Robert I. Jeffrey, D.C., L.Ac.

Confidential Patient Health Record

PLEASE PRINT CLEARLY:

Date:________________________________

Name:____ Address:____

City:____ State: ______________________ Zip Code:_____________________

Home Phone:____ Cell Phone:____

Birth Date:__________________ Age:_____________ Sex: M F

E-mail Address ____

Shipping Address ____

____

Business Employer: __________________________________ Circle one: Single Married Divorced Widowed Separated

Business Phone: ____________________________________ Type of Work: ____________________________________

Name of Spouse:______________________________

Spouse's Employer:___________________________________ Business Phone:_____________________________________

Type of Work:____

Referred to this office by:____

Name and Number of Emergency Contact: ____

CURRENT HEALTH CONDITION

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

Chief Complaint (reason you are here) (use a separate sheet if more room is needed):_________________________________

____

Office Use Only:

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 Do you wear a shoe lift? ____ Yes ____ No Orthotics? ____Yes ____ No

MEDICAL HISTORY

Check any of the following you or your relatives have had:

	Arthritis	Asthma	Cancer	Diabetes	Epilepsy	Glaucoma	Heart Trouble	Hypothyroidism	Kidney Trouble	Nervous Breakdown	Stomach Ulcer	Stroke	Ulcer
You													
Father													
Mother													
Brother													
Sister													
Spouse													
Children													
Grandparents													

Check any other illnesses you have had:

_____ Anemia _____ eye disease _____ gall stones _____ thyroid disease _____ polio

_____ eczema _____ hemorrhoids _____ liver _____ chicken pox _____ rheumatic fever

_____ bronchitis _____ hepatitis _____ malaria _____ measles _____ jaundice

_____ diverticulosis _____ hernia _____ mumps _____ mononucleosis _____ herpes

_____ emphysema _____ pancreatitis _____ HIV

Check any tests of immunizations you have ever had and the year you had them:

( )	year	test	( )	year	Immunization
___	______	chest X-ray	___	______	small pox
___	______	kidney x-ray	___	______	tetanus
___	______	G.I. series	___	______	polio
___	______	colon x-ray	___	______	typhoid
___	______	gall bladder x-ray	___	______	flu
___	______	electrocardiogram	___	______	mumps
___	______	T.B. Test	___	______	measles
___	______	other x-rays	___	______	overseas
________________________________			___	______	others

Allergies you have:

Food:____

Animals:____

Drugs:____

Please check and describe:

Major Surgery/Operations: _____ Appendectomy _____ tonsillectomy _____ Gall Bladder _____ Hernia _____ Back Surgery

_____ Broken Bones _____ Other:____

Major Accidents or falls:____

Have you ever been hospitalized (other than above):_______________________________________

Previous chiropractic Care: ______ None If yes, Doctor's Name and Approx. Date of Last Visit:______________________

Acupuncture Care: ______ None If yes, Acupuncturist's Name and Approx. Date of Last Visit:______________________

Other healthcare physician: ______ None If yes, Doctor's Name and Aprox. Date of Last Visit:______________________

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	______________________________
______________________________	______	M / F	______________________________
______________________________	______	M / F	______________________________

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

SUBSTANCE SURVEY

Please list any prescription medications you are currently taking or have taken in the last year:

Medications	Diagnosis
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity and Frequency
______________	______________	______________
______________	______________	______________
______________	______________	______________

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year. (Use other side of needed).

Product	Symptom	Quantity and Frequency
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________
______________	______________	______________

Have you ever taken:

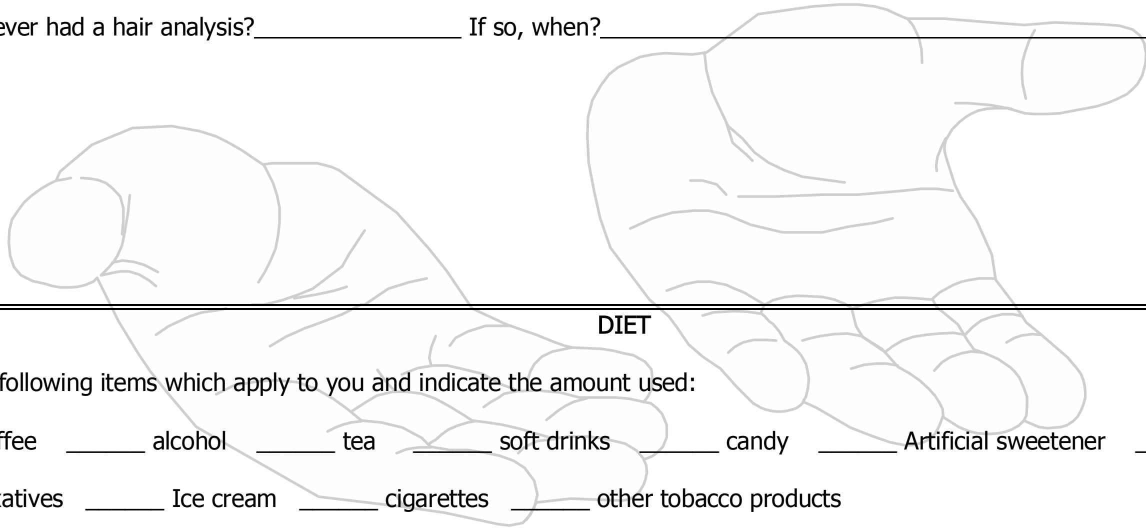
_______ Birth control pills _______ Thyroid Pills _______ Estrogen (Premarin, etc.)

_______ Allergy shots _______ Antibiotics _______ Cortisone/prednisone

_______ Other hormone shots _______ Other (please explain):____

Do you wear contacts?___________________ Pacemaker?__________________________________

Have you ever had a hair analysis?________________ If so, when?____



DIET

Check the following items which apply to you and indicate the amount used:

_______ coffee _______ alcohol _______ tea _______ soft drinks _______ candy _______ Artificial sweetener _______ antacids

_______ laxatives _______ Ice cream _______ cigarettes _______ other tobacco products

LIFE STYLE

How much time do you spend outside everyday?____

Do you usually wear sunglasses when you are outside?____

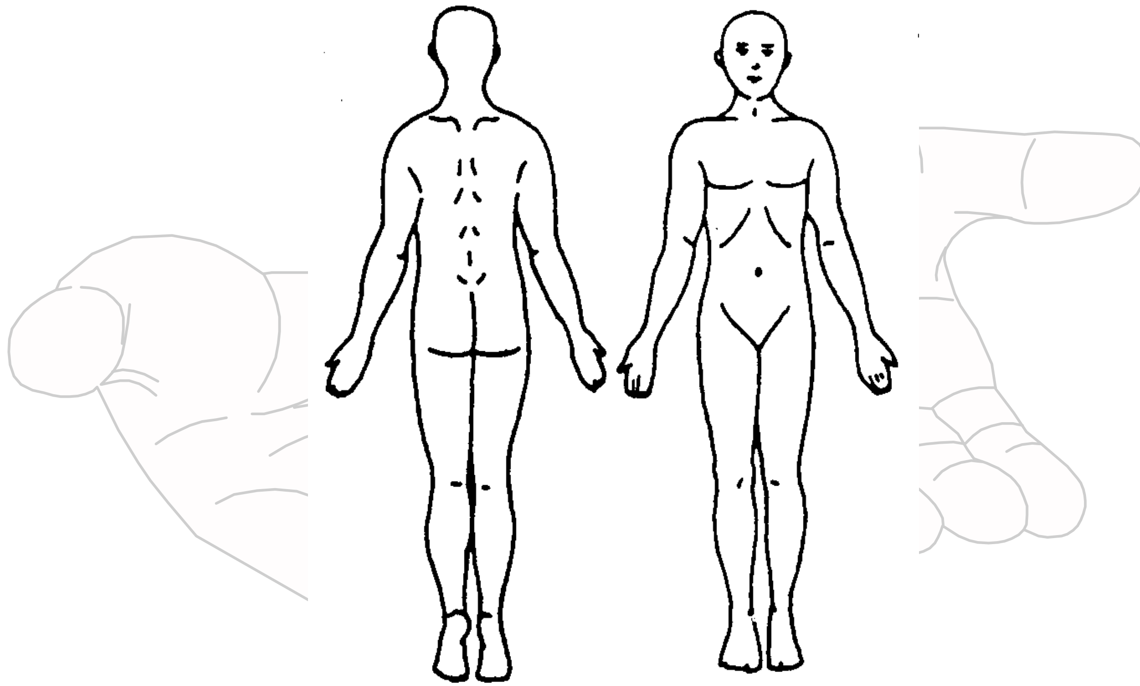
How often do you watch t.v.?____

How often do you exercise?____

Describe the type of exercise.____

____

What other type of exercise do you enjoy?____



Please outline on the diagram the area of your discomfort

METABOLIC ASSESSMENT

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
use laxatives frequently	0	1	2	3
Category II (Gastric Enzymes)				
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 (Gastric Irritation)				
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 (Pancreatic Enzymes)				
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	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting	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)				
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 from 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 (Blood Glucose Fluctuation)				
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 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 Fatigue)				
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

Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition. For nutritional purposes only. All Rights Reserved. Copyright © 2008, Datis Kharra

Category IX (Cortisol Elevation)

Symptom				
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 (Thyroid - Decreased Metabolic Activity)

Symptom				
Tired, sluggish	0	1	2	3
Feel cold - hands, feet, 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 - Increased Metabolic Activity)

Symptom				
Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous 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 - Decreased Metabolic Activity)

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

Category XIII (Pituitary - Increased Metabolic Activity)

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

Symptom				
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) - Male Hormones

Symptom				
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) Female Hormones

Symptom				
Are you perimenopausal	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 Hormones)

How many years have you been menopausal?

Symptom			
Do you ever have uterine bleeding since menopause?	Yes	No	
Hot flashes	0	2	3
Mental fogginess	0	2	3
Disinterest in sex	0	2	3
Mood swings	0	2	3
Depression	0	2	3
Painful intercourse	0	2	3
Shrinking breasts	0	2	3
Facial hair growth	0	2	3
Acne	0	2	3
Increased vaginal pain, dryness or itching	0	2	3

PART III

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? ___________

List the three worst foods you eat during the average week? ____________________, ______________________, ________________________

List the three healthiest foods you eat during the average week? ______________________, _______________________, __________________

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

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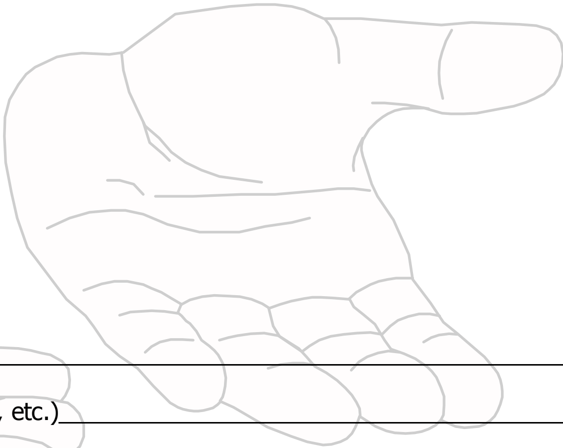
SYMPTOMS COMMENTS



General

Abnormal weight gain	unexplained fever or chills
Abnormal weight loss	loss of feeling of well being
Fatigue	overweight/underweight

Dental history

Do you currently need dental work?__________ If so, what?______________________________

# of fillings?____________________ Type? (amalgam, gold, resin, etc.)______________________

# of teeth pulled?_______________ Do you wear dentures or partials?______________________

Scars

Do you have any major scars anywhere on your body? _____________ If so, where? ______________

____

____

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 a superbill that I can submit to my health insurance. I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment at the time the services are provided.

I hereby authorize the Doctor to treat my condition as he deems appropriate through use of manipulation throughout my spine, acupuncture, myotherapy and nutritional/herbal support. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions, nor for any medical diagnosis.

Patient's Signature X____Date__________________

Guardian or Spouse's
Signature Authorizing Care_________________________________ Date__________________

Jeffrey Chiropractic and Massage

11611 San Vicente Blvd. Suite 605, Los Angeles, California 90049

PERMISSION & AUTHORIZATION FORM
REGARDING THE USE OF
NUTRTION RESPONSE TESTING

PLEASE READ BEFORE SIGNING:

I specifically authorize the natural health practitioners at Jeffrey Chiropractic and Massage 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 imbalances 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: ____________________

Signed: ____

(If a minor, signature of parent or guardian required)

Witness: ____

Informed Consent Agreement

NMT: The Feinberg Technique Treatment Consent Form

NeuroModulation Technique ("NMT") is intended to determine the patient's perception of conditions contributing to illness. I desire to be screened with NMT, and hereby consent to participate in this type of screening and treatment.

The procedure has been explained to me, and I understand that certain adverse effects may result from the treatment. These could include, but are not limited to, a temporary soreness in muscles of the arms tested, or a temporary flare-up of my symptoms. Other possible side effects include symptoms of heightened immune function or detoxification such as fever, chills, headache or body aches.

I understand that NMT: *The Feinberg Technique* is not a medical diagnostic procedure, and therefore does not diagnose disease. Diagnosis requires particular types of clinical examination procedures by a physician trained in diagnosis. By contrast, NMT is intended to determine the patient's perception of conditions contributing to illness. I understand that Muscle Response Testing, ("MRT") employed in NMT, like any medical testing procedure, is not 100% accurate.

I understand that alternative methods of treatment are available. These have been described to me. If I am suffering from severe allergenic reactions to substances, I will consult an appropriate physician and, if so advised, take medication (to prevent itching, tissue swelling, fever, cough, pains, etc.) to keep my symptoms under control while I am being treated with NMT: The Feinberg Technique.

I understand that determination of the existence and identification of particular infectious agents in the body requires specific laboratory testing. NMT: The Feinberg Technique does not diagnose any infectious agent, nor is it a substitute for appropriate laboratory testing. Rather, NMT evaluates the perceptions of the autonomic control system, and immune system with regard to such issues, and attempts to optimize autonomic function with respect to immune system control.

NMT: The Feinberg Technique is not a method of diagnosing or treating cancer. Medical oncologists are the only health care personnel appropriately trained to manage the treatment of cancer. NMT is not a substitute for appropriate medical care of cancer.

I agree to cooperate and take an active role in my treatment by maintaining a positive attitude regarding treatment, continuing contact with and treatment from medical practitioners, and communicating progress and side effects to the health care provider administering NMT. I understand that I am to continue all medication and other treatment modalities as they have been prescribed unless otherwise directed by the doctor who prescribed them.

I understand that there is no guarantee concerning the effect of the treatment. I understand that I am free to discontinue treatment at any time, but acknowledge that I am responsible for full payment of the normal and necessary fees associated with my screening and treatment.

I also understand that clinical data is presently being collected on the technique that requires the gathering of certain information in accordance with research protocols. I understand that the results of this study may be published in a medical or scientific journal, and that a number or letter designating my case, but not my name, may be used in reports of this study.

I have read, or have had read to me, the above statements, and have been provided with the opportunity to ask any pertinent questions I have regarding this screening and treatment program. I have been informed that I am to contact the doctor if any problems are encountered during my treatment. I understand the conditions stated above, and hereby consent to participate in this type of screening and treatment. By signing below I agree to the terms and procedures set forth above.

IN WITNESS WHEREOF, I have executed the foregoing this _____day of ___________, _____.

_______________________________ _______________________________

Patient's Signature *Patient's Printed Name*

_______________________________ _______________________________

If minor, signature of parent or guardian *Parent or Guardian's Printed Name*

_______________________________ _______________________________

Practitioner *Witness*