Welcome to Secoya Health. We are dedicated to providing you with personalized and preventive care to help you reach your health goals.

Initial visits include: initial consultation; applied kinesiologic and chiropractic structural exam; body composition analysis, first treatment; and/or other necessary kinesiologic tests.
This comprehensive appointment is $297. Additional costs may include: specialized lab testing; nutritional supplements and homeopathic remedies; Bio-Meridian Analysis; special programs; and/or orthopedic appliances.

When you schedule an appointment for your healthcare needs, that time is set aside for you. Given the busy nature of our practice and the high demand for patients to receive care, we charge 1/3 of the exam cost to a credit card to hold your appointment. The 1/3 charged at the time of scheduling will be credited toward your initial exam fee on the day of your appointment. **If you need to cancel or reschedule your initial appointment, we ask that you give a minimum of 72 business hours' notice. If not cancelled within 72 business hours, you will forfeit your appointment reservation fee. All follow up appointments we require 24 business hours' notice for any cancellation**. This will allow us to contact another person on the waiting list. If you cancel within 24 business hours you will be charged for half the appointment. By signing below, you authorize that the card on file can be charged if this notice is not given.

Secoya Health is a "fee for service" practice and payment is due at the time of service. We accept cash, checks, Visa, Discover, and MasterCard. As a courtesy, we do provide our patients with an itemized bill to submit for insurance reimbursement.

The following sheets are very important. Please answer all of the questions thoroughly at least three days before your appointment and bring them with you to your initial exam. Please wear comfortable clothing & shoes to your appointment.

IMPORTANT: Prior to your appointment please do not have any caffeine or alcohol 12 hours prior to your exam as well as refrain from exercising, saunaing, or taking any nutritional supplements on the day of your exam. We have all patients remove their shoes in our office so please bring a clean pair of shoes, slippers, or socks if you are uncomfortable with being barefoot. Also, we ask that you bring any medications and/or nutritional supplements (vitamins, herbs, oils, etc.) you deem a necessity in your health routine. Out of respect for those patients who are sensitive, we also ask that you refrain from wearing any perfumes or colognes for your appointments at Secoya Health.

We ask that you arrive **15 min. early** to your initial appointment.
Thank you for choosing Secoya Health for your healthcare needs.

Patient Signature ____
(or guardian)

Date ______________

Mandatory Disclosures

Informed Consent for Chiropractic Treatment

Chiropractic adjustments are a conservative and very safe procedure. We are required by law to notify you of any risk involved. The only serious complication of a chiropractic adjustment is a vertebral artery injury, commonly known as a stroke. It is extremely rare – statistics show this may occur about once in a million to once in 10 million adjustments. Most importantly, there has never been a case of vertebral artery injury at this clinic.

______ I understand the remote possibility of injury from chiropractic treatment and elect to receive the recommended treatment.

Privacy Policies and Authorizations

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED/DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

We have always been very concerned with protecting your privacy, but now the federal and state law requires us to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. This notice will remain in effect until further notice.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information within this clinic in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities such as reviewing office procedures and training staff. Patient information will be disclosed in hardcopy only. No fax or internet transmissions will be sent.

We may also disclose your health information with your written consent. Your authorization may be revoked in writing at any time. Your revocation will take effect upon receipt. Any authorization you have signed that we receive from any other source will also be considered valid.

Your Family and Persons Involved in Your Care: We ask that patients take responsibility to make and cancel their own appointments, except in the case of minors or disadvantaged adults. We confirm your appointment time by telephone and may leave a message on either a voicemail or with another person in your household if you are not available. We will also use our professional judgment when allowing another person to pick up supplements or requested information relayed on your behalf.

You have the right to get a copy of your health record by giving us a written request. We reserve the right to charge for copying costs.

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging I have received a copy of this authorization.

______________________________ ______________________________ ______________________
Patient Name Patient Signature Date

______________________________ ______________________________
Personal Representative Personal Representative Signature

New Patient Evaluation

Please complete the following questions carefully. This information will help us to build a personalized wellness program for you. Information you provide is strictly confidential.

