doctor with clues that may improve chronic problems like weight control, fatigue, pains, arthritis, diabetes, high blood pressure, as well as a variety of other conditions

Fill in the blanks. Circle or check all that apply.

| | | |
|---|--|---|
| <p>Current Age _____</p> <p>Male _____ Female _____</p> <p>Drink soft drinks? YES NO If yes...</p> <p><input type="checkbox"/> less than once per week</p> <p><input type="checkbox"/> 1-3 drinks per week</p> <p><input type="checkbox"/> 1-2 drinks per day</p> <p><input type="checkbox"/> 3-5 drinks per day</p> <p><input type="checkbox"/> >5 drinks per day</p> <p>REGULAR NUTRASWEET SPLENDA</p> | <p>Have you ever smoked? YES NO</p> <p>If YES, how many years _____</p> <p>Do you currently smoke? YES NO</p> <p>Did you quit? NO YES When _____.</p> <p>(current/past smokers circle one below)</p> <p><input type="checkbox"/> 1/2 pack/day</p> <p><input type="checkbox"/> 1 pack/day</p> <p><input type="checkbox"/> 2 or more packs/day</p> <p><input type="checkbox"/> Other _____</p> | <p>Alcohol consumption (if yes, check one below)</p> <p><input type="checkbox"/> less than once per week</p> <p><input type="checkbox"/> 1-3 drinks per week</p> <p><input type="checkbox"/> 1-2 drinks per day</p> <p><input type="checkbox"/> 3-5 drinks per day</p> <p><input type="checkbox"/> >5 drinks per day</p> <p>I drink _____ cups of coffee per day.</p> <p><input type="checkbox"/> Need/like to drink coffee/soda to get started.</p> |
|---|--|---|

Current drugs use:

| | | |
|--|---|---|
| <p>1. Use aspirin</p> <p>2. Use acetaminophen (Tylenol)</p> <p>3. Use Advil/Motrin/ibuprofen</p> <p>4. Use Aleve/naproxen</p> <p>5. Use antacids/Tums</p> <p>6. Take a stool softener</p> <p>7. Take daily fiber supplement</p> <p>8. Taken antibiotics more than once (last 3 yrs)</p> <p>9. Ever been on prednisone/steroid drugs</p> <p>10. Ever had chemotherapy</p> <p>11. Ever had radiation therapy</p> | <p>12. Ever been on a vaginal yeast treatment</p> <p>13. Take high blood pressure drugs (name) _____</p> <p>14. Take thyroid drugs (name) _____</p> <p>15. Take heart drugs (name) _____</p> <p>16. Take stomach acid/ulcer drugs (name) _____</p> <p>17. Take blood thinner (name) _____</p> <p>18. Take allergy drugs (name) _____</p> <p>19. Take hormone replacement/estrogen (name) _____</p> <p>20. Take birth control pills (name) _____</p> <p>21. Take sleeping drugs (name) _____</p> | <p>22. Take anti-depressive drugs (name) _____</p> <p>23. Take anti-anxiety drugs (name) _____</p> <p>24. Take lithium _____</p> <p>25. Take cholesterol lowering drugs _____</p> <p>26. Over-the-counter drugs not listed above (list) _____</p> <p>_____</p> <p>_____</p> <p>27. Take multivitamin (name) _____</p> |
|--|---|---|

Past Drug History

| | |
|---|---------------------------------------|
| 28. Birth Control Pills Number of years _____ | 29. Anticonvulsant/antiseizure? _____ |
|---|---------------------------------------|

Surgeries/Medical Procedures

| | | |
|------------------------------------|--------------------------|--------------------------------|
| 30. Adenoids removed | 31. Cataract surgery | 32. Neck surgery |
| 33. Angioplasty | 34. Gall bladder removed | 35. Pacemaker implanted |
| 36. Appendectomy | 37. Hiatal hernia | 38. Reconstructive surgery |
| 39. Back surgery | 40. Hip replacement | 41. Sinus surgery |
| 42. Benign tumors | 43. Hysterectomy | 44. Spinal fusion |
| 45. Biopsy | 46. Inguinal hernia | 47. Splenectomy |
| 48. Brain surgery | 49. Kidney removed | 50. Thyroid removed/irradiated |
| 51. Breast augmentation (implants) | 52. Knee replacement | 53. Tonsillectomy |
| <input type="checkbox"/> Saline | 54. Knee surgery | 55. Tubes in ears |
| <input type="checkbox"/> Silicone | 56. Laminectomy | 57. Tubes tied (fallopian) |
| 58. Bypass surgery | 59. Laparoscopy | 60. Vasectomy |
| 61. Cancer | 62. Lung removed | 63. OTHER SURGERY (list) |
| 64. Carpal tunnel surgery | 65. Malignant tumors | _____ |
| | | _____ |

