Bender Chiropractic Health and Vitality Center
NEW PATIENT INFORMATION FORM

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

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:

_____

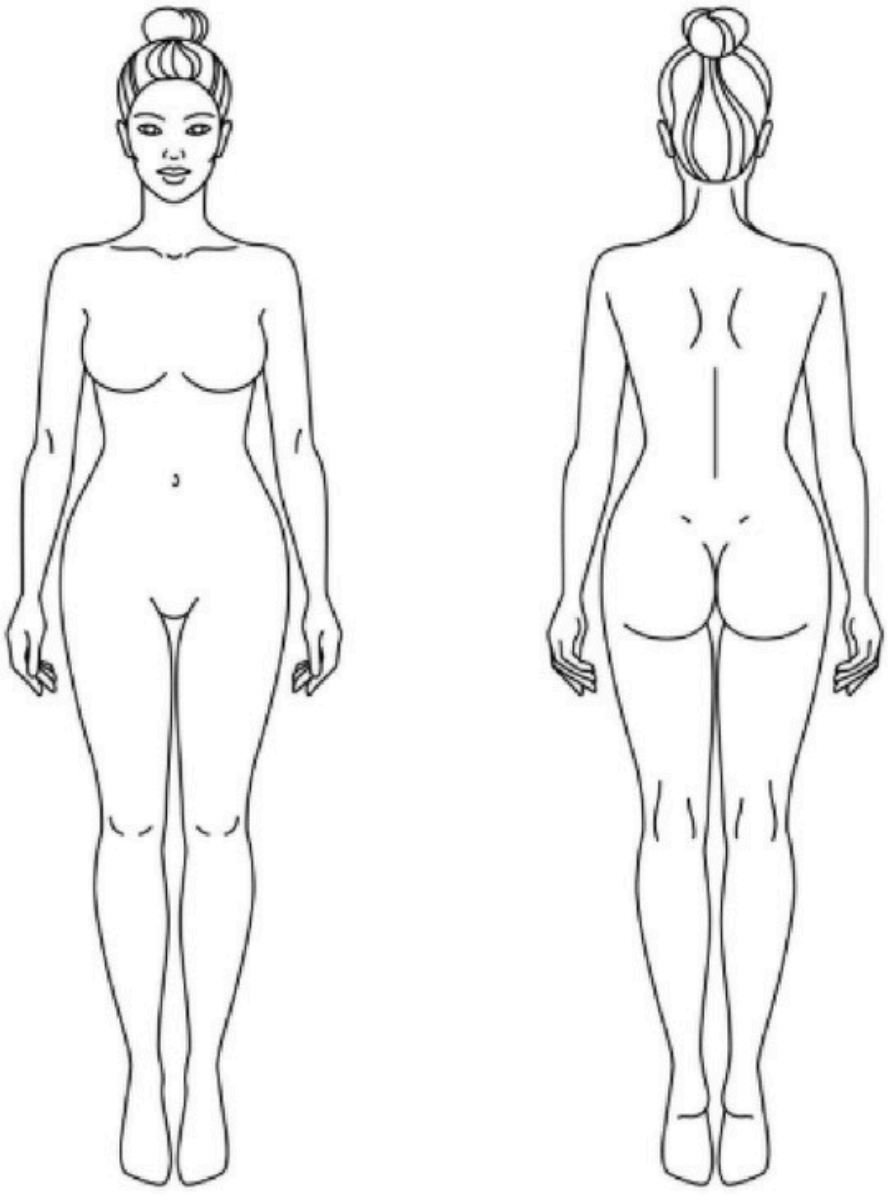
What can we do to make you happier?_____

_____

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:

Systems Survey Form | Restricted to Professional Use

Standard Process

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 ½-1 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

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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)

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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

____ ____ ____ TOTAL
1 2 3

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

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

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL

Digestion
_____ Hydrochloric Acid Point
_____ Enzyme Point
_____ Murphy's Sign

Large Intestine (Palpate)
_____ Ascending
_____ Transverse
_____ Descending

Adrenals
Pass/Fail Pupil Dilation Exam
Postural Hypotension
_____ Supine
_____ Standing

Pass/Fail Zinc Taste Test
Pass/Fail Cuff Test
_____ Cuff Pressure
_____ pH of Saliva
_____ 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.

Bender Chiropractic Health and Vitality Center

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www.benderchiro.com

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

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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:_____

Informed Consent to Care

You are the decision maker for your health care. Part of our role is to provide you with information to assist you in making informed choices. This process is often referred to as “informed consent” and involves your understanding and agreement regarding the care we recommend, the benefits and risks associated with the care, alternatives, and the potential effect on your health if you choose not to receive the care.

We may conduct some diagnostic or examination procedures if indicated. Any examinations or tests conducted will be carefully performed but may be uncomfortable.

Chiropractic care centrally involves what is known as a chiropractic adjustment. There may be additional supportive procedures or recommendations as well. When providing an adjustment, we use our hands or an instrument to reposition anatomical structures, such as vertebrae. Potential benefits of an adjustment include restoring normal joint motion, reducing swelling and inflammation in a joint, reducing pain in the joint, and improving neurological functioning and overall well-being.

It is important that you understand, as with all health care approaches, results are not guaranteed, and there is no promise to cure. As with all types of health care interventions, there are some risks to care, including, but not limited to: muscle spasms, aggravating and/or temporary increase in symptoms, lack of improvement of symptoms, burns and/or scarring from electrical stimulation and from hot or cold therapies, including but not limited to hot packs and ice, fractures (broken bones), disc injuries, strokes, dislocations, strains, and sprains. With respect to strokes, there is a rare but serious condition known as an “arterial dissection” that typically is caused by a tear in the inner layer of the artery that may cause the development of a thrombus (clot) with the potential to lead to a stroke. The best available scientific evidence supports the understanding that chiropractic adjustment does not cause a dissection in a normal, healthy artery. Disease processes, genetic disorders, medications, and vessel abnormalities may cause an artery to be more susceptible to dissection. Strokes caused by arterial dissections have been associated with over 72 everyday activities such as sneezing, driving, and playing tennis.

Arterial dissections occur in 3-4 of every 100,000 people whether they are receiving health care or not. Patients who experience this condition often, but not always, present to their medical doctor or chiropractor with neck pain and headache. Unfortunately a percentage of these patients will experience a stroke.

The reported association between chiropractic visits and stroke is exceedingly rare and is estimated to be related in one in one million to one in two million cervical adjustments. For comparison, the incidence of hospital admission attributed to aspirin use from major GI events of the entire (upper and lower) GI tract was 1219 events/ per one million persons/year and risk of death has been estimated as 104 per one million users.

It is also important that you understand there are treatment options available for your condition other than chiropractic procedures. Likely, you have tried many of these approaches already. These options may include, but are not limited to: self-administered care, over-the-counter pain relievers, physical measures and rest, medical care with prescription drugs, physical therapy, bracing, injections, and surgery. Lastly, you have the right to a second opinion and to secure other opinions about your circumstances and health care as you see fit.

I have read, or have had read to me, the above consent. I appreciate that it is not possible to consider every possible complication to care. I have also had an opportunity to ask questions about its content, and by signing below, I agree with the current or future recommendation to receive chiropractic care as is deemed appropriate for my circumstance. I intend this consent to cover the entire course of care from all providers in this office for my present condition and for any future condition(s) for which I seek chiropractic care from this office.

Patient Name: _____ Signature: _____ Date:

Parent or Guardian: _____ Signature: _____ Date:

Witness Name: _____ Signature: _____ Date:

Bender Chiropractic Health & Vitality Center

New Patient Cancellation Policy

Welcome to Bender Chiropractic Health & Vitality Center! We look forward to serving you on your healthcare journey!

We are reserving about an hour for you to meet with your doctor and our clinical assistant, so short-notice cancellations create a large gap in our schedule where we could be helping other patients.

Because of that, we ask for at least a 24-hour notice if you need to cancel orreschedule your appointment. You can call anytime, just be sure to leave avoicemail with a detailed message if you are calling after hours.

Ifwe don’t receive a 24-hour notice, a $25 cancellation fee will be charged toyour credit card on file.

Thank you!

_____ _____

Signature Date

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: _____