DO NOT TAKE ANY NUTRITIONAL SUPPLEMENTS ON THE DAY OF YOUR EXAM

Initial visit date and time: _______________________________ Referred by: ________________________

Name: _____________________________________ Birth date: _____/_____/_____ Age: ______ M / F

Address: ____________________________________City: __________________State: ____ Zip: _______

Phone (circle preferred): Home________________Work__________________Cell__________________

Email: ______________________________________Would you like to receive our emails? YES / NO

Preferred Method of Contact (circle one): Email/Phone/Text/All Cell Phone Provider: ________________

Do you have Medicare benefits? YES / NO

Marital Status: Single Married Divorced Widowed No. of Children: _________________________

Occupation: ____

1. Please list the current health conditions/symptoms that concern you and rate their severity on a scale from (1 to 10) 10 being the most severe.

____
____
____
____
____

2. What treatments have you tried for these conditions and has anything helped?

____
____
____

3. What are your hopes and goals for your health in the next 6-12 months?

____
____
____
____

4. **Nutritional Supplements** Please list any nutritional supplements/products you are *currently* using.

___

___

___

___

5. **Medications** Please list any medications you are currently taking and how long you have taken them (including birth control pills, aspirin, pain medication, sleep aids, etc.)

___

___

___

___

___

6. **Surgeries**

Have you ever had full-body anesthesia (wisdom teeth, to remove tonsils, etc.)? Y / N

Do you have breast implants? Y / N Other surgical implants or prostheses? Y / N

Have you had elective surgery (tummy tuck, face-lift, mole removal, etc)? Y / N

Do you have any internal metal or plastic (such as pins, clamps, plates, etc)? Y / N

Do you have body piercings or tattoos? Y / N

Explain:___

___

7. **Stress**

Please rate your current stress level on a scale of (1 to 10) 10 being the highest stress:___

Please list the 5 most stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life or your health?

a.___

b.___

c.___

d.___

e.___

What step(s) are you taking to reduce your stress level?

___

___

___

___

From birth to the age of thirteen, did you experience the absence of a parent, a parent's sickness, divorce, witness substance abuse or experience any emotional, physical, or sexual abuse? If yes, please share at what age and the type of stress.

____

____

____

____

____

8. **Sleep**

How is your sleep? (check all that apply)

☐ I sleep very well ☐ Restless ☐ Difficulty falling asleep ☐ Difficulty staying asleep

☐ Bad dreams ☐ I wake feeling rested ☐ I wake feeling tired
Other:________________________

How many times per night do you wake up? _________________

What time do you usually go to sleep? ______________________

How many hours of sleep do you get per night? _______________

How many times per night do you wake to urinate? ____________

9. **Exercise**

What kind of exercise do you enjoy on a frequent basis?

____

____

____

How often? ______________________________________ For how long at a time? _______________

Please check all that you are *currently* experiencing:

Muscular-Skeletal System

_______ Neck pain	_______ Leg problems	_______ Sore muscles
_______ Pain between shoulders	_______ Swollen joints	_______ Weak muscles
_______ Low back pain	_______ Painful joints	_______ Walking problems
_______ Arm problems	_______ Stiff joints	

Gastro-Intestinal System

_______ Poor appetite	_______ Nausea	_______ Black stool
_______ Excessive hunger	_______ Vomiting food	_______ Bloody stool
_______ Difficulty chewing	_______ Abdominal pain	_______ Hemorrhoids
_______ Difficulty swallowing	_______ Diarrhea	_______ Heartburn
_______ Excessive thirst	_______ Constipation	

Cardio-Vascular-Respiratory

_______ Chest pain	_______ Coughing phlegm	_______ Low blood pressure
_______ Pain over heart	_______ Coughing blood	_______ Heart problems
_______ Difficulty breathing	_______ Rapid heartbeat	_______ Varicose veins
_______ Persistent cough	_______ High blood pressure	_______ High cholesterol

