Print Clear Form

absolute health
8360 E. Raintree Dr., Suite 135
Scottsdale, AZ 85260
(480) 991-9945 Phone
(480) 948-3204 Fax

Biofeedback – Health & History Assessment

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____ Zip Code _____

Telephone: Home _____ Cell _____ Work _____

Date of Birth _____ Age _____ Email Address _____

Employer _____ Occupation _____

Emergency Contact Name _____Ph Number(s) _____Relation_____

How did you hear about Absolute Health? _____

Please circle: Female or Male Please circle: Married Divorced Separated Single Widowed

Name of spouse _____ Spouse's Date of Birth _____

Children's Names and Birth Dates:

_____ _____

_____ _____

_____ _____

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Please answer all questions below:

1.	# of organs removed (all teeth = 1)		11.	Personal Stress (Scale of 0-10) 0=NONE 10=MAX	
2.	# of prescription drugs		12.	# Sugar products consumed daily	
3.	# of cigarettes per day		13.	# Exercise sessions/wk - 20 min. each	
4.	# of steroid drugs		14.	# Alcoholic beverages consumed daily	
5.	# of metal dental fillings		15.	# Caffeine products consumed daily	
6.	# of street drugs		16.	# Extreme toxic exposures/year	
7.	# of allergies		17.	# Major traumatic injuries/life (Mental, emotional, physical, accidents, etc)	
8.	# of unresolved mental factors (grief, sadness, anger, greed, etc)		18.	# Major infections	
9.	I am responsible for my body (Scale of 0-10) 0=NO 10=YES		19.	# Glasses of 8 oz water daily	
10.	% of fat in diet (Average is 45%)		20.	# Pounds overweight (that YOU feel)	

Client History and Disclaimer

Please check if you have had or have been told by a medical doctor that you have any of the following:

☐ Aids / HIV
☐ Alcoholism
☐ Allergy Shots
☐ Anemia
☐ Anorexia
☐ Appendicitis
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Breast Lumps
☐ Bronchitis
☐ Bulimia
☐ Cancer
☐ Cataracts
☐ Chemical Dependency
☐ Depression
☐ Diabetes
☐ Emphysema
☐ Epilepsy
☐ Fractures
☐ Glaucoma
☐ Goiter
☐ Gout
☐ Heart Disease
☐ Hepatitis
☐ Hernia
☐ Herniated Disc
☐ Herpes
☐ High Cholesterol
☐ Kidney Disease
☐ Liver Disease
☐ Measles
☐ Migraine Headaches
☐ Mononucleosis
☐ Multiple Sclerosis
☐ Osteoporosis
☐ Pacemaker
☐ Parkinson's
☐ Pinched Nerve
☐ Pneumonia
☐ Polio
☐ Prostate Problems
☐ Psychiatric Care
☐ Rheumatoid Fever
☐ Scarlet Fever
☐ Stroke
☐ Thyroid Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcers
☐ Other
_____
_____
_____

Family History: Please indicate if any family members have had any of the following and if so, who:

☐ Diabetes _____
☐ Hypertension _____
☐ Stroke _____
☐ Alcohol Problems _____
☐ Mental/ Emotional Problems _____
☐ Heart Disease _____
☐ Hepatitis /Liver Disease _____
☐ Cancer _____
☐ Congenital Problems _____
☐ Other _____

Please describe any concerns and your objectives in seeking a L.I.F.E. Biofeedback Wellness Session:

_____
_____
_____
_____
_____

I understand that the attending Biofeedback Technician is not an allopathic doctor (M.D.) and does not portray herself/himself to be, but is providing biofeedback and wellness services. I understand that the services provided identify energetic imbalances. Procedures utilized include stress reduction protocols and biofeedback wellness consultation. I fully understand that the attending Biofeedback Technician does not offer allopathic drugs, surgery, chemical stimulants or any other conventional treatments. In addition, she/he does not diagnose, treat, or otherwise prescribe for my disease, conditions or illness, or perform any act that would constitute the practice of medicine for which a license is required. I have solicited the attending Biofeedback Technician's services in good faith, exercising my free will and following dictates of my own conscience which allows me to select what I understand is most beneficial to my health. I am fully aware and release the Biofeedback Technician to do biofeedback testing, wellness consultation and other stress reduction protocols. The clinic has a 24-hour cancellation policy. Late cancellations or no-shows will incur a charge of $35.00.Please arrive 10 minutes prior to your appointment time. Late arrivals may be rescheduled and will incur a charge of $35.00. Payment is due at the time services are rendered. By signing below, I acknowledge that I have read and understand all parts of this waiver and that I have had the opportunity to ask questions with regard to the described procedures, and that I hereby affirm: I am not here for medical diagnostic or treatment procedures and that I am here on this, and any subsequent visit, solely on my own behalf.

Signature _____ Date _____

Absolute Health Sara Mancuso, DC / Elizabeth De La Torre Hogan, NMD

Patient Name: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient or Representative Date

_____
Printed Name

Informed Consent for Chiropractic Care

8360 E Raintree Dr.
Suite 135
Scottsdale, AZ 85260
480-991-9945 Office
480-948-3204 Fax

Chiropractic care, like all forms of health care, offers considerable benefit. Effective chiropractic treatment, when delivered professionally, includes some level of risk. Most often, this level of risk is very minimal, though in rare cases, chiropractic care has led to injury. The types of complications that have been reported, secondary to chiropractic care, include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One complication associated with chiropractic care is a vertebral artery injury. Though the occurrence of this is very uncommon (happening at a rate between one instance per million, to one per two million cervical spine/neck adjustments), vertebral artery injury could lead to stroke.

Prior to receiving chiropractic care in this office, a health history and physical examination will be completed. These procedures are to be performed to assess your specific condition, your overall health, and in particular, your spine health. These procedures will assist us in determining if chiropractic care is needed, or if any further examination or studies are needed. In addition, these examinations will help us to determine if there is any reason to modify your care, or provide you with a referral to another health care professional. All relevant findings will be reported to you along with a care plan prior to beginning care.

By signing below, you attest that you have read this form, and accept that there are risks associated with chiropractic care. You further give your consent to examinations that the doctor deems necessary, and to chiropractic care, including spinal adjustments, as reported in your initial assessment.

_____ _____

Patient Signature Parent or Legal Guardian Signature

_____ _____

Patient Name (printed) Relationship to Patient

_____ _____

Witness Signature (office staff) Date

Notice of Privacy Practices for Protected Health Information (PHI)

By signing below, I acknowledge having read, and understand the notice of HIPAA regulations upheld by Absolute Health and those affiliated in conducting business with Absolute Health. I understand a physical copy will be given to me at my request.

_____ _____

Patient or Parent/Guardian Signature Date

Absolute Health
8360 E. Raintree Drive, Suite 135
Scottsdale, AZ 85260
Phone 480-991-9945
Fax 480-948-3204

MEDICAL RECORDS RELEASE

Patient's Name: _____

Date: _____

DOB: _____

Phone Number: _____

I hereby authorize you to release to/from ABSOLUTE HEALTH LLC all medical records and information including the diagnosis and records of treatment or examination rendered to me.

Sensitive Information: I understand that this may include information relating to:

- Acquired Immunodeficiency Syndrome (AIDS) or infection with human immunodeficiency virus (HIV)
- Behavioral health services, psychiatric care, mental health treatment
- Sexually transmitted diseases
- Diagnosis/treatment for alcohol and/or drug abuse
- Information for research purpose
- Blood Work

Date: _____ ***Patient/Insured Signature:*** _____

Date: _____ ***Staff Signature:*** _____