For your convenience, we have provided the questionnaire forms that are needed for your initial visit. You may type in your responses or you may print out the pages and fill them in by hand. Please sign the documents and bring them on your initial visit.

Patient Case History

Name _____ Date _____

Social Security # ___ - ___ - ____

Address _____ City _____

State _____ Zip _____

Home Phone _____ Work Phone _____

Cellphone _____

Age _____ Birthdate _____ Marital Status M S W D

Occupation _____

Spouse's Name _____ Referred By _____

Nearest relative and telephone _____

What is your major complaint? _____

_____

Other complaints _____

How long have you had this condition? _____ What aggravates your condition? _____

Is the condition getting worse? ☐ Yes ☐ No ☐ Constant ☐ Comes and goes

Who is your primary doctor? _____ Date of last checkup _____

Date of last blood work _____

List surgical operations and year _____

List medications you are now taking _____

Have you ever been in a car accident or sustained any other trauma? _____ List year _____

Confidential

Center for Health & Longevity
Dr. Stanley I. Miller, D.C.
Your Trusted Source for Gentle and Effective Pain Relief

1 Ribier Ct. Monsey, N.Y. 10952 T 845-425-3232 F 845-406-3433
4405 16th Ave. Brooklyn, N.Y. 11204 T 718-853-4927 F 718-853-0629
www.drstanleyimiller.com

Patient Case History

Do you suffer from daily fatigue? _____

Do you have difficulty sleeping? _____

Do you get colds or infections often? _____

Do you have low libido? _____

For women: Are your cycles irregular? _____ **Do you have PMS symptoms?** _____

Do you have constipation or diarrhea or both? _____

Do you bloat after meals? Do you frequently belch? _____

Are you gassy? _____

Do you get stomach pain before or after meals? _____

Do you have stomach reflux? _____

Do you get urinary infections? _____ **Difficulty or burning urination?** _____

Are your legs or arms puffy (edema)? _____

Do you suffer from headaches? How often? Circle which part of your head. (top, front, back, sides). How long have you had headaches? _____

Do you have chest pains? _____ **Do you get out of breath walking up stairs?** _____

Do you have high blood pressure? _____ **What does it usually read?** _____

What is your cholesterol? _____ **Triglycerides?** _____

Do you have diabetes? _____

Is your thyroid sluggish? _____ **Overactive?** _____

Do you suffer from eczema or psoriasis? _____

Do you have arthritis? _____

Are you concerned about osteoporosis? _____

Are you worried about the premature onset of degenerative disease such as Alzheimer's, Parkinson's, or Multiple Sclerosis? _____

Has any family member contracted cancer or heart disease? _____

Are you ready to take responsibility for your health? _____

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Insurance Information

Name _____

Is your condition due to an auto accident? ☐ **Yes** ☐ **No**

Do you have health Insurance? ☐ **Yes** ☐ **No**

Policy # _____

Are you covered by Medicare? ☐ **Yes** ☐ **No**

Medicare # _____

Medicare

I request that payment of authorized Medicare benefits be made on my behalf to Dr. Stanley Miller for services furnished to me by the provider. I authorize any holder of medical information abut me, to release to the centers for Medicare Services and its agents any information needed to determine these benefits or the benefits payable for related service.

_____

Patient Signature

_____

Date

Private

I authorize my insurance carrier to send payments for chiropractic services performed in the office of Dr. Stanley Miller, to Stanley Miller, D.C.P.C. I also give permission to Dr. Stanley Miller to release to my insurance carrier any information necessary regarding my condition and care in order to determine benefits payable for related service.

_____

Patient Signature

_____

Date

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Attachment 9-5

Notice of Privacy for: Patient's Protected Health Information

This notice describes how health care information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This office abides by the terms described in this policy.

