Patient Name: _____

Appointment Date: M T W Th F Date: _____ **Time:** _____ **AM / PM**

CHIROPRACTIC WELLNESS PROGRAM

Welcome to Triad Health Center! We are excited to begin helping you on your journey through natural healthcare.

Inside of this packet, you will find: instructions to prepare for your initial consultation and examination with Dr. Schwartz, an outline of expectations, and a detailed intake paperwork questionnaire.

Prior to your consultation…

You will need to fill out the intake paperwork forms completely and as detailed as possible. You must complete the paperwork and either bring with you to your appointment or email it back to us **at least 2 hours prior to your appointment: staff@triadhealthcenter.com**. If you have any past imaging or treatment plans you think are relevant from the past 2 years, please bring copies with you.

What will occur?

Be sure to arrive at least 15 minutes early for your appointment to allow time for parking, check-in, and to complete any additional paperwork upon arrival.

Check in with our Front Desk team. One of our medical assistants will collect this paperwork packet from you and scan your insurance card(s) and photo ID. If you need assistance completing your intake paperwork, our team will assist you (*please be sure to arrive 30 minutes early if you need assistance completing this paperwork*).

At your first appointment you will meet with Dr. Schwartz for an in-depth consultation and discussion of your health needs and goals.

You will also be given a few preliminary exams that will help determine the severity of your condition:

- Diagnostic & Holistic Health Exam
- Orthopedic Testing
- Neurological Testing
- Digital Spinal Xrays (if recommended)

The length of the entire first appointment is typically 60-90 minutes.

Following your intake appointment, a follow up will be scheduled to review the doctors' findings, treatment plan, and insurance coverage, at no additional cost. We will show you our plan to get you back on the path to optimal health!

What do I need to bring?

This packet of paperwork fully completed. Your insurance card(s) and photo ID. Copies of imaging or treatment plans from the past two years. A notebook and pen. And we highly encourage your spouse attend this appointment with you.

What is the policy on rescheduling this appointment?