CONDITIONS YOU HAVE HAD OR BEEN DIAGNOSED WITH AT ANY TIME IN PAST

- | | | |
|---|--|--|
| 66. ADD/ADHD 69. Alcoholism 72. Allergies <input type="checkbox"/> animal <input type="checkbox"/> dust <input type="checkbox"/> food <input type="checkbox"/> grass <input type="checkbox"/> mold <input type="checkbox"/> pollen <input type="checkbox"/> ragweed <input type="checkbox"/> other _____ | 67. Emphysema 70. Epilepsy 73. Eczema 75. Fibromyalgia 77. Fractures 79. Frequent colds/flu 81. Gastritis 83. Glaucoma 85. Gonorrhea 87. Gout 89. Heart disease 90. Hepatitis 91. Hernia 93. Herpes (mouth) 94. Herpes (genital) 95. High blood pressure 97. High cholesterol 99. HIV positive 101. Hypoglycemia 104. Kidney disease 107. Liver disease 110. Low blood pressure 113. Manic depression 116. Measles 119. Menopause 122. Migraine headaches 125. Miscarriage 128. Mononucleosis 131. Multiple sclerosis 134. Mumps 137. Osteoporosis 140. Pregnancies # _____ <input type="checkbox"/> number of vaginal births # _____ <input type="checkbox"/> number of caesarian births # _____ <input type="checkbox"/> number of abortions # _____ | 68. Pneumonia 71. Polio 74. Prostate problem 76. Psoriasis 78. Psychiatric care 80. Rheumatoid arthritis 82. Rheumatic fever 84. Ringworm 86. Scarlet fever 88. Sensitivities <input type="checkbox"/> cigarette smoke <input type="checkbox"/> exhaust <input type="checkbox"/> food <input type="checkbox"/> gas <input type="checkbox"/> perfume/cologne <input type="checkbox"/> other (list) _____ _____ |
| 92. Anemia <input type="checkbox"/> helped by taking iron <input type="checkbox"/> not helped by taking iron 96. Angina 98. Anorexia 100. Appendicitis 103. Arthritis 106. Asthma 109. Athlete's foot 112. Bladder infections 115. Bleeding disorders 118. Breast lump/cysts 121. Bronchitis 124. Bulimia 127. Bursitis 130. Cancer 133. Cataracts 136. Cavities (dental) FEW SOME MANY 139. Chicken pox 142. Diabetes 143. Depression 144. Drug abuse history | 102. Shingles 105. Sinusitis, Acute or Chronic 108. Stroke 111. Suicide attempt 114. Tendinitis 117. Thyroid problems 120. Tonsillitis 123. Tuberculosis 126. Tumors/growths 129. Typhoid fever 132. Ulcers 135. Vaginal infections 138. Whooping cough 141. OTHER CONDITIONS _____ _____ | |

JOINT, MUSCLE, BONE SYMPTOMS (in the past year)

- | | | |
|--|--|---|
| 145. Entire body aches, painful to touch 148. Chronic pain 150. Bones sore and painful 152. Swollen joints 154. Tingling pain sensation 157. Muscle spasms 159. Muscle twitching 161. Muscle cramps 163. Leg cramps at night | 146. Leg cramps during activity 149. Calf muscles cramp while walking 151. Loss of muscle tone 153. Poor flexibility 155. Poor posture 158. Pinched nerve in low back 160. Muscle spasms in low back 162. Tightness in shoulder muscles | 147. Low back pain <input type="checkbox"/> aggravated by prolonged sitting <input type="checkbox"/> aggravated by prolonged standing <input type="checkbox"/> aggravated by heavy lifting 156. Low back <input type="checkbox"/> pain <input type="checkbox"/> stiffness or tightness <input type="checkbox"/> weakness |
|--|--|---|

JOINT, MUSCLE, BONE SYMPTOMS (in the past year)

- | | | |
|--|--|---|
| 164. Pain (specify on pain diagram) | 165. Neck | 166. Pins & needles or numbness |
| <input type="checkbox"/> buttocks | <input type="checkbox"/> weakness | <input type="checkbox"/> arm/hand/fingers |
| <input type="checkbox"/> hip | <input type="checkbox"/> pain | <input type="checkbox"/> hip/leg/foot |
| <input type="checkbox"/> along outside of leg | <input type="checkbox"/> stiffness | 167. Burning in: hands feet |
| <input type="checkbox"/> knee | <input type="checkbox"/> muscle spasms | 168. Loss of feeling in: hands feet |
| <input type="checkbox"/> ankle | <input type="checkbox"/> grinding/popping sounds | 169. Trembling hands |
| <input type="checkbox"/> foot/toes | <input type="checkbox"/> crink in neck on occasion | 170. Loss of grip strength |
| <input type="checkbox"/> big toe only | <input type="checkbox"/> pinched nerve sensation | 171. Middle back stiffness |
| <input type="checkbox"/> middle back | 172. Weakness | 173. Can't raise arm above shoulder level |
| <input type="checkbox"/> shoulder | <input type="checkbox"/> arm | 174. Can't raise arm over head |
| <input type="checkbox"/> left arm | <input type="checkbox"/> hand | 175. Pinched nerve sensation in shoulder |
| <input type="checkbox"/> upper arm | <input type="checkbox"/> fingers | 176. Cold hands |
| <input type="checkbox"/> right side under rib cage | <input type="checkbox"/> leg | 177. Cold feet |
| <input type="checkbox"/> left side under rib cage | <input type="checkbox"/> middle back | 178. Double jointed |
| <input type="checkbox"/> shoots from front to back | 179. Headaches | 180. Can dislocate shoulder or hip |
| <input type="checkbox"/> chest | <input type="checkbox"/> back of the head | 181. Get injured easily |
| <input type="checkbox"/> chest pain while walking | <input type="checkbox"/> temples | 182. Injuries heal slowly |
| <input type="checkbox"/> chest or back with deep breath in | <input type="checkbox"/> one-sided left right | 183. Bursitis/tenonitis |
| <input type="checkbox"/> between shoulder blades | <input type="checkbox"/> after eating | 183. Swelling of feet and ankles |
| <input type="checkbox"/> elbow | <input type="checkbox"/> migraine | 184. Limbs feel too heavy to hold up |
| <input type="checkbox"/> forearm | <input type="checkbox"/> relieved by eating sweets/alcohol | 185. Heaviness in legs |
| <input type="checkbox"/> hand | <input type="checkbox"/> during menstrual period | |
| <input type="checkbox"/> fingers | <input type="checkbox"/> sinus | |

GASTROINTESTINAL SYMPTOMS (in the past year)

- | | | |
|--|--|--|
| 186. Frequent/routine burping | 187. After eating ... | 188. Abdominal cramps |
| 189. Find it hard to burp | <input type="checkbox"/> Fatigue/sleepiness within 1-3 hrs | 190. Chronic abdominal pain |
| 191. Abdominal bloating | <input type="checkbox"/> Indigestion 1-3 hrs | 192. Lower bowel gas |
| 193. Sudden, acute indigestion | <input type="checkbox"/> Stomach pains better | 194. History of constipation |
| 195. Relief of symptoms with carbonated drinks | <input type="checkbox"/> Fullness for extended time | 196. Alternating constipation and diarrhea |
| 197. Stomach upsets easily | <input type="checkbox"/> Heartburn | 198. Diarrhea for more than 3-4 days |
| 199. Nausea with taking pills | <input type="checkbox"/> Calmer | 200. Seasonal diarrhea |
| 201. Butterfly sensations in stomach | <input type="checkbox"/> Craving not relieved | 202. Itching at or near anus |
| 203. Stomach pains | <input type="checkbox"/> Bloating, belching, or gas w/l 1 hr | 204. Mucous in stools |
| <input type="checkbox"/> when emotionally upset | 205. Poor appetite | 206. Bowel Movements |
| <input type="checkbox"/> made better by eating | 207. Eat all the time | <input type="checkbox"/> Less than 5 times per week |
| <input type="checkbox"/> increased by eating | 208. Eat good amount of meat | <input type="checkbox"/> 1-2 per day |
| <input type="checkbox"/> increased by stress with acidic foods | 209. Crave sweets | <input type="checkbox"/> 3 or more large bowel movements daily |
| 210. Certain foods make you sick | 211. Crave breads/bakery | 212. Hard, round, painful stools |
| 213. Intolerance to greasy food | 214. Thirsty all the time | 215. Red blood in stool |
| 216. Wake up in the night craving sweets | 217. Tired/weak if meal is missed | 218. Light (clay) colored stools |
| 219. Tend to snack between dinner & bed | 220. Irritable if a meal is missed | |
| 221. Feel like you'd collapse if went without food | 222. Black stools when not taking iron supplements | |

SKIN, HAIR, NAIL SYMPTOMS (in the past year)

| | | |
|---|---------------------------------------|--|
| 223. Toe and fingernail fungus | 224. Skin rashes | 225. Nails peel, crack, break easily |
| 226. Thick skin and finger nails | 227. Spider veins on nose and/or face | 228. Skin tags |
| 229. Grey colored skin | 230. Chronic leg sores | 231. Acne |
| 232. Puffy, wrinkly skin | 233. Get boils or sties | 234. Dry, flaky skin and/or dry brittle hair |
| 235. Bumpy skin on back of arms | 236. Poor wound healing | 237. Hair falls out |
| 238. Thinning/loss of outside portion of eyebrows | 239. Bruises easily | 240. Hair grows slowly |

EAR, EYE, NOSE, MOUTH SYMPTOMS (in the past year)

| | | |
|--|---------------------------------------|---|
| 241. Yellow in whites of eyes | 242. Ear infection | 243. Breathe through mouth |
| 244. Swollen (bulging) eyes | 245. Ear discharge or ears stuffed up | 246. Inflamed or bleeding gums |
| 247. Itchy eyes | 248. Ringing and/or buzzing in ears | 249. Cold sores, fever blisters |
| 250. Red or inflamed eyes | 251. Nasal congestion | 252. Sour taste in mouth |
| 253. Discharge from eyes | 254. Running nose | 255. Swollen tongue |
| 256. Watery eyes | 257. Itching of nose | 258. Bad breath |
| 259. Puffiness or dark circles under eyes | 260. Loss of smell | 261. Loss of taste |
| 262. Eyes sensitive to bright light | 263. Nose bleeds | 264. Itching of roof of mouth or throat |
| 265. Failing eyesight | 266. Mucous in throat | 267. Throat infections |
| 268. Loss of vision when standing suddenly | 269. Post nasal drip | 270. Difficulty swallowing |

KIDNEY, URINARY TRACT SYMPTOMS (in the past year)

| | | |
|---|--|--|
| 271. Frequent urination | 272. Dripping after urination | 273. Strong smelling urine |
| 274. Rarely need to urinate | 275. Painful/burning when passing urine | 276. Cloudy urine |
| 277. Urination when you cough or sneeze | 278. Difficulty urinating | 279. A sense of bladder fullness |
| 280. Wake up to urinate at night 1 2 3 4 5 | 281. Back leg pain associated with dripping after urination | 282. Increased straining with less urine passed |
| 283. Can't hold urine | 284. Rose colored (bloody) urine | 285. General water retention |

