Patient History

Welcome to Advanced Alternative Medicine Center. We appreciate the trust you have placed in us to work together with you to regain and maintain your health. We pride ourselves in our commitment to our patients. We look after each patient as we would the closest member of our family.

Being healthy is a lifetime commitment. It requires that a person make decisions that are constructive to ones body. Just as a person takes their car in for a tune-up when it is running well to keep it that way, we believe your body should have a Health Care "tune-up" on a regular basis to keep your body operating at its highest level possible.

As a Doctor of Chiropractic, I am often incorrectly thought to be a "back doctor." However, I am a doctor who helps the body to heal itself, without drugs, by balancing the nervous system, removing stress and promoting normal function. I work with you, not on you.

My own personal philosophy is to treat the body as a whole, rather than just a bunch of individual parts. My experience and vast amounts of continuous training in Alternative Health Care methods helps me to treat the body as a whole. Through education and understanding I hope to give you the knowledge you will need to improve your health to an optimal level. It is vitally important that you take an active role in discussing with me ALL your questions and concerns.

We look forward to a long and positive relationship with you. Please consider us your family's Total Health Care Office and do not hesitate to ask us how we can be of help in any and all circumstances regarding your health, and the health of your family members.

Yours for Better Health, Naturally;

Dr. Richard A. Huntoon

Most patients who come to our office have one of two objectives in mind concerning their health care. Some patients come for symptomatic relief of pain or discomfort (relief care). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (corrective care). Dr. Huntoon will weigh your needs and desires when recommending your treatment program.

Relief Care

Relief care is that care necessary to get rid of your symptoms or pain, but not the cause of it. It is the same as drying a floor that was getting wet from a leak, but not fixing the leak.

Corrective Care

Corrective care differs from relief care in that its goal is to get rid of the symptoms or pain while correcting the cause of the problem. Corrective care varies in length of time, but is more lasting.

Check the type of care desired so that we may be guided by your wishes whenever possible.

❑ Relief Care ❑ Corrective Care

❑ Check here if you want the doctor to select the type of care appropriate for your condition

Patient's Signature:_____ Date:_____

Confidential Patient Health Record

Personal History

Name: _____ Address: _____

City: _____ State/Prov: _____ Zip/Postal Code: _____

Home phone: _____ Birth date: _____ Age: _____ Sex: ❑ M ❑ F

Social Security: _____ Drivers license number: _____

Business employer: _____ ❑ Married ❑ Single ❑ Widowed ❑ Divorced ❑ Separated

Business phone: _____ Type of work: _____

Name of spouse: _____ Spouse's Social Security #: _____

Spouses employer: _____ Spouse's type of work: _____

Referred to this office by: _____ Name and ages of children: _____

Name of emergency contact: _____

Number of emergency contact: _____ Relationship: _____

Current Health Condition

Unwanted health condition: _____

Other Doctors seen for this condition: ❑ Yes ❑ No Who? _____

Type of treatment: _____ Results: _____

When did this condition begin? _____ Has this condition occurred before? Yes ❑ No ❑

Is condition: ❑ Job Related ❑ Auto Accident ❑ Home Injury ❑ Fall ❑ Other:

Date of accident: _____ Time of accident: _____ Have you made a report of your accident to your employer: ❑ Yes ❑ No

Drugs you now take: ❑ Nerve Pills ❑ Pain Killers/Muscle Relaxers ❑ Blood Pressure Medicine ❑ Insulin ❑ Other Do you wear orthotics? ❑ Yes ❑ No

Do you suffer from any condition other than that which you are now consulting us? _____

Past Health History

Please check and describe:

❑ Major Surgery/Operations ❑ Appendectomy ❑ Tonsillectomy ❑ Gall Bladder ❑ Hernia ❑ Back Surgery ❑ Broken Bones ❑ Other

Major accident or falls: _____

Hospitalization (other than above): _____

Previous chiropractic care: ❑ None ❑ Doctor's Name & Approximate Date of Last Visit: _____

Below are a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of care.