Nervous System

_______ Numbness	_______ Fainting	_______ Forgetfulness
_______ Loss of feeling	_______ Headaches	_______ Confusion
_______ Dizziness	_______ Muscle jerking	_______ Depression

Urinary System

_______ Excessive urination	_______ Painful urination	_______ Frequent UTI's
_______ Scanty urination	_______ Discolored urine	

Bowel Function

How many bowel movements do you average per day? __________

Food Choices

1. **Meal Habits**

Do you: ☐ Skip meals often? ☐ Have irregular eating times? ☐ Eat food past 9pm?

What percentage of the meat you purchase is organic? _______________

What percentage of the produce you purchase is organic? _____________

Please indicate how many **days per week** you consume the following:

____ Frozen dinners
____ Red meat
____ Chicken or turkey
____ Fish
____ Pork
____ Fresh vegetables
____ Fresh fruit
____ Frozen or canned fruit
____ Frozen or canned vegetables
____ Wild game
____ Eggs
____ Pasta
____ Rice
____ Boxed cereals

Do you eat at restaurants? Y / N If yes, how often?____

Do you prepare meals at home? Y / N If yes, how often? ___________________________________

How many times per week do you cook or reheat your food in a microwave? ______________________

2. **Water**

Do you drink tap water? Y / N

Do you use a water filter at home? Y / N If yes, what brand? ___________________________

Do you buy purified drinking water? Y / N If yes, what brand? ___________________________

3. **Food Stressors** Please indicate how many **days per week** you consume the following foods:

Stimulants
___Coffee
___Black tea
___Soft drinks
___NutraSweet drinks
___Alcohol
___Chocolate
___Candy or sweets

Toxic Oils
___Fried foods
___Fast food
___Potato chips
___Roasted nuts
___Mayonnaise
___Margarine
___Peanut butter

Commercial Dairy
___Cow's milk
___Yogurt
___Ice cream
___Cottage cheese
___Sour cream
___Cheese

Highly Heated Foods
___Bread
___Crackers
___Bagels
___Muffins
___Cookies - pastries

4. **Food Chart** Please list everything you eat and drink for 2 days:

	Breakfast	Snack	Lunch	Snack	Dinner	Snack
Day 1						
Day 2						

Toxic Exposure

1. **Smoking**
   Do you currently smoke? Y / N If yes, how much?________________________________
   How long have you smoked (currently or in the past)? ________________________________

2. **Drugs**
   Do you currently use recreational drugs (ex. marijuana, cocaine, uppers, downers)? Y / N
   If yes, which ones, and how often? *Reminder: This is strictly confidential information.*
   ____
   ____

3. **Personal Care and Home Products** Please check all that you use:

   ___Hair Perm
   ___Antiperspirant
   ___Facial make-up
   ___Hair spray
   ___Air fresheners (spray)
   ___Air fresheners (plug-ins)
   ___Hair gel
   ___Dryer sheets
   ___Roach/ant spray (in home)
   ___Hair color – semi or permanent
   ___Toilet freshener
   ___Fingernail polish
   ___Perfume/Cologne
   ___Lawn fertilizer (non-organic)

   What type of mattress do you sleep on?
   ____

   Do you work with or near chemicals? Y / N
   Explain:____

   Do you have any metal fillings? Y / N How many?________________________________

4. **Appliances** Please check all that you use:
   ____Gas stove
   ____Electric stove
   ____Electric heater
   ____Electric blanket
   ____Water bed
   ____Microwave oven
   ____Non-stick cookware
   ____Air purifier - What Brand?________________________________

5. **Pets**
   Do you have a pet? Y / N If yes, what kind and how many?__________________
   Is the pet allowed in the house? Y / N On your bed? Y / N

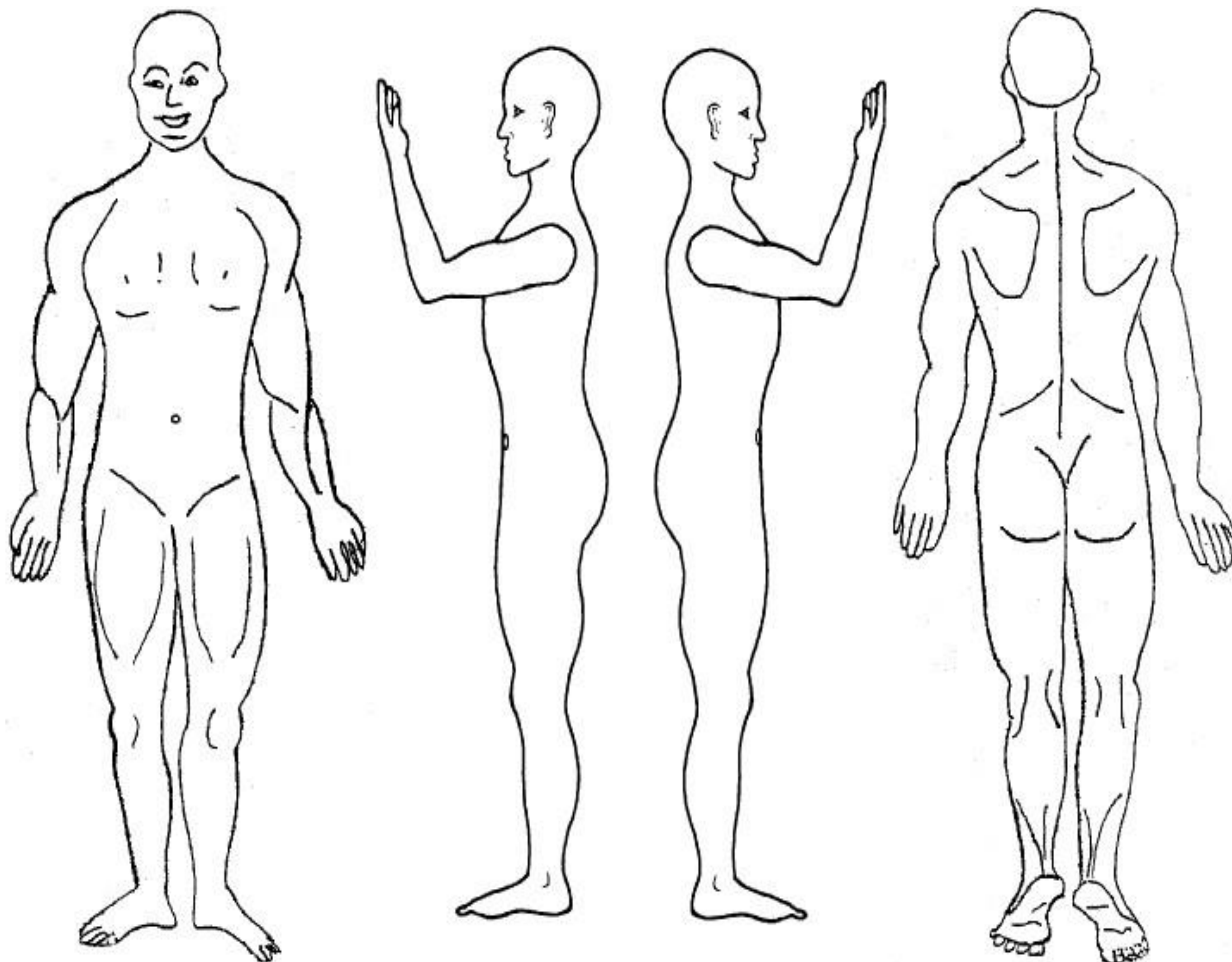
6. **Electromagnetic Exposure**
   Do you live or work near high voltage power lines? Y / N

   How many hours do you spend daily:
   ____Watching TV
   ____Working on a computer
   ____Talking on a phone
   ____Wearing a pager
   ____Wearing a wrist watch
   ____Wearing a hearing aid
   ____In a car
   ____Near electrical equip.
   ____Near a clock radio

Scar/Trauma Chart

Name: ____

Date: ________________



Directions

All Scars. Please draw a red line on the drawing where you have scars, even if they are very old. Don't forget C-sections, vaccination scars, episiotomies, surgeries, earring puncture holes, tattoos, facelift scars, vasectomies, etc.