ENERGY, MOOD, MEMORY SYMPTOMS (in the past year)

| | | |
|---------------------------------------|--|--------------------|
| 286. Chronic fatigue | 287. Slurred speech | 288. Depression |
| 289. Trouble waking up in the morning | 290. Lack of mental alertness | 291. Hyperactivity |
| 292. Feel tired in the afternoon | 293. Poor concentration | 294. Impatience |
| 295. Feel weak and shaky | 296. Poor memory | 297. Moodiness |
| 298. Feel jittery | 299. Sugar causes irritability and mood swings | 300. Nervousness |
| 301. Convulsions | 302. Apathy | 303. PMS |

LUNGS, IMMUNITY SYMPTOMS (in the past year)

| | | |
|---|--------------------------|---|
| 304. Sensitive to exhaust fumes/smoke/smog, chemicals | 305. Severe cough | 306. Difficulty breathing |
| 307. Catch colds easily when weather changes | 308. Cough up blood | 309. Difficulty breathing at night |
| 310. Swollen lymph glands | 311. Coughing up phlegm | 312. Rattling mucous when you breath |
| 313. Slow to recover from colds or flu's | 314. Wheezing | 315. Infections tend to settle in lungs |
| 316. Catch colds or flu easily | 317. Sneezing | 318. Live or work around people who smoke |
| 319. Lung congestion | 320. Shortness of breath | 321. Regularly exposed to fumes |
| 322. Chronic cough | | |

CARDIOVASCULAR SYMPTOMS (in the past year)

| | | |
|--|-----------------------------------|-------------------------------------|
| 323. Heart pounds easily | 324. Rapid beating heart | 325. Feel energized from exercise |
| 326. Heart misses beats or has extra beats | 327. Regular Aerobic exercise? | 328. Exhaustion on slightest effort |
| 329. Heart flutters | 330. Ever exercised regularly? | 331. Blushing for no apparent cause |
| 332. Heart trouble | 333. Can't tolerate much exercise | |

SLEEP SYMPTOMS (in the past year)

| | | |
|----------------------------|---|---------------------------------------|
| 334. Intense dreams | 335. Restless leg at night | 336. Can't fall asleep |
| 337. Nightmares | 338. Restless uneasy sleeper | 339. Need for 10-12 hours sleep/night |
| 340. Never remember dreams | 341. Awake frequently throughout the night | 342. Night sweats |
| 343. Sleep walk | 344. Wake up at night, can't fall back to sleep | 345. Bedwetting |

MISCELLANEOUS SYMPTOMS (in the past year)

| | | |
|---|--|--------------------------------|
| 346. Body odor | 347. Gain weight easily | 348. Light headedness/fainting |
| 349. Cold sensitive | 350. Difficulty gaining weight | 351. Loss of balance |
| 352. Axillary (armpit) temperature below 97.6°F | 353. Overweight | 354. Uncoordinated |
| 355. Infertility | 356. Dizziness | 357. Accident prone |
| 358. Low, sex drive | 359. Dizziness or "headrush" on standing | 360. Head feels heavy |

Males only --- SYMPTOMS (in the past year)

| | |
|--|------------------------------------|
| 361. Ejaculation causes pain | 362. Pain/coldness in genital area |
| 363. Difficulty attaining/maintaining an erections | 364. Low sperm count |
| 365. Premature ejaculation | 366. Varicose veins on scrotum |

Females only --- SYMPTOMS (in the past year)

| | | |
|--|---|--|
| <i>Within 2 weeks prior to period</i> | 367. Monthly weight gain | 368. Suicidal feeling |
| 369. Depression | 370. Asthma attacks | 371. Headaches TENSION MIGRAINE |
| 372. Moodiness or irritability | 373. Low backache | 374. Leg cramps/tenderness |
| 375. Bloating and swelling | 376. Tender breasts | 377. Anxiety |
| 378. Nausea/vomiting | 379. Anger | 380. Easily distracted |
| <i>During period</i> | | |
| 381. Abdominal bloating | 382. Nausea and/or vomiting | 383. Low/no desire for sex |
| 384. Headaches | 385. Menstrual pain | 386. Dislike for intercourse |
| 387. Diarrhea | 388. Craving for sweets | 389. Missed periods |
| 390. Pelvic soreness | 391. Insomnia | 392. Vaginal itching |
| 393. Increased urinary frequency | 394. Light scanty blood flow | 395. Vaginal discharge |
| 396. Anxiety about menstrual cycle | 397. Pain and cramps without blood flow | 398. Dull ache radiating to low back or legs |
| 399. Must lie down on first and second day of period | 400. Pain during period progressively getting worse | 401. Heavy menstrual bleeding |
| <i>Not apparently related to period</i> | | |
| 402. Unable to get pregnant | 403. Pain in ovaries | 404. Hot flashes |
| 405. Dryness of skin, hair, and vagina | 406. Breasts are sore to touch all month | 407. Night sweats |
| 408. Uterine cysts | 409. Vaginal pain | 410. Vaginal bumps and sores |
| 411. Ovarian cysts | 412. Pubic area sore | 413. Vaginal itching |
| 414. Family history of breast cancer | 415. Painful intercourse | 416. Low abdominal pain |
| 417. Did not begin menstruating until over 15 years of age | | 418. PAP smear positive within last year |
| 419. Began menstruating at or before 10 years of age | | |