Check any of the following diseases you have had:

- ❑ Pneumonia
- ❑ Mumps
- ❑ Influenza
- ❑ Arthritis
- ❑ Small Pox
- ❑ Rheumatic Fever
- ❑ Pleurisy
- ❑ Epilepsy
- ❑ Polio
- ❑ Chicken Pox
- ❑ Tuberculosis
- ❑ Diabetes
- ❑ Cancer
- ❑ Whooping Cough
- ❑ Mental Disorders
- ❑ Anemia
- ❑ Measles
- ❑ Heart Disease
- ❑ Lumbago
- ❑ Thyroid
- ❑ Eczema
- ❑ Lyme Disease

Intake

- ❑ Coffee
- ❑ Tea
- ❑ Alcohol
- ❑ Cigarettes
- ❑ White Sugar

Have you ever been tested positive for HIV? ❑ Yes ❑ No

Check any of the following diseases you have had in the PAST 6 MONTHS:

Musculo-Skeletal

- ❑ Low Back Pain
- ❑ Pain Between Shoulders
- ❑ Neck Pain
- ❑ Arm Pain
- ❑ Joint Pain/Stiffness
- ❑ Walking Problems
- ❑ Difficult Chewing/Clicking Jaw
- ❑ General Stiffness

Nervous System

- ❑ Nervousness
- ❑ Numbness
- ❑ Paralysis
- ❑ Dizziness
- ❑ Forgetfulness
- ❑ Confusion/Depression
- ❑ Fainting
- ❑ Convulsions
- ❑ Cold/Tingling Extremities
- ❑ Stress

General

- ❑ Fatigue
- ❑ Allergies: seasonal/food
- ❑ Loss of Sleep
- ❑ Fever
- ❑ Headaches

Genito-Urinary

- ❑ Bladder Trouble
- ❑ Painful/Excessive Urination
- ❑ Discolored Urine

Gastro Intestinal

- ❑ Poor/Excessive Appetite
- ❑ Excessive Thirst
- ❑ Frequent Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Hemorrhoids
- ❑ Liver Problems
- ❑ Gall Bladder Problems
- ❑ Weight Trouble
- ❑ Abdominal Cramps
- ❑ Hiatal Hernia
- ❑ Gas/Bloating After Meals
- ❑ Heartburn
- ❑ Black/Bloody Stool
- ❑ Colitis/Bowel Inflammation

C-V-R

- ❑ Chest Pain
- ❑ Short Breath
- ❑ Blood Pressure Problems
- ❑ Irregular Heartbeat
- ❑ Heart Problems
- ❑ Lung Problems/Congestion
- ❑ Varicose Veins
- ❑ Ankle Swelling
- ❑ Stroke

EENT

- ❑ Vision Problems
- ❑ Dental Problems
- ❑ Sore Throat
- ❑ Ear Aches
- ❑ Hearing Difficulty
- ❑ Stuffed Nose

Male

- ❑ Prostate/Sexual Dysfunction

Female

When was your last period?_____

Are you pregnant?

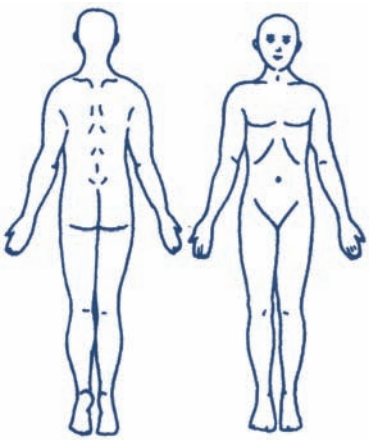
❑ Yes ❑ No ❑ Not Sure

- ❑ Menstrual Irregularity
- ❑ Menstrual Cramps
- ❒ Vaginal Pain/Infection
- ❑ Breast Pain/Lumps
- ❑ Other Problems _____

Family History

The following members have a same or similar problem as I do:

- ❑ Mother
- ❑ Father
- ❑ Brother
- ❑ Sister
- ❑ Spouse
- ❑ Child



Please outline on the diagram the area of your discomfort

Patient History

Treatment recommendations are not designed based on insurance coverage but rather on what you need.

Our office will be happy to provide you with a receipt that you can submit to your insurance company.

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the doctor's office will prepare any necessary reports and forms to assist me in making collection from the insurance company for a fee of $50.00 and that any services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate treatment, any fees for professional service rendered me will be immediately due and payable.

I hereby authorize the doctor to treat my condition as he deems appropriate. It is understood and agreed the amount paid the Doctor, is for examination only and the information will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature: _____ Date: _____

Consent to Treat a Minor: _____ Date: _____

Guardian or Spouse's Signature of authorizing care: _____ Date: _____

DR. RICHARD A. HUNTOON
ADVANCED
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CENTER

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Patient Appointment Agreement

NOTE: This form will be kept on file. It will not be used without first contacting me (the patient) to notify me of the charge and discussing the reason for the charge.

Purpose of Agreement: We are a unique health care office in that when you schedule a New Patient appointment with the doctor you will actually be getting an hour and a half of the doctor's full attention to aid him in understanding how best to help you in healing. On going appointments for established patients are scheduled for 30 minutes. Consequently, missed appointments create a much bigger problem than it would at an office where you only get 5 minutes of the doctor's attention. By not correctly canceling a scheduled appointment, someone else who is in need of care will miss the opportunity for treatment.

Agreement: In order to work together to improve your health we must have an agreement of mutual respect. Dr. Huntoon will hold 90 minutes of his time for New patients to give you his full attention and expertise in your healing. Ongoing patients will be given 30 minutes of his time. You will honor that appointment by attending promptly or canceling with more than 24 hours notice prior to the appointment.

Dr. Huntoon takes health very seriously. To be a patient at his office, it is expected that you are serious about your health as well. Scheduling an appointment indicates you will be at that appointment. Failure to cancel your appointment with less than 24 hours of it's scheduled time will result with a "Cancellation Fee." This fee is $150.00 for New Patient Introductory Visits, and $50.00 for ongoing treatment.

Obviously it is impossible to list all the emergencies that may inhibit a person from keeping their scheduled appointment. Dr. Huntoon and his office staff will always consider such emergencies when enforcing this policy. In the case of inclement weather such as snow, Dr. Huntoon will always be at the office. If the office will be closed, we will contact you.

By signing this agreement, it will serve the following two purposes:

1) It will help you, the patient, get well by getting the care you need.

2) It will help the office to serve as many people as possible.

By signing this agreement, I am acknowledging that I will keep my scheduled appointment(s). Failing to keep my scheduled appointment, without proper cancellation, then I, in advance, give Advanced Alternative Medicine Center and Dr. Huntoon permission to charge my credit card the appropriate fee as set above for such a violation.

Again, this form will be kept on file and will not be used without first notifying me of the charge and the reason for the charge.

Signature:_____ Date:_____

Credit Card # and Type:_____ Exp. Date:_____

over

Patient Appointment Agreement

For office use only

If credit card needs to be used:

Patient Spoken to: ❑ Yes Phone Confirmation Date:_____Time: _____

Date Processed:_____ , 20___ Confirmation number:_____ Amount:_____

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Medication Intake Form

Name: _____ **Date:** _____

Various health concerns can sometimes be caused by the intake of medication. It is important for your overall health and the maintenance of that health that we get a complete understanding of your medication history. Please fill out this form as completely as possible.

1. What medication are you currently taking and for what time frame have you been taking it?

   What is it for?

   _____ _____

   _____ _____

   _____ _____

   _____ _____

2. What medication have you been on in the past and for what time frame did you take it?

   What was it for?

   _____ _____

   _____ _____

   _____ _____

   _____ _____

3. Have you ever taken antibiotics? ❑ yes ❑ no

   How many times in your life have you taken them? ❑ 0-5 ❑ 6-10 ❑ more than 10

   When was the last time you took them? _____

4. Did your doctor follow-up with instructions on how to re-establish normal flora after the antibiotic regime was over? ❑ yes ❑ no

   If yes, what were the instructions? _____

   _____

   _____

over

Medication Intake Form

5. If you are a woman, have you ever taken birth control pills? ❑ yes ❑ no
   How long are/were you taking them? _____
   Are you currently taking them? ❑ yes ❑ no
   Did you ever stop taking them? ❑ yes ❑ no
   If so for how long did you stop? _____

6. If you are a man, have you ever taken Viagra or other like medicine? ❑ yes ❑ no
   If yes, are you currently taking them? ❑ yes ❑ no
   If yes, for how long? _____

7. Do you currently take vitamins or other health supplements? ❑ yes ❑ no
   If so, what are they? _____

   _____

   Where do you get them from?
   ❑ Health Food Store ❑ Direct Mail ❑ Other _____

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Diet History

Name:_____ **Date:** _____

Purpose: This form has been adopted to help both you and Dr. Huntoon determine, through the foods you are currently eating, how your weight and health are being effected, and what is the best way to help you improve your current state of health. Be as complete as possible and include everything you eat and drink for the next five (5) days. **Do Not** change anything in your current eating habits while filling out this form. It is important to get an accurate picture of your current eating habits in an effort to understand your current health concerns. If it is a food that has a label with it, please include the label with the page for the day you ate that item, and return the information to the office when you are done.

