

Bender Chiropractic Health and Vitality Center
NEW PATIENT INFORMATION FORM

Page 1 of 2

Please print clearly:

Name _____ Date _____

Address _____ Apt.# _____

City _____ State _____ ZIP _____

Shipping Address _____

Home Phone (____) ____ - _____ Cell Phone (____) ____ - _____

e-mail address: _____

REFERRED BY: _____

Occupation _____ Employer _____

Date of Birth _____ Age ____ Sex: M/F Height ____ Weight ____

Overall health (circle one): Excellent / Good / Fair / Poor / Other: _____

Chief complaint (reason you are here): (use separate sheet if more room needed)

Previous treatments for this complaint _____

Other complaints or problems: (use separate sheet if needed) _____

Current medications/drugs being taken: (use separate sheet if needed) _____

Are you currently under the care of a physician or other health care professionals?

(If yes, please give name and date of last visit):

Nutritional supplements you are taking: _____

Do you smoke, drink coffee or alcohol? (if yes indicate how much)

Cigarettes _____ Coffee _____ Alcohol _____

=====

Office Use Only:

Findings

Recommendations

BP:

Height:

Weight:

Fat %:

HRV:

SS:

Picture:

Bender Chiropractic Health and Vitality Center

33580 Harper Avenue, Clinton Twp. MI 48035 (586) 296-6242

www.benderchiro.com

PERMISSION & AUTHORIZATION FORM REGARDING THE USE OF NUTRITION RESPONSE TESTING™

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Bender Chiropractic Health and Vitality Center to perform a Nutrition Response Testing health analysis and to develop a natural, complementary health improvement program for me which may include dietary guidelines, nutritional supplements, etc. in order to assist me in improving my health, **and not for the treatment, or "cure" of any disease.**

I understand that **Nutrition Response Testing is a safe, non-invasive, natural method** of analyzing the body's physical and nutritional needs, and that deficiencies or imbalance in these areas could cause or contribute to various health problems.

I understand that Nutrition Response Testing is not a method for "diagnosing" or "treating" of any disease including conditions of cancer, AIDS, Infections, or other medical conditions, and that these are not being tested for or treated.

No promise or guarantee has been made regarding the results of Nutrition Response Testing or any natural health, nutritional or dietary programs recommended, but rather I understand that Nutrition Response Testing is a means by which the body's natural reflexes can be used as an aid to determining possible nutritional imbalances, so that safe natural programs can be developed for the purpose of bringing about a more optimum state of health.

I have read and understand the foregoing.

This permission form applies to subsequent visits and consultations.

Date: _____

Print Name: _____

Address: _____

City _____ State ____ Zip _____

Phone: (____) ____ - _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

Bender Chiropractic Health and Vitality Center
NEW PATIENT INFORMATION FORM

Page 2 of 2

Name: _____ Date _____

HISTORY:

List any major illnesses (with approx. dates): _____

List any surgery or operations with approx. date: _____

Past Accidents or injuries: _____

Marital Status: S M D W Name of Spouse _____

Describe health of spouse: _____ Number of children if any _____

Name of Child	Age	Sex	Any physical conditions or concerns?
---------------	-----	-----	--------------------------------------

_____	_____	M/F	_____
-------	-------	-----	-------

_____	_____	M/F	_____
-------	-------	-----	-------

_____	_____	M/F	_____
-------	-------	-----	-------

Any family history of serious illnesses (circle those which apply): Cancer / Diabetes / Heart / Other _____