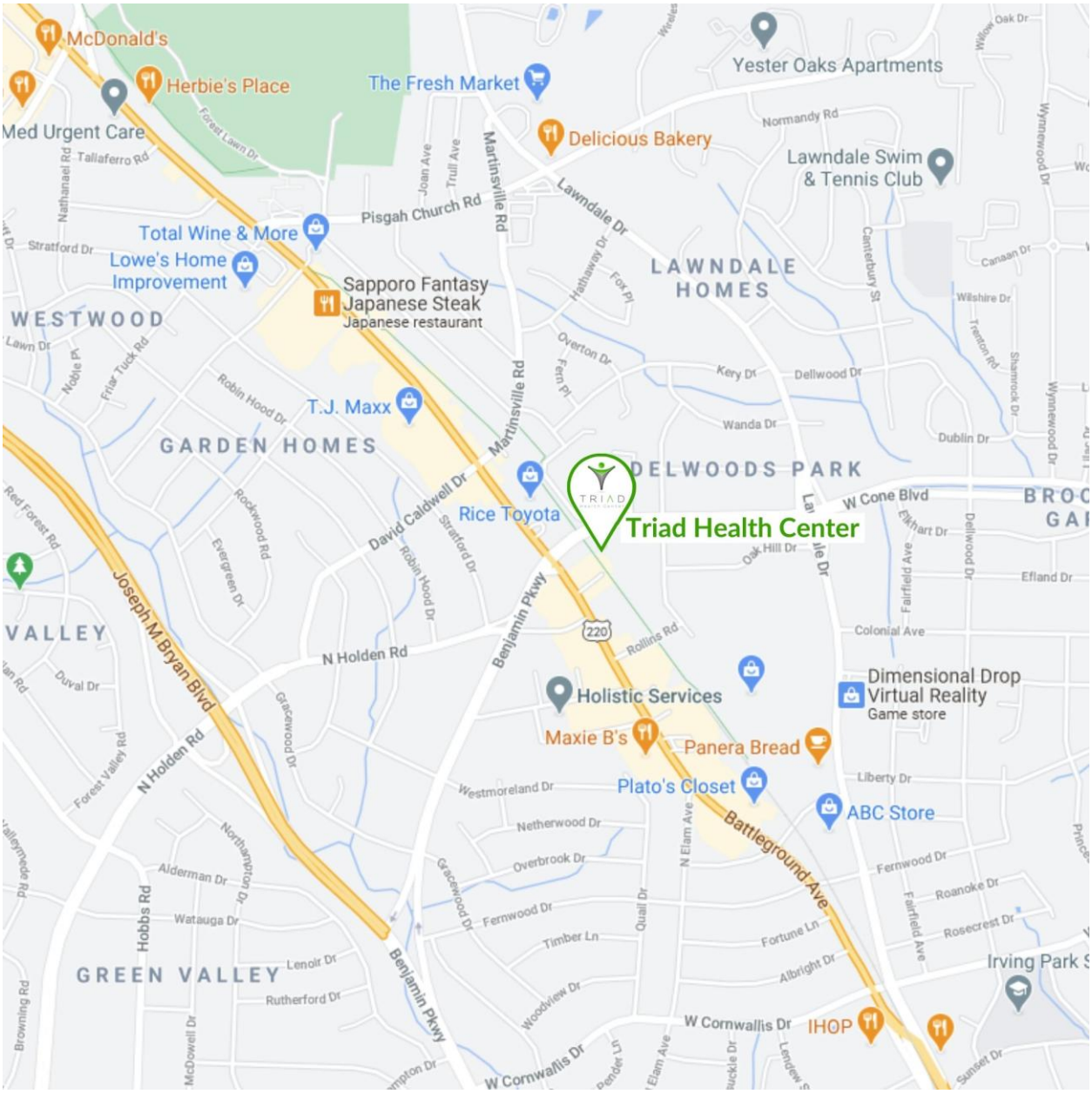
If you are more than 15 minutes late for your appointment or your paperwork is not completed or with you, the appointment is considered cancelled. You may reschedule this appointment up to 24 hours in advance. Outside of a catastrophic occurrence, you will be charged for any less-than-24 hour cancelations, late arrivals, or no-shows (see our Patient Policies on Page 4).

Directions to Triad Health Center:

We are located at **2311 W Cone Blvd Suite 228, Greensboro, NC 27408**

We are on the corner of W Cone Blvd and Battleground Ave. Our clinic is in the **Northwestern Plaza office complex**, which sits directly behind the All Pets Considered store and UPS Store. There is a McDonald's catty corner from our building.

If you need further directions, please call us: 336-288-4677



EXPECTATIONS

"You didn't get sick over night. Do not expect to get better over night."

The majority of patients who enter our office have been developing their illness for 20-30+ years. The process of getting well is much like the stock market; you will have good days and bad days. However, as you look back on your care you will realize you have always been progressing. I have been treating very sick people, including myself, for many years and I have never seen or experienced a progression to health in any other way.

My point is you are going to have bad days, and that does not mean you are regressing. You will also have good days, and those good days do not mean that you are cured.

True healing takes time. You can cover up symptoms in hours or days, but to remove a cause you will need to be patient and committed to the process. I can tell you from personal experience as it took 3-4 years to regain my complete health. With that said, after 6 months of treating the cause I was able to see the light at the end of the tunnel. My hope had returned. The same can be for you!

What You Can Expect From Us:

1. **Our commitment** to get to the true cause of your illness.

2. **Our support**, as we are here to offer you not just hope but a path to follow.

3. **Encouragement** based on our experience of treating very sick patients and going from pain to purpose in our own health battles.

4. **Value,** we understand that the majority of our patients have financial burdens many of which occur because of their illness. Therefore, we created a health investment discount package to make it more affordable (based on the minimal amount of visits, testing and fees). We obviously have to charge for our services, as we are a business, but by no means over charge in regards to today's medical fees. It is our goal to restore your health and life.

What NOT To Expect From Us:

1. **Do not expect a "get fixed quick scheme"** or a **"magic bullet"**. Most illnesses do not occur overnight and true healing takes time.

2. **Do not expect to be coddled** - we are going to be tough because we have to be! We will not necessarily tell you what you want to hear but we will tell you what you need to hear to regain your health and life. Most of the patients that we treat are in the death zone. We have found the only way to pull them out of the death zone is to not coddle but to speak truth into their lives.

What We Expect From You:

1. **Commitment to lifestyle changes.** It's not easy, but when getting to the cause, lifestyle changes and physical therapy routines must occur to return back to a state of health.

2. **Commitment to the protocols** that we outline for your case. It is the individuals that stick closely to the protocols and that remain diligent that get the most consistent results.

3. **Patience**. REMEMBER you didn't get sick over night and you will not get better overnight.

We are excited to help you reach your optimal health potential!

Dr. David Schwartz, D.C., D.PSc

Chiropractic Treatment Informed Consent

A patient entering Triad Health Center gives the doctor and doctor's staff permission and authority to care for them in accordance with appropriate test, diagnosis, and analysis. The clinical procedures performed are usually beneficial and seldom cause any problem. In rare case, underlying physical defects, deformities or pathologies may render the patient susceptible for injury. The doctor, of course, will not provide specific healthcare, if he/she is aware that such care may be contraindicated. It is the responsibility of the patient to make it known or to learn through health care procedures from whatever he/she is suffering from: latent pathological defects, illnesses, or deformities, which would otherwise not come to the attention of the physician.

I have been advised that medical and chiropractic care, like all forms of health care, hold certain risks. While the risks are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with chiropractic adjustments.

Treatment objectives as well as the risks associated with chiropractic adjustments and, all other procedures provided at Triad Health Center have been explained to me to my satisfaction and I have conveyed my understanding of both to Triad Health Center staff. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

_____ _____

Patient Signature **Date**

FEMALES ONLY

Authorization for Digital Xrays

Please read carefully and check the boxes, include the appropriate date, then sign below if you understand and have no further questions, otherwise see our receptionist for further explanation.

☐ The first day of my last menstrual cycle was on _____ date.

☐ I have been provided a full explanation of when I am most likely to become pregnant, and to the best of my knowledge, I am not pregnant.

By my signature below I am acknowledging that the doctor and or a member of the staff has discussed with me the hazardous effects of ionization to an unborn child, and I have conveyed my understanding of the risks associated with exposure to x-rays. After careful consideration I therefore, do hereby consent to have the diagnostic x-ray examination the doctor has deemed necessary in my case.

_____ _____

Patient Signature **Date**

Authorization for Records Release

I authorize Triad Health Center to release all necessary information concerning my health condition to my billing company, insurance company, Medicare, attorney, and/or adjuster in order to process any claim for reimbursement of charges incurred by me. In addition, I authorize Triad Health Center to release any information regarding my health condition to other health care providers involved in my care. This assignment will remain in effect until revoked by me in writing. I agree that a photocopy of this form is to be considered as valid as the original. I confirm that all information I have provided is true and correct to the best of my knowledge. I confirm that I have read and fully understand this agreement and authorize Triad Health Center to proceed with chiropractic tests, diagnosis, analysis, and adjustments.

_____ _____

Patient Signature **Date**

_____ Staff Initials

Nutritional Informed Consent

According to the Federal Food, Drug and Cosmetic Act, as amended, Section 201 (g) (1), the term "*Drug*" is defined to mean: "*Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease.*"

A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy.

Although a Vitamin, a Mineral, Trace Element, Amino Acid, or Herb may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a Drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as any primary treatment and / or therapy for any disease or particular bodily symptom.

Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and bio-mechanical processes of the human body.

Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (Drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

I have read and understand the above information:

_____ _____

Patient Signature **Date**

Sale of Nutritional Supplements at Triad Health Center, PLLC

You are under no obligation to purchase nutritional supplements at our clinic. As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or big box stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

As always, if you have questions or concerns, please discuss them with our staff.

I have read and understand the above information:

_____ _____

Patient Signature **Date**

_____ Staff Initials

Patient Policy Form

Welcome to Triad Health Center! We are excited to provide you with your health care needs and are honored to work with you to achieve your optimal health goals.

Please review our office policies. Initial each line item to indicate your understanding, then sign and date the bottom of this form as acknowledgement of our patient policies outlined below.

_____ **PAYMENT POLICY** Payment for all services and products is due at the time of the visit. As the patient, you are responsible for the total charges incurred for each visit. We accept Visa, MasterCard, Discover and American Express credit cards and debit cards for payment, as well as HRA, FSA, HSA and Christian Health Share.

Besides Medicare, we do not directly bill these services to health insurance. If you are seeking a method of reimbursement, you may request an itemized super bill receipt following each payment, and a super bill will be supplied by email within 72 business hours of receiving your request. The insurance company will reimburse you directly.

We may recommend natural and alternative supplements, which may be purchased from Triad Health Center. Most insurance companies do not cover the supplemental items that we recommend and sell. FSA, HRA, and HSA may or may not cover the supplemental items that we recommend and sell, and it is your (the client's) responsibility to research coverage and communicate with the FSA / HRA / HSA company regarding coverage.

_____ **SUPPORT POLICY** Any additional questions outside of scheduled consultations, including phone calls or emails from Dr. Schwartz or his support staff, are an extra charge, based in 15-minute increments at $60.

_____ **ARRIVAL POLICY** For all appointments, be sure to arrive and be ready at least 15 minutes early. Early arrival allows for a relaxed and unhurried experience, and ensures time to take care of any paperwork prior to appointment time. If late arrival is inevitable, your appointment may need to be shortened in order for the practitioner to stay on schedule. The original reservation fee will be charged.

_____ **LATE ARRIVAL POLICY** We regret that late arrivals will not receive extension of scheduled appointments. The original reservation fee will be charged.

_____ **RESCHEDULE & CANCELLATION POLICY** We require at least 24 hours notice if you need to reschedule or cancel an appointment. If a client fails to cancel within 24 hours, they will be asked to pay in full the amount of this missed appointment, and use it as a pre-payment for future services. An additional late/missed appointment charge of $30 will be assessed. **Cancellation and reschedule requests must be received via phone or email: 336-288-4677 or staff@triadhealthcenter.com.**

_____ **NO SHOW POLICY** Clients who fail to show for appointments will be asked to pre-pay for future services and an additional missed appointment charge of $30 will be assessed.

_____ **PATIENT MEMBER CARD POLICY** Once your Chiropractic Wellness care is established, you will be given a complimentary Patient Member Card to use to check in to each appointment. If you misplace your card, we may issue a temporary card up to three times, then we will ask you to purchase a new Patient Member Card at the price of $5.00.

_____ **CONFIDENTIALITY POLICY** The discussions between the practitioner and the client is confidential and is protected by state laws and the Health Insurance Portability and Accountability Act (HIPAA).

_____ **BREAK IN CARE POLICY** Clients who have not been seen at Triad Health Center for Chiropractic Wellness services for a year or more will be asked to fill out this form again.

_____ **TERMINATION OF CARE PLAN PROGRAM POLICY** If treatment is terminated prior to completing a care plan program option, financial responsibility to the patient is assessed at a per visit fee.

_____ **COMMUNICATION POLICY** I give permission for the staff at Triad Health Center to contact me via telephone, text or email and to leave me messages that may contain appointment or medical information if I am not available.

I have read and understand the above stated policies and will comply with them in all aspects.

_____ _____

Patient Signature **Date**

_____ Staff Initials

Notice of Privacy Practice

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your Personal Health Information. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as dictated by our office policy, we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled 'HIPAA' on tables in the reception. Should you want to keep a copy of this for your records, you may ask our receptionist to create a copy.

PERMITTED DISCLOSURES

1. Treatment purposes - discussion with other health care providers involved in your care.
2. Inadvertent disclosures - open treating area means open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes - to process a claim or aid in investigation.
5. Emergency - in the event of a medical emergency we may notify a family member.
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons – discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails for appointment and event reminders - we may call your home and leave messages regarding a missed appointment or make you aware of changes in practice hours or upcoming events.
11. Change of ownership - in the event this practice is sold, the new owners would have access to your PHI.

YOUR RIGHTS

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance (72 hours).
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain one copy of your records at no charge, when timely notice is provided (72 hours). X-rays are original records and you are therefore not entitled to them. If you would like us to outsource them to an imaging center, to have copies made, we will be happy to accommodate you. However, you will be responsible for this cost ($10.00).

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Triad Health Center at (336) 288-4677. If we are unavailable, you may make an appointment with our receptionist to see your doctor within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to: DHHS, Office of Civil Rights, 200 Independence Ave. SW, Room 509F HHH Building, Washington DC 20201.

I have received a copy of Triad Health Center's Patient Privacy Notice. I understand my rights as well as the practice's duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this "Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present. I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient Printed Name **Date of Birth**

_____ _____

Patient Signature **Date**

_____ Staff Initials

TRIAD Health Center

CHIROPRACTIC WELLNESS INTAKE PAPERWORK

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____

Email: _____

DOB: _____ Gender: ☐ Male ☐ Female

Age: _____ Height: _____ Weight: _____

SSN: _____ Insurance Info: _____

Status:

☐ Married ☐ Widowed

☐ Separated ☐ Single

☐ Divorced ☐ Partnership

I live with (check all that apply):

☐ Spouse ☐ Children

☐ Partner ☐ Friends

☐ Parents ☐ Alone

Primary Care Physician / Practice: _____

Occupation: _____ Hours / Week: _____ ☐ Retired

Employer: _____ Work Address: _____

What is your typical daily work activity? ☐ Sitting ☐ Standing ☐ Driving ☐ Work at Computer

☐ Light Lifting ☐ Heavy Lifting ☐ Manual Labor ☐ Other: _____

In case of emergency, whom should we contact:

Name	Relationship	Phone

How did you hear about our Chiropractic Wellness Program?

Have you experienced Chiropractic treatment before? ☐ Yes ☐ No *If yes,* when? _____

If yes, approximately how many treatments did you receive? _____

How was your overall improvement? ☐ Excellent ☐ Good ☐ Fair ☐ No Change ☐ Worse

Is today's visit a result of ANY type of accident? ☐ Yes ☐ No *If yes,* date of accident? _____

If yes, what type? ☐ Auto ☐ Work ☐ Other: _____

Has this accident been reported? ☐ Yes ☐ No *If yes,* to whom?_____

Have you EVER been in an auto accident? ☐ Yes ☐ No

If yes, when (list all accident dates)? _____

Did you experience any possible / known whiplash or other injury? Describe: _____

_____

Current Complaints

What are your major complaints? Please list when each symptoms began, providing as much description as possible. Then **on a scale from 0 to 10, circle to rate your level of severity / pain for each**, with 0 being no symptoms and 10 being most severe.

Symptom 1: _____ Began: _____

(no symptom) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (severe)

What (if anything) triggered the onset of this problem? _____

_____

What (if anything) triggers an episode? _____

_____

When is the problem at its worst? ☐ morning ☐ noon ☐ mid-day ☐ evening ☐ night

How long does it last? ☐ Constant ☐ On / Off during the day ☐ Comes and goes throughout week

What have you done to treat it in the past? _____

_____

What were the results? ☐ Favorable ☐ Unfavorable, explain: _____

Symptom 2: _____ Began: _____

(no symptom) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (severe)

What (if anything) triggered the onset of this problem? _____

_____

What (if anything) triggers an episode? _____

_____

When is the problem at its worst? ☐ morning ☐ noon ☐ mid-day ☐ evening ☐ night

How long does it last? ☐ Constant ☐ On / Off during the day ☐ Comes and goes throughout week

What have you done to treat it in the past? _____

_____

What were the results? ☐ Favorable ☐ Unfavorable, explain: _____

Symptom 3: _____ Began: _____

(no symptom) 0 ----- 1 ----- 2 ----- 3 ----- 4 ----- 5 ----- 6 ----- 7 ----- 8 ----- 9 ----- 10 (severe)

What (if anything) triggered the onset of this problem? _____

_____

What (if anything) triggers an episode? _____

_____

When is the problem at its worst? ☐ morning ☐ noon ☐ mid-day ☐ evening ☐ night

How long does it last? ☐ Constant ☐ On / Off during the day ☐ Comes and goes throughout week

What have you done to treat it in the past? _____

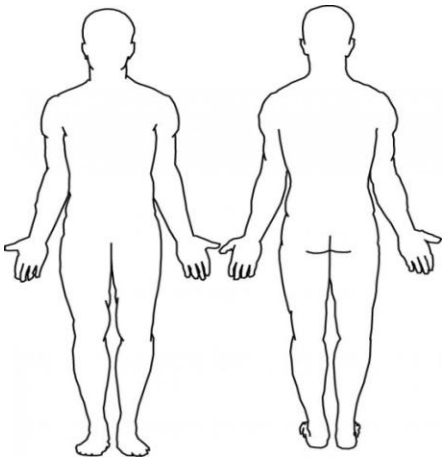
_____

What were the results? ☐ Favorable ☐ Unfavorable, explain: _____

Please mark the areas on the diagram to the right with the following letters to illustrate and describe your symptoms:

R = Radiating **B** = Burning **D** = Dull **A** = Aching

N = Numbness **S** = Sharp / Stabbing **T** = Tingling



What relieves your symptoms? _____

What makes them feel worse? _____

How much would you say these symptoms affect / restrict your activity level? Explain below:

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

Please list which activities are affected / restricted (e.g. walking, sitting, standing, running, sleeping, etc):

Are there any other health symptoms, potentially not pain-related, that you would like our help with? (e.g. nutrition, weight loss, thyroid, emotional trauma, diabetes, fatigue, sleep, thermography, etc.)

What are your health and lifestyle goals you hope to achieve while under Chiropractic care?

Health History

Have you suffered from these issues or similar problem(s) in the past? ☐ Yes ☐ No

If yes, How many times? _____ When was the last episode? _____

Please identify all types of jobs you have had in the past that have imposed physical stress on your body:_____

_____

Are you currently under drug and/or medical care? ☐ Yes: _____ ☐ No

Please list your current and past health conditions (e.g. Diabetes, Joint Pain, SIBO, Fibromyalgia, heart condition, childhood diseases, digestive issues, autoimmune condition, neurological issues, skin, etc.):

Is there anything else in your medical history that you consider to be relevant (even from childhood)?

What are your current medications?

Medication	Dose	Reason for Taking

What are your current vitamins / supplements?

Supplement	Dose	Reason for Taking

TRIAD Health Center

THIS SECTION IS FOR MEN ONLY

Date of last Thermography Scan _____ Results: ☐ Normal ☐ Abnormal

Date of last Prostate Exam _____ Results: ☐ Normal ☐ Abnormal

Do you experience (check all that apply):

☐ Discharge from penis ☐ Ejaculation problem ☐ Genital pain ☐ Impotence ☐ Infection

☐ Lump in testicles ☐ Poor libido (sex drive) ☐ Prostate enlargement ☐ Prostate infection

Any other hormone-related comments we should know? _____

_____

THIS SECTION IS FOR WOMEN ONLY

Age at first period: _____ years

Are you periods now: ☐ Regular ☐ Irregular ☐ Heavy ☐ Scanty ☐ Spotting ☐ No periods

Date of last Thermography Scan _____ Results: ☐ Normal ☐ Abnormal

Date of last Pap Smear _____ Results: ☐ Normal ☐ Abnormal

Date of last Mammogram _____ Results: ☐ Normal ☐ Abnormal

Do you experience (check all that apply):

☐ Ovarian cysts ☐ Poor libido (sex drive) ☐ Endometriosis ☐ Fibroids ☐ Infertility ☐ Miscarriage(s)

☐ Vaginal pain ☐ Vaginal discharge ☐ Vaginal odor ☐ Vaginal itch ☐ Breast cysts ☐ Breast lumps

Have you had a Hysterectomy? ☐ Yes, Partial ☐ Yes, Total ☐ No

Any other hormone-related comments we should know? _____

_____

Please list past or present allergies, including allergies to medications. (Check all that apply.)

☐ Adhesives	☐ Animals	☐ Aspirin	☐ Bee Stings
☐ Ceftin	☐ Chocolate	☐ Dairy	☐ Dust
☐ Eggs	☐ Flax / Linseed	☐ Food Dyes / Colors	☐ Gluten
☐ Grains	☐ Latex	☐ Meat	☐ Molds
☐ Oxytocin / Codeine	☐ Peanuts / Nuts / Seeds	☐ Penicillin	☐ Pollen / Ragweed
☐ Rubber	☐ Seasonal Allergies	☐ Shellfish	☐ Soaps / Cleansers
☐ Soy	☐ Thickeners / Carrageenan	☐ Wheat	☐ X-ray Dye
☐ Other:	☐ Other:	☐ Other:	☐ Other:

Please list all past surgeries and the condition each surgery was for, including dates.

How well have things been going for you (check all that apply)?

	Very Well	Fair	Poorly	Very Poorly	Does Not Apply
At school					
In your job					
In your social life					
With close friends					
With sex					
With your attitude					
With your partner					
With your spouse					
With your parents					
With your children					
Other: _____					

Have you ever had psychotherapy or counseling? ☐ Yes ☐ No

If yes: ☐ Currently ☐ Previously, from _____ to _____

What kind? _____

Comments: _____

Do you exercise regularly? ☐ Yes ☐ No

If yes:

How often?	✓
4 x / week or more	
3 x / week	
2 x / week	
1 x / week	
2 x / month	
1 x / month	

How long is each session?	✓
≤ 15 minutes	
16-30 minutes	
31-45 minutes	
> 45 minutes	

What type of exercise?	✓
Jogging / Walking	
Running	
Biking	
Other:	

Do you have artificial joints or implants? ☐ Yes ☐ No

Do you have any of these devices? ☐ Pacemaker ☐ Hearing Aid ☐ Insulin Pump ☐ No, none

Have you ever used recreational drugs? ☐ Yes ☐ No

Have you ever used alcohol? ☐ Yes ☐ No

If yes, how often do you drink alcohol?

☐ No longer consume alcohol ☐ 1-3 drinks/wk ☐ 4-6 drinks/wk ☐ 7-10 drinks/wk ☐ >10 drinks/wk

Have you ever used tobacco? ☐ Yes ☐ No

If yes, number of years as a nicotine user: _____ years. Amount per day: _____. Year quit _____

What type of nicotine have you used? ☐ Cigarette ☐ Smokeless ☐ Cigar ☐ Pipe ☐ Patch/Gum

Are you exposed to second hand smoke regularly? ☐ Yes ☐ No

Does anyone in your family suffer with the same condition(s)? ☐ Yes ☐ No

If yes, whom? ☐ Grandmother ☐ Grandfather ☐ Mother ☐ Father ☐ Sister(s) ☐ Brother(s) ☐ Son/Daughter

Have they ever been treated for their condition? ☐ Yes ☐ No ☐ I don't know

Is there any other family history or hereditary conditions we should know about? ☐ Yes ☐ No

If yes, please explain:

What is the attitude of those close to you about your condition? ☐ Supportive ☐ Non-supportive

Are you interested in any of our other programs or services at Triad Health Center?

☐ Functional Medicine ☐ Emotional Release Therapy ☐ Thermography ☐ Lab testing ☐ Family wellness care

* I certify that the above questions were answered accurately and fully to the best of my ability. I understand that providing incorrect information can be dangerous to my health.

_____ _____

Patient Signature **Date**

_____ Staff Initials

☐ **CHECK HERE if you have imaging and/or treatment plans from the past 2 years for Dr. Schwartz to review. Please bring these to your appointment or send to us: staff@triadhealthcenter.com**

YOU HAVE COMPLETED YOUR INTAKE FORMS

Please bring these forms with you to your appointment or return your completed PDF file to us by email at least 2 hours prior to your scheduled appointment time: staff@triadhealthcenter.com

Upon arrival to our office, you will be asked to provide our office with a copy of your insurance card(s) and proof of identification. Please remember to bring these with you to your appointment.