| Family History | | Vaccinations | |
|---|---|--|--------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Gestational Diabetes | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Mumps | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Substance abuse | <input type="checkbox"/> Rubella | <input type="checkbox"/> Diphtheria |
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Depression | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pneumonia/Flu-# of times ____ | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Varicose veins | | |

| Frame size | Ideal Weight | Ethnicity |
|--|--------------------------------------|---|
| <input type="checkbox"/> Small boned? | Lbs | <input type="checkbox"/> Caucasian |
| <input type="checkbox"/> Medium frame? | Circle Blood Type | <input type="checkbox"/> Asian |
| <input type="checkbox"/> Large frame? | <input type="checkbox"/> A positive | <input type="checkbox"/> African |
| Exercise | <input type="checkbox"/> A negative | <input type="checkbox"/> American Indian |
| <input type="checkbox"/> No exercise | <input type="checkbox"/> B positive | <input type="checkbox"/> Hispanic |
| <input type="checkbox"/> Very little exercise | <input type="checkbox"/> B negative | <input type="checkbox"/> Jewish |
| <input type="checkbox"/> 1-2 aerobic sessions per week | <input type="checkbox"/> O positive | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> 3-4 aerobic sessions per week | <input type="checkbox"/> AB positive | <input type="checkbox"/> Pacific Islander |
| <input type="checkbox"/> 5 or more aerobic sessions per week | <input type="checkbox"/> O negative | <input type="checkbox"/> Other (describe) _____ |
| <input type="checkbox"/> Cannot tolerate much exercise | <input type="checkbox"/> AB negative | |

Yes, I would significantly change my diet if it would improve my health.
 Yes, I am interested in optimal health.
 Yes, I would like to have more energy.
 Yes, I would like to lose weight.
 Yes, I know that everyone is different. I would be interested in knowing which foods strengthen and which foods weaken my body.

This section is entirely voluntary: The following questions are geared to help the doctor in evaluating where your beliefs are at spiritually. There is a connection between mind, body and spirit. Although the doctor is not a pastor, nor is he a psychologist, it is necessary for the doctor to evaluate your condition from every perspective to gain insight into what is going on and how best to help you.

Check those box(es) that describe your beliefs (as many as apply):

- I believe that there is a God/creator.
- I am a Christian (believe in Jesus Christ)
- I am a Muslim
- I am a Buddhist
- I am Jewish
- I am an atheist/agnostic (do not believe in a god)
- Other (please describe) _____

Which Church/synagogue/temple/mosque do you attend? _____ City _____

By signing below, I acknowledge the above to be true to the best of my knowledge.

Signature _____ Date _____ Doctor's Initials/date _____

Body Symptom Diagram

Name _____ Date _____

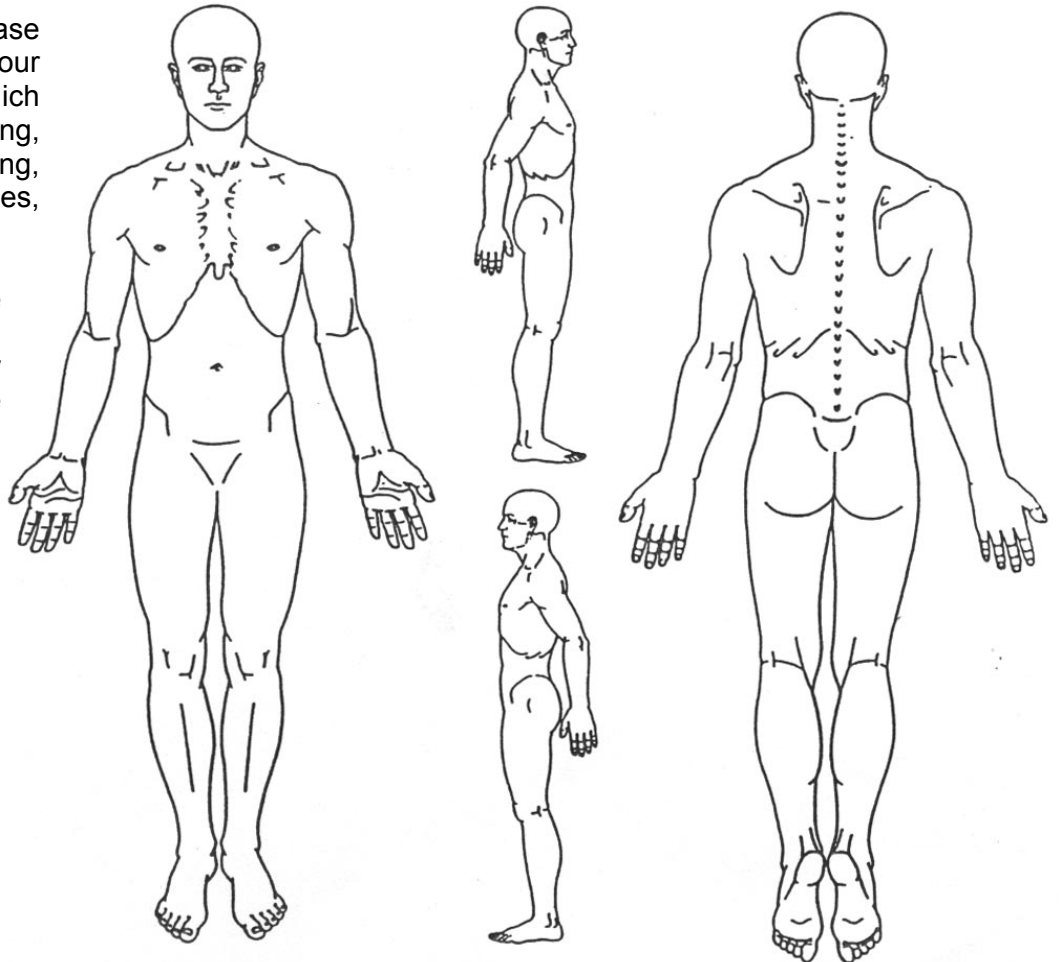
Describe the conditions you would like the doctor to address:

| | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

| | | | | |
|--|----|-------|----|-------|
| <p>On a 0-100 scale with 0 being no symptoms and 100 being the worst symptoms imaginable, please write the numbers in the box to the right (corresponding to the numbers above) indicating the level of symptoms (pain, fatigue, burning, indigestion, etc) for the conditions listed above.</p> | 1. | _____ | 5. | _____ |
| | 2. | _____ | 6. | _____ |
| | 3. | _____ | 7. | _____ |
| | 4. | _____ | 8. | _____ |

On the body diagram, please mark the areas of all your symptoms. Please note which symptoms are achy, burning, numb, stabbing, pounding, tingling, pins and needles, congested, itchy rash, etc.

(Placing the appropriate condition number noted above on the diagram below may help the doctor isolate the problem area better.)



Signature _____ Date: _____

Email newsletter opt-in request



Berglund Health & Wellness Center

- . Clinic promotions - stay updated on our lectures, events, etc.
- . Learn about health - receive Dr. Berglund's articles via email
- . New product updates - stay posted on which new natural products we carry
- . Website updates - information on our website, our blog, our forum, and our store

(hosted by Constant Contact)

sign me up!



The Truth Ministry

- . Missions & ministry updates - what's the Berglund family up to on the missions field?
- . Ministry events - information on local events hosted by The Truth
- . Trip reports - detailed reports and links to photos of recent missions trips

visit www.thetruthministry.net for more information

(hosted by Google Groups)

sign me up!

Name: _____

Email: _____

* You will always have the option to opt-out/unsubscribe

** We NEVER sell email addresses



"Like" us on Facebook

- Get daily articles, comments, discussions, and updates from Dr. Berglund via our Facebook page
- To "sign up", simply search for "Berglund Health & Wellness Center" and click "like"

If you'd like Dr. Berglund to "friend" you first and have us send you a "we suggest you like this page" link, please fill out the information below:

Name (as you have it listed on Facebook) _____

I would like Dr. Berglund to suggest his page to me after "friending" me on Facebook (check here):



5027 Green Bay Road, Suite 118 • Kenosha, WI • drb@berglundcenter.com • www.berglundcenter.com

Dr. Michael Berglund
PEDIATRIC & FAMILY PRACTICE

262.925.8600

RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name _____ Date ____/____/____

My signature on this form acknowledges that I have read and understood the Berglund Health & Wellness Center's Notice of Privacy Practices. I understand that this document provides and explanation of the ways in which my health information may be used or disclosed by Berglund Health & Wellness Center and of my rights with respect to my health information.

I have been provided with the opportunity to discuss any concerns I may have regarding the privacy of my health information.

Patient Signature _____
Date

If patient is unable to sign or is not of age to give proper authorization::

Representative Signature _____
Date

Name of Personal Representative _____

Relationship to Patient _____

Address _____

Home Phone # () _____ - _____

Work Phone # () _____ - _____

Patient is unable to sign because _____

I give permission for my personal health information TO BE RELEASED to my immediate family (spouse and/or parents) upon their request.

Patient Signature _____
Date

TO BE COMPLETED BY ADMITTING CLINICIAN IF FORM IS NOT SIGNED

1. Was patient provided with a copy of the Notice of Privacy Practices? YES NO

2. Briefly describe efforts made to obtain patient's acknowledgement of receipt of the Notice and explain why the patient did not sign this form: _____



BERGLUND

Health & Wellness Center

5027 Green Bay Road, Suite 118 • Kenosha, WI • drb@berglundcenter.com • www.berglundcenter.com

Dr. Michael Berglund
PEDIATRIC & FAMILY PRACTICE

262.925.8600

Notice of Privacy Practices

Berglund Health & Wellness Center

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. USE AND DISCLOSURE OF HEALTH INFORMATION

Berglund Health & Wellness Center (BH&WC) may use your health information (information that constitutes protected health information as defined by the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the purposes stated below. BH&WC have established a policy to guard against unnecessary disclosure of your health information.

Your health information may be used to: **Provide Treatment:** BH&WC may use your health information to provide care to you and disclose your health information to others who provide care for you. For example, physicians involved in your care will need information about your symptoms in order to prescribe appropriate medications. BH&WC may also disclose your health care information to individuals outside of the provider involved in your care including family members, pharmacists, suppliers of medical equipment or other health professionals.

Obtain Payment: BH&WC may include your health information in invoices to collect payment from third parties for the care you receive. For example, BH&WC may be required by your health insurance to provide information regarding your care in order to reimburse you and/or BH&WC. In addition, BH&WC may need to explain your need for health care and the services that will be provided to you in order to obtain prior approval from your insurance.

Conduct Health Care Operations: BH&WC may use and disclose health information for its own operations in order to facilitate the function of BH&WC and as necessary to provide quality care to all of our patients. Health care operations include activities such as:

Quality assessment and improvement activities: • Activities designed to improve health or reduce health care costs.