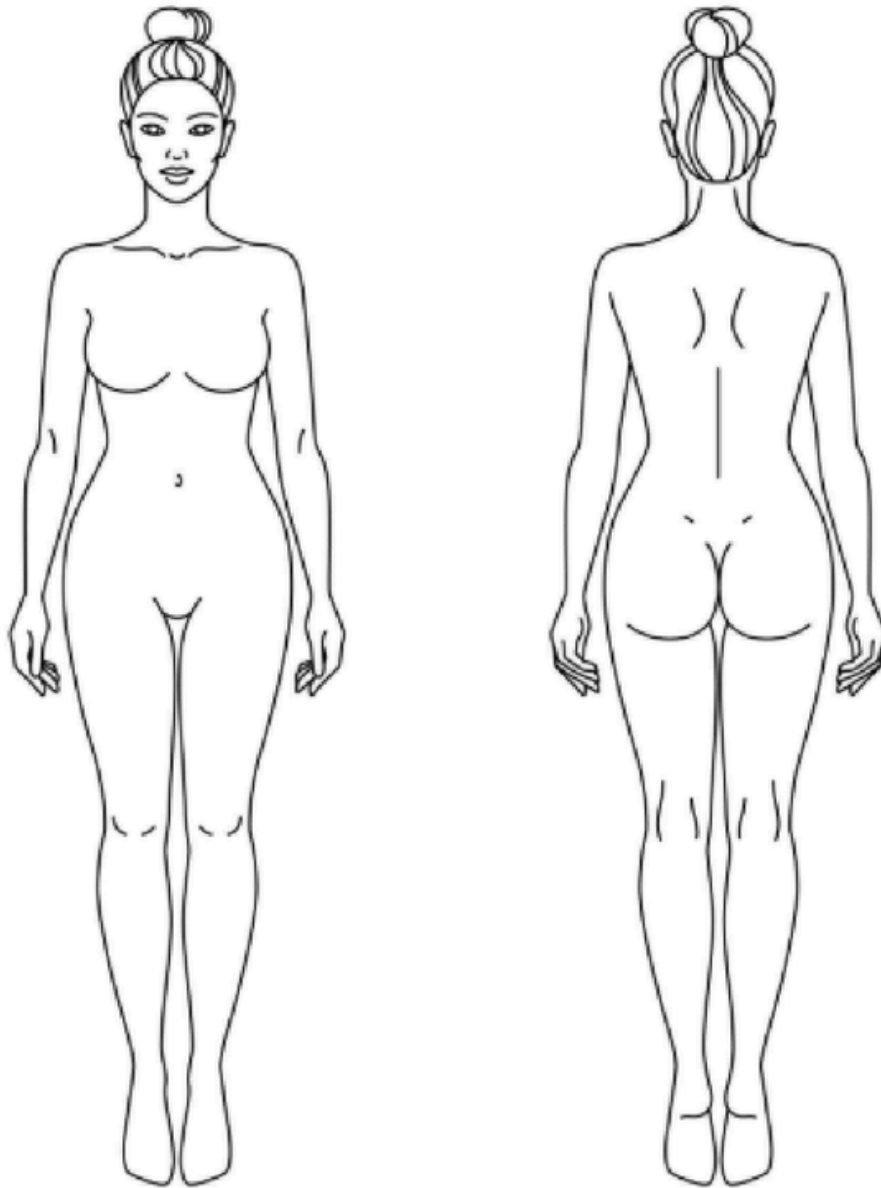
Any household pets or other animals you or family members are in close contact with: _____

What can we do to make you happier? _____

SIGNED: _____ DATE _____

Name _____ Date _____

Please put a mark anywhere on your body that you have a scar.
That includes piercings, tattoos, surgery scars, stretch marks, and child
bearing scars of any kind.



Notes:

NAME:

AGE:

HEALTH CARE PROFESSIONAL:

DATE:

INSTRUCTIONS: Circle the number that applies to you. If a symptom does not apply, don't circle anything for that symptom.

Circle the corresponding number.	
1	MILD symptom (occurs rarely)
2	MODERATE symptom (occurs several times a month)
3	SEVERE symptom (occurs almost constantly)

GROUP 1

1. 1 2 3 Acid foods upset
2. 1 2 3 Get chilled often
3. 1 2 3 "Lump" in throat
4. 1 2 3 Dry mouth, eyes, nose
5. 1 2 3 Pulse speeds after meal
6. 1 2 3 Keyed up, fail to calm
7. 1 2 3 Gag occasionally
8. 1 2 3 Unable to relax, startle easily
9. 1 2 3 Extremities cold, clammy
10. 1 2 3 Strong light irritates
11. 1 2 3 Occasionally weak urine flow
12. 1 2 3 Heart pounds after retiring
13. 1 2 3 "Nervous" stomach
14. 1 2 3 Appetite reduced occasionally
15. 1 2 3 Cold sweats often
16. 1 2 3 Get heated easily
17. 1 2 3 Nerve discomfort
18. 1 2 3 Staring, blink little
19. 1 2 3 Sour stomach frequent

1 2 3 TOTAL

GROUP 2

20. 1 2 3 Joint stiffness after arising
21. 1 2 3 Muscle, leg, toe cramps at night
22. 1 2 3 "Butterfly" stomach, cramps
23. 1 2 3 Eyes or nose watery
24. 1 2 3 Eyes blink often
25. 1 2 3 Eyelids swollen, puffy
26. 1 2 3 Indigestion soon after meals
27. 1 2 3 Always seem hungry, feel "lightheaded" often
28. 1 2 3 Digestion rapid
29. 1 2 3 Vomit occasionally
30. 1 2 3 Hoarseness frequent
31. 1 2 3 Uneven breathing
32. 1 2 3 Pulse slow
33. 1 2 3 Gagging reflex slow
34. 1 2 3 Difficulty swallowing
35. 1 2 3 Temporary constipation or diarrhea
36. 1 2 3 "Slow starter"
37. 1 2 3 Get "chilled"
38. 1 2 3 Perspire easily
39. 1 2 3 Sensitive to cold
40. 1 2 3 Upper respiratory challenges

1 2 3 TOTAL

GROUP 3

41. 1 2 3 Eat when nervous
42. 1 2 3 Excessive appetite
43. 1 2 3 Hungry between meals
44. 1 2 3 Irritable before meals

45. 1 2 3 Get "shaky" if hungry
46. 1 2 3 Fatigue, eating relieves
47. 1 2 3 "Lightheaded" if meals delayed
48. 1 2 3 Heart palpitates if meals missed or delayed
49. 1 2 3 Fatigue in afternoon
50. 1 2 3 Overeating sweets upsets
51. 1 2 3 Awaken after few hours sleep, hard to get back to sleep
52. 1 2 3 Crave candy or coffee in afternoon
53. 1 2 3 Moods of "blues" or melancholy
54. 1 2 3 Craving for sweets or snacks

1 2 3 TOTAL

GROUP 4

55. 1 2 3 Hands and feet go to sleep easily, numbness
56. 1 2 3 Sigh frequently, "air hunger"
57. 1 2 3 Aware of "breathing heavily"
58. 1 2 3 High-altitude discomfort
59. 1 2 3 Open windows in closed room
60. 1 2 3 Immune system challenges
61. 1 2 3 Afternoon "yawner"
62. 1 2 3 Get "drowsy" often
63. 1 2 3 Swollen ankles worse at night
64. 1 2 3 Muscle cramps, worse during exercise; get "charley horse"
65. 1 2 3 Difficulty catching breath, especially during exercise
66. 1 2 3 Tightness or pressure in chest, worse on exertion
67. 1 2 3 Skin discolors easily after impact
68. 1 2 3 Tendency to anemia
69. 1 2 3 Noises in head or "ringing in ears"
70. 1 2 3 Fatigue upon exertion

1 2 3 TOTAL

GROUP 5

71. 1 2 3 Dizziness
72. 1 2 3 Dry skin
73. 1 2 3 Burning feet
74. 1 2 3 Blurred vision
75. 1 2 3 Itching skin and feet
76. 1 2 3 Hair loss
77. 1 2 3 Occasional skin rashes
78. 1 2 3 Bitter, metallic taste in mouth in morning
79. 1 2 3 Occasional constipation
80. 1 2 3 Worrier, feels insecure
81. 1 2 3 Nausea occasionally after eating
82. 1 2 3 Greasy foods upset
83. 1 2 3 Stools light-colored
84. 1 2 3 Skin peels on foot soles

85. 1 2 3 Discomfort between shoulder blades
86. 1 2 3 Occasional laxative use
87. 1 2 3 Stools alternate from soft to watery
88. 1 2 3 Sneezing attacks
89. 1 2 3 Dreaming, nightmare-type bad dreams
90. 1 2 3 Bad breath (halitosis)
91. 1 2 3 Milk products cause upset
92. 1 2 3 Sensitive to hot weather
93. 1 2 3 Burning or itching anus
94. 1 2 3 Crave sweets

1 2 3 TOTAL

GROUP 6

95. 1 2 3 Loss of taste for meat
96. 1 2 3 Lower bowel gas several hours after eating
97. 1 2 3 Burning stomach sensations, eating relieves
98. 1 2 3 Coated tongue
99. 1 2 3 Pass large amounts of foul-smelling gas
100. 1 2 3 Indigestion 1/2-1 hour after eating; may be up to 3-4 hours after
101. 1 2 3 Watery or loose stool
102. 1 2 3 Gas shortly after eating
103. 1 2 3 Stomach "bloating"

1 2 3 TOTAL

GROUP 7A

104. 1 2 3 Difficulty sleeping
105. 1 2 3 On edge
106. 1 2 3 Can't gain weight
107. 1 2 3 Intolerance to heat
108. 1 2 3 Highly emotional
109. 1 2 3 Flush easily
110. 1 2 3 Night sweats
111. 1 2 3 Thin, moist skin
112. 1 2 3 Inward trembling
113. 1 2 3 Heart races
114. 1 2 3 Increased appetite without weight gain
115. 1 2 3 Pulse fast at rest
116. 1 2 3 Eyelids and face twitch
117. 1 2 3 Irritable and restless
118. 1 2 3 Can't work under pressure

1 2 3 TOTAL

GROUP 7B

119. 1 2 3 Increase in weight
120. 1 2 3 Decrease in appetite
121. 1 2 3 Fatigue easily
122. 1 2 3 Ringing in ears
123. 1 2 3 Sleepy during day
124. 1 2 3 Sensitive to cold
125. 1 2 3 Dry or scaly skin
126. 1 2 3 Temporary constipation
127. 1 2 3 Mental sluggishness
128. 1 2 3 Hair coarse, falls out
129. 1 2 3 Tension in head upon arising
wears off during day
130. 1 2 3 Slow pulse below 65
131. 1 2 3 Changing urinary function
132. 1 2 3 Sounds appear diminished
133. 1 2 3 Reduced initiative

1 2 3 TOTAL

GROUP 7C

134. 1 2 3 Failing memory with age
135. 1 2 3 Increased sex drive
136. 1 2 3 Episodes of tension in head
137. 1 2 3 Decreased sugar tolerance

1 2 3 TOTAL

GROUP 7D

138. 1 2 3 Abnormal thirst
139. 1 2 3 Bloating of abdomen
140. 1 2 3 Weight gain around hips or waist
141. 1 2 3 Sex drive reduced or lacking
142. 1 2 3 Tendency for stomach issues
143. 1 2 3 Immune system challenges
144. 1 2 3 Menstrual disorders

1 2 3 TOTAL

GROUP 7E

145. 1 2 3 Dizziness
146. 1 2 3 Headaches
147. 1 2 3 Hot flashes
148. 1 2 3 Hair growth on face
or body (female)
149. 1 2 3 Sugar in urine (not diabetes)
150. 1 2 3 Masculine tendencies (female)

1 2 3 TOTAL

GROUP 7F

151. 1 2 3 Weakness, dizziness
152. 1 2 3 Tired throughout day
153. 1 2 3 Nails weak, ridged
154. 1 2 3 Sensitive skin
155. 1 2 3 Stiff joints
156. 1 2 3 Perspiration increase
157. 1 2 3 Bowel discomfort
158. 1 2 3 Poor circulation
159. 1 2 3 Swollen ankles
160. 1 2 3 Crave salt
161. 1 2 3 Areas of skin darkening
162. 1 2 3 Upper respiratory sensitivity
163. 1 2 3 Tiredness
164. 1 2 3 Breathing challenges

1 2 3 TOTAL

GROUP 8

165. 1 2 3 Muscle weakness
166. 1 2 3 Lack of stamina
167. 1 2 3 Drowsiness after eating
168. 1 2 3 Muscular soreness
169. 1 2 3 Heart races
170. 1 2 3 Hyperirritable
171. 1 2 3 Feeling of a band around head
172. 1 2 3 Melancholia (feeling of sadness)
173. 1 2 3 Swelling of ankles
174. 1 2 3 Change in urinary function
175. 1 2 3 Tendency to consume
sweets/carbohydrates
176. 1 2 3 Muscle spasms
177. 1 2 3 Blurred vision
178. 1 2 3 Involuntary muscle action
179. 1 2 3 Numbness
180. 1 2 3 Night sweats
181. 1 2 3 Rapid digestion
182. 1 2 3 Sensitivity to noise
183. 1 2 3 Redness of palms of hands and
bottom of feet
184. 1 2 3 Visible veins on chest and abdomen
185. 1 2 3 Hemorrhoids
186. 1 2 3 Apprehension (feeling that
something bad is going to happen)

187. 1 2 3 Nervousness causing
loss of appetite
188. 1 2 3 Nervousness with indigestion
189. 1 2 3 Gastritis
190. 1 2 3 Forgetfulness
191. 1 2 3 Thinning hair

1 2 3 TOTAL

FEMALE ONLY

192. 1 2 3 Very easily fatigued
193. 1 2 3 Premenstrual tension
194. 1 2 3 Menses more painful than usual
195. 1 2 3 Depressed feelings
before menstruation
196. 1 2 3 Painful breasts during menses
197. 1 2 3 Menstruate too frequently
198. 1 2 3 Hysterectomy/ovaries removed
199. 1 2 3 Menopausal hot flashes
200. 1 2 3 Menses scanty or missed
201. 1 2 3 Acne, worse at menses

1 2 3 TOTAL

MALE ONLY

202. 1 2 3 Less involved in
exercise/social activities
203. 1 2 3 Difficult to postpone urination
204. 1 2 3 Weak urinary stream
205. 1 2 3 Feeling of "blues" or melancholy
206. 1 2 3 Feeling of incomplete
bowel evacuation
207. 1 2 3 Lack of energy
208. 1 2 3 Muscles in arms and legs seem
softer/smaller
209. 1 2 3 Tire too easily
210. 1 2 3 Avoid activity
211. 1 2 3 Leg nervousness at night
212. 1 2 3 Diminished sex drive

1 2 3 TOTAL

IMPORTANT | Please list below the five main physical complaints you have in order of their importance.

1. _____ 4. _____
2. _____ 5. _____
3. _____

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion	Large Intestine (Palpate)	Adrenals	Pass/Fail Zinc Taste Test
_____ Hydrochloric	_____ Ascending	Pass/Fail Pupil Dilation Exam	Pass/Fail Cuff Test
_____ Acid Point	_____ Transverse	Postural Hypotension	_____ Cuff Pressure
_____ Enzyme Point	_____ Descending	_____ Supine	_____ pH of Saliva
_____ Murphy's Sign		_____ Standing	_____ Pulse

BARNES THYROID TEST

The test is conducted by the patient in the morning before leaving bed, with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test such as getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

PRE-MENSES FEMALES AND MENOPAUSAL FEMALES (any two days during the month)
FEMALES HAVING MENSTRUAL CYCLES (the second and third days of flow or any five days in a row)
MALES (any two days during the month)

Day 1 _____ Day 2 _____ Day 3 _____ Day 4 _____ Day 5 _____

RESTRICTIONS ON USE

The systems survey is to be used only by trained health care professionals. If you are a patient, you should not use the systems survey. If you are not a trained health care practitioner, you should not use the systems survey. Health care practitioners should only use the systems survey to provide services that are within the scope of their license or professional training. The systems survey is intended to be used as a helpful tool for health care practitioners in collecting information concerning the health and wellness of patients.

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I have read and understand the foregoing.

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Date: _____

Print Name: _____

Address: _____

City _____ State ____ Zip _____

Phone: (____) ____ - _____

Signed: _____

(If minor, signature of parent or guardian required)

Witness: _____

Section 8: Notice of Privacy Practices Acknowledgement
Initial Uses Authorization Form
Bender Chiropractic Health and Vitality Center

Effective: 4-15-2003

By signing this form, you acknowledge that you were presented with a copy of the Notice of Privacy Practices of Bender Chiropractic Health and Vitality Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. The most current Notice of Privacy Practices will be placed on display in the office at all times. You may obtain additional copies of our most current notice by requesting it from our privacy official, Dr. William L. Bender

Bender Chiropractic Health and Vitality Center also uses protected health information for the following reasons: (you may opt out of this authorization). Marketing; internal referral board, testimonials, pictures on bulletin board, or information unrelated to healthcare and other marketing materials. _____ (please initial to give us authorization)

If you have any questions regarding this notice or our health information privacy policies, please contact:

Dr. William L. Bender

You can reach the Privacy Official at: Bender Chiropractic Health and Vitality Center, 33580 Harper Avenue, Clinton Township, MI, 1-586-738-6833

Hours Available: A message may be left for our privacy official any time the clinic is open and your call will be returned within 7 business days.

Your Email address: _____ (you may receive PHI through email)

Print Patient Name: _____

Signature Patient/Personal Representative: _____

Relationship of Personal Representative: _____

Date of Signature: _____

=====

Staff complete only if NO signature is obtained, If it is not possible to obtain the patient's acknowledgment, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

Patient refused to sign this acknowledgement even though the patient was asked to do so and the patient was given the Notice of Privacy Practices
Other:

Staff Signature: _____ date: _____

New Patient Cancellation Policy Script

Scheduling and 1st email

After you have scheduled the new patient's appointment (with address), say:

"OK, great! Now to reserve your spot, we need to get a credit card on file. We won't charge the card now; we just ask for at least 24 hours' notice if you need to cancel or reschedule. If we don't receive that notice, a \$25 cancellation fee will be charged to the card. But when you reschedule, that amount will be applied to your new patient appointment.

After we wrap up, I'll email you all the details, including our cancellation policy."

If the patient asks why there's a cancellation fee or voices concern or pushback:

- "We reserve about an hour for you with our doctor and clinical assistant, so short-notice cancellations create a huge gap in our schedule where we can't help other patients."
- "Many offices require payment upfront nowadays, but we only charge the card if we don't get a 24 hour notice."

If the patient asks about emergencies

"If there's an emergency, just call us as soon as you can. We're usually able to waive the fee in true emergency situations."

If the patient is uncomfortable providing CC info over the phone:

"I understand your concern but just so you know, our system is completely protected to safeguard your information. So would you be ok with sharing that number?"

OR

"We can't run your card without your permission."

If they still don't feel comfortable giving the CC info:

"Ok, I'll go ahead and make an exception because I want you to get the help you need."

Email cancellation notice

We ask for at least 24 hours' notice if you need to cancel or reschedule your new patient appointment. If we don't receive that notice, a \$25 cancellation fee will be charged to the card on file.