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 structural exam is $149. 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: Do not consume any *nutritional supplements* the day of your appointment. Also, we ask that you bring any medications and/or nutritional supplements (vitamins, herbs, oils, etc.) you deem necessary 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 at a rate of $.90 per page and a $12.00 retrieval fee.

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 contact):
Home_____Work_____Cell_____

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

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

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

Gastro-Intestinal System

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

Cardio-Vascular-Respiratory

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

Nervous System

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

Urinary System

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

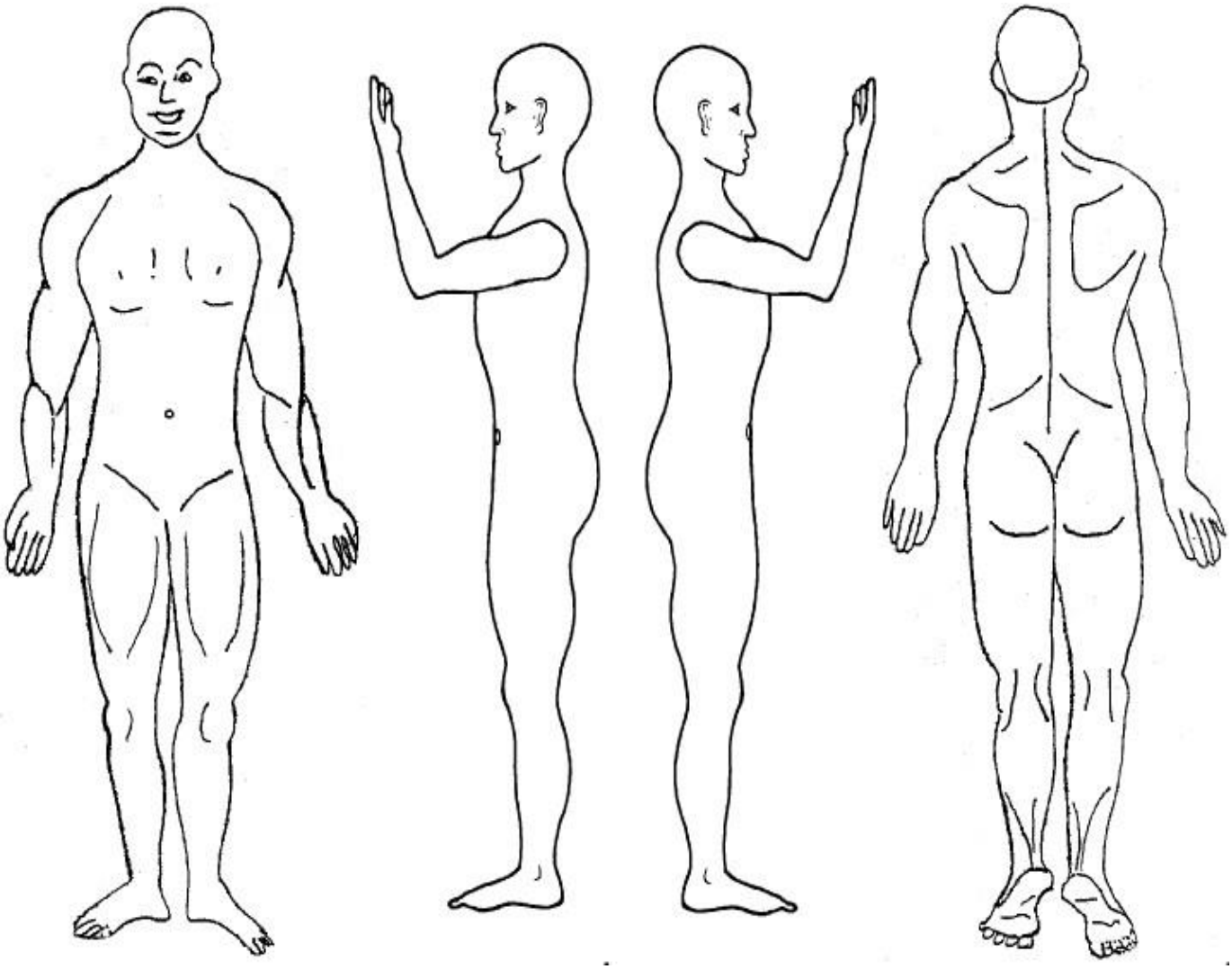
Bowel Function

How many bowel movements do you average per day? _____

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")