- Protocol development, case management, and care coordination.
- Contacting health care providers and patients with information about treatment alternatives and
- other related functions that do not include treatment.
- Professional review and performance evaluation.
- Training programs including those in which students, trainees, or practitioners in health care learn under supervision.
- Training of non-health care professionals.
- Accreditation, certification, licensing or credentialing activities.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses formulary development.
- Business management and general administrative activities of BH&WC.
- Certain marketing activities for BH&WC.

For example, BH&WC may use your health information to evaluate its staff performance, combine your health information with other BH&WC patients in evaluating how to more effectively serve all of their patients, disclose your health information to BH&WC staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you or your family as part of general fundraising and community information mailings (unless you do not want to be contacted).

For facility directory:

BH&WC may disclose certain information about you including your name, general health status, and where you are located in a facility directory while you are in the facility. Provider may disclose this information to people who ask for you by name. If you do not want BH&WC to include your information in the directory, you must notify the clinic at 262-925-8600.

For appointment reminders:

BH&WC may use and disclose your health information to contact you as a reminder that you have an appointment for treatment or care with BH&WC.

For treatment alternatives:

BH&WC may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

When legally required:

BH&WC will disclose your health information when it is required to do so by any Federal, State, or Local law.

When there are risks to public health:

BH&WC may disclose your health information for the following public activities and purposes:

- To prevent or control disease, injury or disability, report disease, injury, vital events such as birth or death and the conduct of public health surveillance, investigations and interventions.
- To report adverse events, product defects, to track products or enable product recalls, repairs, and replacements of the Food and Drug Administration.
- To notify a person who has been exposed to communicable disease or who may be at risk of contracting or spreading a disease.
- To an employer about an individual who is a member of the workforce as legally required.

To report abuse, neglect, or domestic violence:

BH&WC are allowed to notify government authorities if BH&WC believes the patient is a victim of abuse, neglect, or domestic violence. BH&WC will make this disclosure only when specifically required or authorized by law or when the patient agrees to the disclosure.

To conduct health oversight activities:

BH&WC may disclose your health information to a health oversight agency for activities including: audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary action. BH&WC, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of and is not directly related to your receipt of health care or public benefits.

In connection with judicial and administrative proceedings:

As permitted or required by State law, BH&WC may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when BH&WC makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For law enforcement purposes:

As permitted or required by State law, BH&WC may disclose your health information to a law enforcement official for certain law enforcement purposes, including, under certain limited circumstances, if you are a victim of a crime or in order to report a crime.

In the event of a serious threat to health or safety:

BH&WC may, consistent with applicable law and ethical standards of conduct, disclose your health information if BH&WC in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health or safety of the public.

For specified government functions:

In certain circumstances, the Federal regulations authorize BH&WC to use or disclose your health information to facilitate specified government functions relating to the military and veterans, national security and intelligence activities, protective services for the President and others, medical suitability determinations and inmates and law enforcement custody.

For worker's compensation:

BH&WC may release your health information for worker's compensation or similar programs.

AUTHORIZATION TO US OR DISCLOSE HEALTH INFORMATION

Other than the circumstances described in the preceding examples, any other use or disclosure of your health information will only be made with your written authorization. If you or your representative authorizes BH&WC to use or disclose your health information, you may revoke that authorization in writing at any time. You may be unable to revoke your authorization for health information that has already been released before your request to revoke authorization is received, or if you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights with respect to your health information that BH&WC maintains:

- **Right to request restrictions:** You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on BH&WC disclosure of your health information to someone who is involved in your care or payment of your care. However, BH&WC are not required to agree to your request. If you wish to make a request for restrictions, please contact the office at 262-925-8600.
- **Right to receive confidential communications:** You have the right to request that BH&WC communicates with you in a certain way. For example, you might ask that BH&WC only conduct communications pertaining to your health information with you privately with no other family members present. If you wish to receive confidential communications, please contact the office at 262-925-8600.
- **Right to inspect and copy your health information:** You have the right to inspect and copy your health information, including billing records. A request to inspect and copy records containing your health information may be made to the office at 262- 925-8600. If you request a copy of your health information, BH&WC may charge you a reasonable fee for copying and assembling costs associated with your request.
- **Right to amend your health information:** You or your representative have the right to request that BH&WC amend your records, if you believe your health information records are incorrect or incomplete. That request may be made as long as the information is maintained by BH&WC. A request for an amendment of records must be made in writing to the office. BH&WC may deny the request if it is not in writing or does not include a reason for the amendment. The request also may be denied if your health information records were not created by BH&WC, if the records your are requesting are not part of BH&WC records, if the health information you wish to amend is not part of the health information you or your representative are permitted to inspect and copy, or if, in the opinion of BH&WC, the records containing your health information are accurate and complete.
- **Right to an accounting:** You or your representative have the right to request an accounting of disclosures of your health information made by BH&WC for certain purposes authorized by law and certain research. The request for an accounting must be made in writing to Drs. Michael or Eileen Berglund, 5027 Green Bay Road, #118, Kenosha, WI 53144. Accounting requests may not be made for periods of time in excess of six (6) years. Accounting requests will be subject to a reasonable cost-based fee.
- **Right to a paper copy of this Notice:** You or your representative have a right to a separate paper copy of this Notice at any time even if you or your representative have received this Notice previously. To obtain a separate paper copy, please contact either of the doctors at 262-925-8600.