All Trauma Areas. Please put a red "X" where you have had trauma even if it is very old. Don't forget previous sprains, burns, falls, whiplash (from auto accidents), radiation, etc.

Internal Metal: Please draw a circle on the drawing if you have any type of internal metal objects, such a surgical steel pin, metal plate, hip replacement, surgical wire mesh, etc.

Date of injury and type of injury. Draw a line from each of the above injury areas and print the type of injury and approximate date of injury. (For example, draw a line from a shoulder trauma area and print "car accident, 1988")

WOMEN'S HEALTH SCREEN

Are you pregnant? Y / N
Are you nursing? Y / N
Have you had a hysterectomy? Y / N If yes, when? _________
Do you have monthly periods? Y / N
Date of last menstrual cycle (1st day of flow) ______
Number of C-sections ______
Number of episiotomies or muscle tears ______

Check the symptoms you experience regularly one to two weeks before your period:

___ Anxiety
___ Irritability
___ Nervous Tension
___ Aggressive or hostile toward family/friends
___ Engage in self destructive behavior
___ Weight gain
___ Water retention
___ Abdominal Bloating
___ Tender, swollen and /or painful breast
___ Breast lumps increase in size and tenderness
___ Discharge from nipples
___ Craving for sweets
___ Increased appetite
___ Heart palpitations
___ Fatigue
___ Headaches
___ Shaky or clumsy
___ Depressed
___ Withdrawn
___ Confused
___ Forgetful
___ Insomnia/difficulty sleeping

Check the symptoms and or behaviors that occur during your period:

___ Cramping in the lower abdomen or pelvic area
___ Sharp intermittent pain
___ Dull aching pain
___ Upset stomach
___ Diarrhea
___ Nausea or vomiting
___ Low back aches
___ Headaches
___ Difficulty concentrating
___ Accident prone
___ Unusual fatigue
___ Decrease productivity
___ Weight gain
___ Painful and /or swollen breasts
___ Irritability
___ Mood swings
___ Depression
___ Painful intercourse

Check any of the following statements that describe your menstrual cycle, energy level or reproductive function:

___ Heavy prolonged menstrual bleeding/clotting
___ Menstrual bleeding that last longer than 5 days
___ Absence of periods for 3 months or more
___ Vaginal itching, burning, dryness
___ Menstruation that occurs too frequently (21 days or less)
___ Irregular periods (once every 3-6 months)
___ Frequently skip periods
___ Menstrual cycle every 36 days or longer
___ Unusually light or heavy periods
___ Unusually light menstrual flow
___ Menses last three days and are light
___ Bleeding or spotting between periods
___ Bleeding or spotting between periods is light
___ Bleeding or spotting between periods is heavy
___ Abnormal vaginal discharge
___ Frequent urination

Check any of the following symptoms if they occur throughout the month:

___ Decline of vital energy and sense of well-being
___ Hot flashes
___ Night sweats
___ Spontaneous sweating
___ Chills
___ Depressed
___ Irritable
___ Anxiety
___ Anger
___ Mood swings
___ Headaches
___ Forgetful
___ Difficulty concentrating
___ Difficulty sleeping
___ Urinary problems
___ Vaginal problems
___ Dry skin
___ Bleeding between periods
___ Irregular periods
___ Stopped menstruating
___ Joint and muscle pain
___ Change in sexual desire
___ Difficulty with orgasm
___ Painful intercourse
___ Loss of muscle tone
___ Vaginal bleeding any time
___ Vaginal bleeding after sex
___ Vaginal discharge