Regarding "your mood" with meals, please choose from the list of moods on the side panel. Try to accurately assess how you are feeling just prior to eating and how you feel after completing your meal. As this is a lot of work, it will make all the difference in Dr. Huntoon being able to make positive changes in your health and life.

Dr. Huntoon will evaluate your diet history and then sit down with you to review what are the best ways to improve your current eating habits.

Please note: The office has detoxification programs designed to remove all the toxins from your digestion and elimination systems. If this is of interest to you, please do not hesitate to ask how we can help you to detox yourself in a natural, healthy way.

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Diet History

List of moods
(continued)

Aggressive
Agonized
Anxious
Apologetic
Arrogant
Bashful
Bliss
Bored
Cautious
Cold
Concentrating
Confident
Curious
Demure
Determined
Disappointed
Disapproving
Disbelieving
Disgusted
Distasteful
Eavesdropping
Ecstatic
Enraged
Envious
Exasperated
Exhausted
Frightened
Frustrated
Grieving
Guilty
Happy
Horrified
Hot
Hung over
Hurt
Hysterical

Diet History

List of moods
(continued)

Indifferent
Idiotic
Innocent
Interested
Jealous
Joyful
Loaded
Lonely
Love Struck
Meditative
Mischievous
Miserable
Negative
Obstinate
Optimistic
Pained
Paranoid
Perplexed
Prudish
Puzzled
Regretful
Relieved
Sad
Satisfied
Shocked
Sheepish
Smug
Surly
Surprised
Suspicious
Sympathetic
Thoughtful
Undecided
Withdrawn

Diet History

Day 1

Doctor Comments	Meals Eaten	Food Eaten	Time Eaten	Amount Eaten	Where Eaten	Mood While Eating
	Breakfast					
	Snack					
	Lunch					
	Snack					
	Dinner					
	Snack					

Diet History

Day 2

Doctor Comments	Meals Eaten	Food Eaten	Time Eaten	Amount Eaten	Where Eaten	Mood While Eating
	Breakfast					
	Snack					
	Lunch					
	Snack					
	Dinner					
	Snack					

Diet History

Day 3

Doctor Comments	Meals Eaten	Food Eaten	Time Eaten	Amount Eaten	Where Eaten	Mood While Eating
	Breakfast					
	Snack					
	Lunch					
	Snack					
	Dinner					
	Snack					

Diet History

Day 4

Doctor Comments	Meals Eaten	Food Eaten	Time Eaten	Amount Eaten	Where Eaten	Mood While Eating
	Breakfast					
	Snack					
	Lunch					
	Snack					
	Dinner					
	Snack					

Diet History

Day 5

Doctor Comments	Meals Eaten	Food Eaten	Time Eaten	Amount Eaten	Where Eaten	Mood While Eating
	Breakfast					
	Snack					
	Lunch					
	Snack					
	Dinner					
	Snack					

New Patient Questionnaire

Name: _____ **Date:** _____

1. What is your purpose or goal for seeking care today? _____

_____

2. Why did you choose my office? _____

3. Why did you choose alternative care over conventional medicine? _____

_____

4. What are your expectations with regards to your care here? _____

_____

5. How long have you had your health problem?

❒ Hours ❒ Days ❒ Weeks ❒ Months ❒ Years

6. When was the first time you experienced your problem?

❒ Birth – 5 yrs. ❒ 6 – 15 yrs. ❒ 16 – 25 yrs. ❒ 26 – 50 yrs. ❒ 50 yrs. – Above

7. What do you think caused your health problem? _____

_____

8. Are there any past accidents or injuries that are related to your current condition? ❒ yes ❒ no
If yes, what would they be? _____

9. Describe how your health problem feels at its worst: _____

_____

10. Is it getting better or worse since yesterday? ❒ Better ❒ Worse

over

New Patient Questionnaire

11. What is this problem preventing you from doing either partially or totally? _____

_____

12. Can you live without doing those activities? ❒ yes ❒ no

13. How important is it for you to get rid of this problem?
    ❒ I can live with it ❒ I **want** to get rid of it
    ❒ I **have** to get rid of it ❒ It's ruining my life

14. Do you really want to get healthy ? ❒ yes ❒ no ❒ Depends on what's involved

15. Are you ready to change what you've been doing in order to become healthy? ❒ yes ❒ no

16. Why should our office help you to get well ? _____

_____

17. Is there anything else related to your condition that I should be aware of? ❒ yes ❒ no
    If yes, what would that be? _____

_____

_____

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