DUTIES OF BH&WC

BH&WC are required by law to maintain the privacy of your health information and to provide you and your representative this Notice of its duties and privacy practices. BH&WC are required to abide by the terms of this Notice and to make the new Notice provisions effective for all health information that it maintains. If BH&WC makes a material change to this notice, they will provide a copy of the revised **Notice to you or your appointed representative**. You or your representative have the right to express complaints to BH&WC and the Secretary of Health and Human Services if you or your representative

believe that your privacy rights have been violated. Any complaints to BH&WC should be made in writing to 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. BH&WC encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

CONTACT PERSON

BH&WC has both Drs. Eileen and Michael Berglund as their contact individuals for all issues regarding patient privacy and your rights under the Federal privacy standards. If you have any questions regarding this Notice or your rights, please contact him at: 5027 Green Bay Road, Suite #118; Kenosha, WI 53144-1771. Phone number: 262-925-8600

EFFECTIVE DATE

This Notice has been effect since October 18, 2004.



Office policies

Patients: Please read carefully, sign, and date. Check off each item that has been read.

Payment options

- If you choose to be a cash patient, we offer a 50% “same day cash” discount. This means that if you pay for your office visit on the SAME DAY as your appointment (with cash, a check, or a credit/debit card), you will receive the discount. If you do not pay for your services on the same day, or you choose to go on a payment plan, you will be billed for the full 100% of that day’s charges.
- Dr. Berglund is an out-of-network provider for all types of insurance except for Medicare and Title I 9/Medicaid/Forward Card. We will be happy to verify your benefits ahead of time, but the verification is not a guarantee of benefits. You will be required to pay for anything your insurance does not cover once your claim is processed. If you choose to be an insurance patient ONLY, our office and billing company will take care of 100% of the insurance billing process. We require payment for deductibles and copays on the same day of service.
- Patients also have the option of taking the 50% “same day cash” discount, getting a printed receipt from our front desk, and then submitting the charges to their insurance company on their own. The benefit is that you are guaranteed at least a 50% discount, in addition to whatever your insurance might pay. The drawback is that you need to submit your own claims. Our office will be more than happy to supply you with a printed receipt with charges, CPT codes, and diagnosis codes, but we are unable to do any insurance processing after this point.

Missed appointments

- Reminder calls are just a courtesy provided by this office. Although we try to remind our patients every time they are scheduled, it is not guaranteed that you will receive a reminder call. It is your responsibility to remember your appointment on the day it is scheduled. If you do not show up for your appointment without notifying us ahead of time, you will be charged a \$20 no show fee.
- Medicare and Medicaid patients can not be charged the \$20 no show fee. However, they will be limited to three “no show” visits every 12 months, starting with the date of their first “no show”. After the 3rd no show visit has been reached, that patient will no longer be able to see Dr. Berglund until one year after the date of the first “no show”.

Supplements

- We offer a 10% discount on in-house supplement refills. (Exceptions apply on a handful of supplements where the retail price has already been reduced.) If you need us to ship supplements to you, we will be more than happy to. However, the 10% discount does not apply if they are shipped. The refill discount also does not apply on “novelty” retail items, such as candy, gum, mixes, bars, cleaning products, etc.
- We require payment for supplements on the same day they are purchased. If you want us to put supplements on hold for you, we will hold them for up to one week. Supplements that have not been purchased after one week will be re-stocked.

- If you need a particular supplement, please call ahead to be sure that we have it in stock, and that our office is open. Please respect Dr. Baertlien's time at our clinic. If you need to pick up supplements, please pick them up during Dr. Berglund's hours.

Bringing children to appointments

- We do provide a room and video player for children. However, please do not expect the staff to "baby-sit" your kids. If you know your kids require supervised attention, it may be best to take them in the treatment room with you, or leave them at home or somewhere where they can be continually supervised. Please be sure that your children clean up after themselves and turn the lights off when they are done using the kids' room.

Handling questions for Dr. Berglund

- We like to keep the friendly and relaxed atmosphere at Berglund Health & Wellness Center. Please, however, respect the boundaries of Dr. Berglund and his staff. Dr. Berglund's office, the area behind the front desk, staff computers & screens, and our supplement closet are off-limits to patients. If you have a question for Dr. Berglund, please ask the front desk and they will gladly assist you.
- If you are at home and have a question for Dr. Berglund ("How often should I take this supplement?", "Was I supposed to use ice or heat?", etc.), please email him at drb@berglundcenter.com, and he will respond to you as soon as he is able. Dr. Berglund does not call patients or return phone calls. If you have a list of questions that involve more detail, please call our office to schedule an appointment. If you do not have internet access, please call our office with your question and talk to our staff. They will talk to Dr. Berglund and call you back as soon as they are able.
- As Dr. Berglund's schedule has become busier, he will no longer be able to just check you on "just a few supplements" without an office visit. His scheduled patients take priority. If you need him to check you on supplements or food, please schedule an appointment to guarantee that Dr. Berglund can give you his complete attention.

Courtesy toward other patients

- Please be courteous to our patients with allergies. When you come in for your appointment, please refrain from wearing perfumes, colognes, or scented lotions. Please also refrain from smoking before coming in. We have many patients who are extremely sensitive to particular scents and chemicals, and these types of products can trigger allergic reactions.

I have read, understand, and agree to the office policies at Berglund Health & Wellness Center.

Patient Signature

Date

Staff Signature

Date