This office uses and discloses your protected health care information for the following reasons:

- To share with other treating health care providers regarding your health care.
- To submit to insurance companies or Workers Compensation Claim to verify that treatment has been rendered.
- To determine patient 's benefits in a health care plan.
- Releasing information required by State or Federal Public Health law.
- To assist in overcoming a language barrier when caring for a patient.
- Business associates providing written assurances for your privacy have been attained
- Emergency situations
- Abuse, neglect or domestic violence
- Appointment reminders to household members or answering machines
- Sign-In logs may be disclosed to verify office visits

Any other uses or disclosures will only be made with your specific written prior authorization.

You have the right to:

- Revoke authorization, in writing at any time by specifying what you want restricted and to whom.
- Speak to our privacy officer who is: Stanley I. Miller, D.C. and can be reached at: 845-425-3232 regarding privacy issues.
- Inspect, copy and amend your protected health information and amend it as allowed by law.
- Obtain an accounting of disclosures of your protected health information.
- To render a complaint to our privacy officer or the Secretary of Health and Human Services.

This office reserves the right to change the terms of this notice and to make new notice provisions for all protected health information that it maintains. Patients may also get an updated copy upon request at any time by asking the staff.

I acknowledge that I have received and reviewed this notice with full understanding.

X _____ X _____

Name of Patient (print) Signature of Patient/Legal Representative Date

Metabolic Assessment Form Key

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list the 5 major health concern in your order of importance:

1.
2.
3.
4.
5.

PART II **Please circle the appropriate number "0 - 3" on all questions below.**
0 as the least/never to 3 as the most/always.

Category I: Colon				
Feeling that bowels do not empty completely	**0**	**1**	**2**	**3**
Lower abdominal pain relief by passing stool or gas	**0**	**1**	**2**	**3**
Alternating constipation and diarrhea	**0**	**1**	**2**	**3**
Diarrhea	**0**	**1**	**2**	**3**
Constipation	**0**	**1**	**2**	**3**
Hard dry or small stool	**0**	**1**	**2**	**3**
Coated tongue of "fuzzy" debris on tongue	**0**	**1**	**2**	**3**
Pass large amount of foul smelling gas	**0**	**1**	**2**	**3**
More than 3 bowel movements daily	**0**	**1**	**2**	**3**
Do you use laxatives frequently	**0**	**1**	**2**	**3**
Category II: Hypochlorydia				
Excessive belching burping or bloating	**0**	**1**	**2**	**3**
Gas immediately following a meal	**0**	**1**	**2**	**3**
Offensive breath	**0**	**1**	**2**	**3**
Difficult bowel movements	**0**	**1**	**2**	**3**
Sense of fullness during and after meals	**0**	**1**	**2**	**3**
Difficulty digesting fruits and vegetables; undigested foods found in stools	**0**	**1**	**2**	**3**
Category III: Hyperacidity (Ulcer)				
Stomach pain, burning or aching 1- 4 hours after eating	**0**	**1**	**2**	**3**
Do you frequently use antacids	**0**	**1**	**2**	**3**
Feeling hungry an hour or two after eating	**0**	**1**	**2**	**3**
Heartburn when lying down or bending forward	**0**	**1**	**2**	**3**
Temporary relief from antacids, food, milk, carbonated beverages	**0**	**1**	**2**	**3**
Digestive problems subside with rest and relaxation	**0**	**1**	**2**	**3**
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol and caffeine	**0**	**1**	**2**	**3**
Category IV: Small Intestine (Pancreas)				
Roughage and fiber cause constipation	**0**	**1**	**2**	**3**
Indigestion and fullness lasts 2-4 hours after eating	**0**	**1**	**2**	**3**
Pain, tenderness, soreness on left side under rib cage bloated	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Nausea and/or vomiting	**0**	**1**	**2**	**3**
Excessive passage of gas	**0**	**1**	**2**	**3**
Stool undigested, foul smelling, mucous-like, greasy or poorly formed	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst and appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**

