Confidential Patient Information

Last Name _____ First Name _____ MI ___

Appointment Date
/ /20___

What name would you like the staff to call you? _____

Address _____

City _____ State _____ Zip _____

Date of Birth	Social Security Number
/ /	- -

Gender	Age	Height	Weight
M F			

Marital Status	Name of Spouse (last name if different)
S M W D	

Phone$_1$: Home Work Cell	Phone$_2$: Home Work Cell	Phone$_3$: Home Work Cell

Spouse's Occupation

Email address _____

Occupation _____

Employer/School Attending _____

Spouse's Employer

Names of Children

Appointment Reminder

We like to help make your appointments here by reminding you. We've found for most people the best way to do this is by texting. By default, we will text you a reminder of your appointment via text the day before your appointment to the cell phone you list above.

- ❑ Absolutely. Great idea. I'd love to get text reminders.
- ❑ I do not wish to have text reminders. I want my reminders as voice calls to this phone _____.

Physician Names

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

- ❑ Friend Name _____
- ❑ Coworker Name _____
- ❑ Relative Name _____
- ❑ Health Care Professional Name _____
- ❑ Lecture Where? _____
- ❑ Google search
- ❑ Clinic Website
- ❑ Facebook
- ❑ Radio show
- ❑ Dr. Berglund's book
- ❑ Know through Church
- ❑ Know through homeschool
- ❑ Other source not listed above _____

_____

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 & 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/orthotics and nutritional supplies and laboratory tests are not covered services/products and you will be asked to pay for them on each visit.

Payment options:
cash
personal check
debit card
MC
VISA
Discover

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?
❑ MEDICAL DOCTOR
❑ CHIROPRACTOR
❑ PHYSICAL THERAPIST
❑ ACUPUNCTURIST
❑ MASSAGE THERAPIST
❑ OTHER _____

Do they interfere with	Symptoms worse in:	Painful/difficult activities?
❑ WORK	❑ MORNING	❑ WALKING
❑ SLEEP	❑ MIDDAY	❑ BENDING
❑ DAILY ROUTINE	❑ NIGHT	❑ LYING DOWN
❑ RECREATION	❑ COLD and/or RAINY WEATHER	❑ LIFTING ☐ 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)

_____

_____

_____

Berglund Health & Wellness Center – 5027 Green Bay Road; Suite #118 - Kenosha, WI 53144-1771 – 262.925-8600

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.

Current Age _____

Male Female

Drink soft drinks? YES NO If yes…

- ❑ less than once per week
- ❑ 1-3 drinks per week
- ❑ 1-2 drinks per day
- ❑ 3-5 drinks per day
- ❑ >5 drinks per day

REGULAR NUTRASWEET SPLENDA

Have you ever smoked? YES NO

If YES, how many years _____

Do you currently smoke? YES NO

Did you quit? NO YES When _____.

(current/past smokers circle one below)

- ❑ 1/2 pack/day
- ❑ 1 pack/day
- ❑ 2 or more packs/day
- ❑ Other _____

Alcohol consumption (if yes, check one below)

- ❑ less than once per week
- ❑ 1-3 drinks per week
- ❑ 1-2 drinks per day
- ❑ 3-5 drinks per day
- ❑ >5 drinks per day

I drink _____ cups of coffee per day.

❑ Need/like to drink coffee/soda to get started.

Current drugs use:

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

_____

_____

_____

_____

27. Take multivitamin (name)

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)
    - ❑ Saline
    - ❑ Silicone
52. Knee replacement
53. Tonsillectomy
54. Knee surgery
55. Tubes in ears
56. Laminectomy
57. Tubes tied (fallopian)
58. Bypass surgery
59. Laporscopy
60. Vasectomy
61. Cancer
62. Lung removed
63. OTHER SURGERY (list)

_____

_____

64. Carpal tunnel surgery
65. Malignant tumors

Berglund Health & Wellness Center – 5027 Green Bay Road; Suite #118 - Kenosha, WI 53144-1771 – 262.925-8600

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

66. ADD/ADHD
69. Alcoholism
72. Allergies
- ❑ animal
- ❑ dust
- ❑ food
- ❑ grass
- ❑ mold
- ❑ pollen
- ❑ ragweed
- ❑ other

_____

_____

92. Anemia
- ❑ helped by taking iron
- ❑ 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
67. Emphysema
70. Epilepsy
73. Eczema
75. Fibromyalgia
77. Fractures
79. Frequent colds/flus
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 #____
- ❑ number of vaginal births #____
- ❑ number of caesarian births #____
- ❑ 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
- ❑ cigarette smoke
- ❑ exhaust
- ❑ food
- ❑ gas
- ❑ perfume/cologne
- ❑ other (list)

_____

_____

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
- ❑ aggravated by prolonged sitting
- ❑ aggravated by prolonged standing
- ❑ aggravated by heavy lifting

156. Low back
- ❑ pain
- ❑ stiffness or tightness
- ❑ weakness

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

164. Pain (specify on pain diagram)
- ❑ buttocks
- ❑ hip
- ❑ along outside of leg
- ❑ knee
- ❑ ankle
- ❑ foot/toes
- ❑ big toe only
- ❑ middle back
- ❑ shoulder
- ❑ left arm
- ❑ upper arm
- ❑ right side under rib cage
- ❑ left side under rib cage
- ❑ shoots from front to back
- ❑ chest
- ❑ chest pain while walking
- ❑ chest or back with deep breath in
- ❑ between shoulder blades
- ❑ elbow
- ❑ forearm
- ❑ hand
- ❑ fingers

165. Neck
- ❑ weakness
- ❑ pain
- ❑ stiffness
- ❑ muscle spasms
- ❑ grinding/popping sounds
- ❑ crink in neck on occasion
- ❑ pinched nerve sensation

172. Weakness
- ❑ arm
- ❑ hand
- ❑ fingers
- ❑ leg
- ❑ middle back

179. Headaches
- ❑ back of the head
- ❑ temples
- ❑ one-sided left right
- ❑ after eating
- ❑ migraine
- ❑ relieved by eating sweets/alcohol
- ❑ during menstrual period
- ❑ sinus

166. Pins & needles or numbness
- ❑ arm/hand/fingers
- ❑ hip/leg/foot

167. Burning in: hands feet

168. Loss of feeling in: hands feet

169. Trembling hands

170. Loss of grip strength

171. Middle back stiffness

173. Can't raise arm above shoulder level

174. Can't raise arm over head

175. Pinched nerve sensation in shoulder

176. Cold hands

177. Cold feet

178. Double jointed

180. Can dislocate shoulder or hip

181. Get injured easily

182. Injuries heal slowly

183. Bursitis/tendonitis

183. Swelling of feet and ankles

184. Limbs feel too heavy to hold up

185. Heaviness in legs

GASTROINTESTINAL SYMPTOMS (in the past year)

186. Frequent/routine burping

187. After eating …
- ❑ Fatigue/sleepiness within 1-3 hrs
- ❑ Indigestion 1-3 hrs
- ❑ Stomach pains better
- ❑ Fullness for extended time
- ❑ Heartburn
- ❑ Calmer
- ❑ Craving not relieved
- ❑ Bloating, belching, or gas w/I 1 hr

188. Abdominal cramps

189. Find it hard to burp

190. Chronic abdominal pain

191. Abdominal bloating

192. Lower bowel gas

193. Sudden, acute indigestion

194. History of constipation

195. Relief of symptoms with carbonated drinks

196. Alternating constipation and diarrhea

197. Stomach upsets easily

198. Diarrhea for more than 3-4 days

199. Nausea with taking pills

200. Seasonal diarrhea

201. Butterfly sensations in stomach

202. Itching at or near anus

203. Stomach pains
- ❑ when emotionally upset
- ❑ made better by eating
- ❑ increased by eating
- ❑ increased by stress with acidic foods

204. Mucous in stools

205. Poor appetite

206. Bowel Movements
- ❑ Less than 5 times per week
- ❑ 1-2 per day
- ❑ 3 or more large bowel movements daily

207. Eat all the time

208. Eat good amount of meat

209. Crave sweets

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)

Within 2 weeks prior to period		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
During period					
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
Not apparently related to period					
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	
❑ Diabetes	❑ Heart Disease	❑ Measles	❑ Hepatitis B
❑ Gestational Diabetes	❑ Alcoholism	❑ Mumps	❑ Polio
❑ Hypoglycemia	❑ Substance abuse	❑ Rubella	❑ Diphtheria
❑ Food allergies	❑ Depression	❑ Chicken Pox	❑ Pertussis
❑ Cancer	❑ Migraine headaches	❑ Pneumonia/Flu-# of times ___	❑ Tetanus
❑ Stroke	❑ Varicose veins		

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

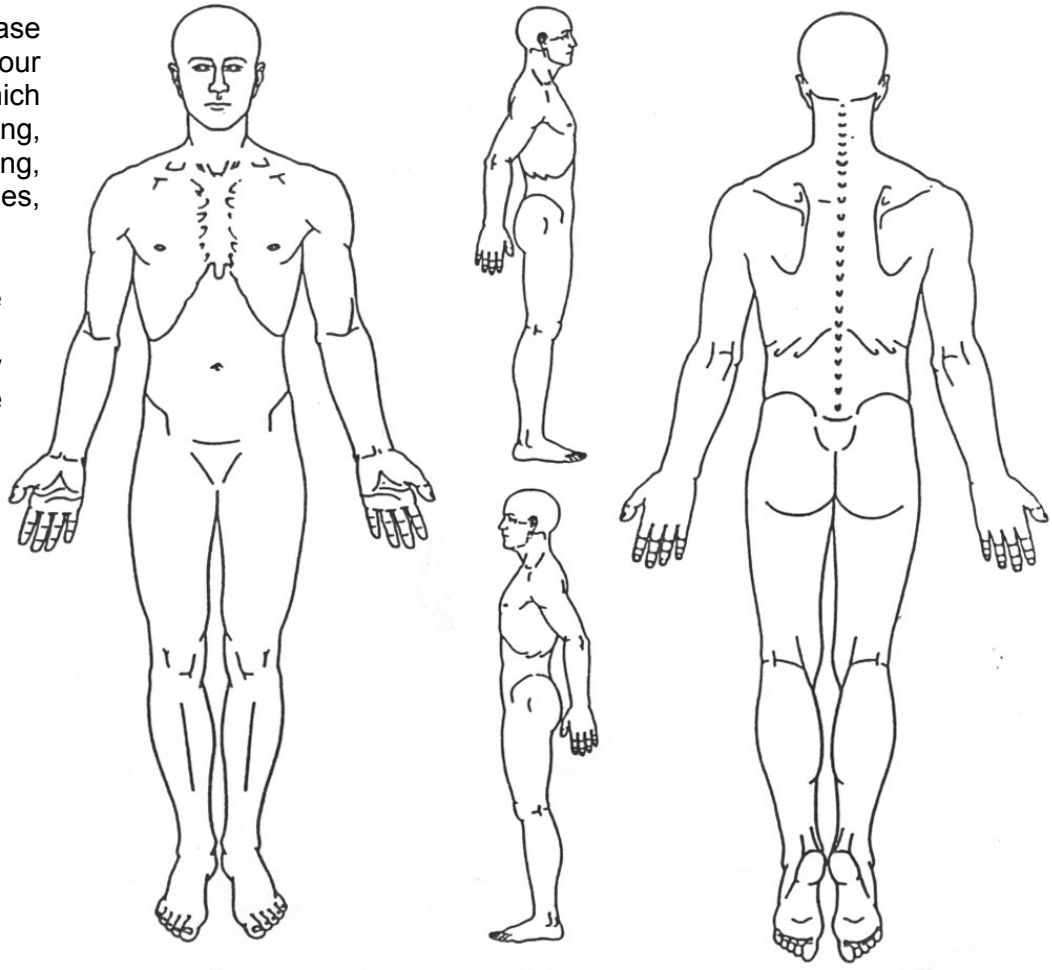
Describe the conditions you would like the doctor to address:

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

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.	1. _____ 2. _____ 3. _____ 4. _____	5. _____ 6. _____ 7. _____ 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: _____

Berglund Health & Wellness Center

Patient Goals

In order of importance, what do you hope to achieve by coming to Berglund Health & Wellness Center?
(e.g. “help me get rid of low back pain,” or “get me so I’m not so tired.”) Use as many spaces as you need.

1. _____

2. _____

3. _____

4. _____

Doctor’s Goals ---------- **(patients, please don’t write below this line)** ----------

1.

2.

3.

4.

- ❑ bfood
- ❑ f-food
- ❑ act cmt C T L S P
- ❑ cmt C T L S P
  - antC
  - seatedC
  - antT
  - dropLS
  - sl-LS
  - standing T
- ❑ xcmt
  - 1st rib R L
  - ribs
  - knees R L
  - ankles R L
  - elbows R L
  - wrists R L
  - shoulders R L
  -
- ❑ cranial O P T F
- ❑ soft tissue massage
- ❑ pulse oximetry

consultation
- ❑ weight loss
- ❑ exercise
- ❑ stretches

Exam
1 2 3 4 5

CMT12 CMT34 XCMT

Food test

urinalysis blood test

B-draw
- ❑ chem
- ❑ lipid _____
- ❑ cbc
- ❑ LDH
- ❑ SGPT (ALT)
- ❑ Ferritin
- ❑ Iron
- ❑ ESR
- ❑ crp
- ❑ GGTP
- ❑ Fibringoen
- ❑ Homocysteine
- ❑

Weakness
- ❑ Thyroid
- ❑ Heart
- ❑ Lungs
- ❑ Stomach
- ❑ Spleen
- ❑ Liver
- ❑ Gall bladder
- ❑ Intestines
- ❑ Kidneys R L
- ❑ Ovary R L
- ❑ Testicle R L

History notes

Screen
- ❑ allergy/sensitivity (sa/s)
- ❑ chiropractic (schiro)
- ❑ biochemistry (sbio)

Reaction
- ❑ See food sheet

More	Less	checklist

Height	Weight	Body Fat	Oxygen Saturation	Heart Rate	blood pressure	Respirations	Temp
in	lbs	%	%	bpm	right / left /	rpm	‘F

BERGLUND
HEALTH & WELLNESS CENTER

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: _____

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 my 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.

BERGLUND
HEALTH & WELLNESS CENTER

Dr. Michael Berglund, DC, DABCI
pediatric & family practice • natural approach

Office Policies

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

Payment Options

☐ The only insurances that Dr. Berglund accepts is Medicare and Medicaid (T19/Forward/Badger Care). These government sponsored insurances will only cover spinal manipulation. If you are coming in for something other than classic chiropractic care, those services can be provided but it will need to be paid in full by the patient. If you'd like to see if your insurance will pay for Dr Berglund's services, we can print you out a receipt that will show the proper codes needed so that you can submit the claim to your own insurance.

Missed Appointments

☐ Reminder calls & texts 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 or text from us. Ultimately, it is your responsibility to remember your appointment on the day/time 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 cannot be charged the $20 no show fee. However, they will be limited to three "no show" visits per 12 months starting with the date of their first "no show". After the third no show visit has been reached, that patient will no longer be able to see Dr. Berglund for 12 months following the date of the first "no show".

Supplements

☐ We require payment for supplements on the same day they are purchased. If you'd like us to put supplements on hold for you, we will hold them for up to one week. After that, the supplements will no longer be held for you.

☐ If you need a particular supplement, please call ahead to make sure we have it in stock and that our office is open.

Courtesy toward other patients

☐ Please refrain from wearing perfumes, colognes, scented lotions and essential oils. Also, please refrain from smoking before coming in. The reason we have this rule is to be sensitive to our patients with asthma/allergies/migraine headaches that might experience serious reactions as a result of these types of scents/chemicals.

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

_____ _____

5027 Green Bay Road, Ste. 118 • Kenosha, WI 53144
www.berglundcenter.com • drb@berglundcenter.com