Category V: Biliary Insufficiency/Statis				
Greasy or high fat foods cause distress	**0**	**1**	**2**	**3**
Lower bowel gas and or bloating several hours after eating	**0**	**1**	**2**	**3**
Bitter metallic taste in mouth, especially in the morning	**0**	**1**	**2**	**3**
Unexplained itchy skin	**0**	**1**	**2**	**3**
Yellowish cast to eyes	**0**	**1**	**2**	**3**
Stool color alternates for clay colored to normal brown	**0**	**1**	**2**	**3**
Reddened skin, especially palms	**0**	**1**	**2**	**3**
Dry or flaky skin and/or hair	**0**	**1**	**2**	**3**
History of gallbladder attacks or stones	**0**	**1**	**2**	**3**
Have you had your gallbladder removed	**Yes**		**No**	
Category VI: Hypoglycemia				
Crave sweets during the day	**0**	**1**	**2**	**3**
Irritable if meals are missed	**0**	**1**	**2**	**3**
Depend on coffee to keep yourself going or started	**0**	**1**	**2**	**3**
Get lightheaded and if meals are missed	**0**	**1**	**2**	**3**
Eating relieves fatigue	**0**	**1**	**2**	**3**
Feel shaky, jittery, tremors	**0**	**1**	**2**	**3**
Agitated, easily upset, nervous	**0**	**1**	**2**	**3**
Poor memory, forgetful	**0**	**1**	**2**	**3**
Blurred vision	**0**	**1**	**2**	**3**
Category VII: Insulin Resistance				
Fatigue after meals	**0**	**1**	**2**	**3**
Crave sweets during the day	**0**	**1**	**2**	**3**
Eating sweets does not relieve cravings for sugar	**0**	**1**	**2**	**3**
Must have sweets after meals	**0**	**1**	**2**	**3**
Waist girth is equal or larger than hip girth	**0**	**1**	**2**	**3**
Frequent urination	**0**	**1**	**2**	**3**
Increased thirst & appetite	**0**	**1**	**2**	**3**
Difficulty losing weight	**0**	**1**	**2**	**3**
Category VIII: Adrenal Hypofunction				
Cannot stay asleep	**0**	**1**	**2**	**3**
Crave salt	**0**	**1**	**2**	**3**
Slow starter in the morning	**0**	**1**	**2**	**3**
Afternoon fatigue	**0**	**1**	**2**	**3**
Dizziness when standing up quickly	**0**	**1**	**2**	**3**
Afternoon headaches	**0**	**1**	**2**	**3**
Headaches with exertion or stress	**0**	**1**	**2**	**3**
Weak nails	**0**	**1**	**2**	**3**

Category IX: Adrenal Hyperfunction

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X: Hypothyroid

Tired, sluggish	0	1	2	3
Feel cold – hands, feel, all over .	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XI: Thyroid Hyperfunction

Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervousness and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII: Pituitary Hypofunction

Diminished sex drive	0	1	2	3
Menstrual disorders of lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII: Pituitary Hyperfunction

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Male Only): Prostate

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males Only): Andropause

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional then in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you a menopausal	Yes		No	
Alternating menstrual cycle lengths	Yes		No	
Extended menstrual cycle, greater than 32 days	Yes		No	
Shortened menses, less than every 24 days	Yes		No	
Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females only)

How many years have you been menopausal?	_____			
Do you ever have uterine bleeding since menopause?	Yes		No	
Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breast	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal, pain, dryness or itching	0	1	2	3

PART III: Foods

How many alcohol beverages they consume per week? _____ How many caffeinated beverages do you consume per day? _____

How many times do you eat out per week? _____ How many times a week do you eat raw nuts or seeds? _____

How many times a week do you eat fish? _____ How many times a week do you workout? _____

List the three worst foods you eat during the average week? _____, _____, _____

List the three healthiest foods you eat during the average week? _____, _____, _____

Do you smoke?_____ If yes, how many times a day _____ , a week _____.

Rate your stress levels on a scale of 1-10 during the average week. _____

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: