Triad Of Health

FAMILY HEALING CENTER

4340 Redwood Highway
Suite D318
San Rafael, CA 94903
415.459.4313 Phone
www.TriadOfHealth.net

Welcome to Triad Of Health!

Step 1: Please take the time to fill out the new patient paperwork that will help us better understand your current symptoms, personal history, and health goals. The more information we have, the more effective our Doctors will be in helping you with your condition.

Step 2: The Doctor will then review and discuss your detailed responses.

Step 3: An appropriate examination will then be done to determine your diagnosis and see if our methods of health care are appropriate for your condition. Give yourself about 1 hour of time for the exam. After the exam we will schedule an appointment for you to come back and then be advised as to whether or not you will need to have labs or X-rays conducted.

Step 4: The Doctor will go over the Report of Findings where you will be informed of how we feel that we can help you and what would be the best course of action to take in order for you to reach your health goals.

Step 5: Once you clearly understand your case and diagnosis, treatment recommendations will be given to you. Your treatment plan will be tailored to your diagnosis and health goals. If you are comfortable with the findings and excited about the plan for new health and a new life, treatment will begin and continue as long as you keep making dramatic progress and your health goals have been met.

Our goal is to help you achieve your health goals as quickly as possible, so that your body can function optimally.

The Highest Good is to find the Structural, Chemical and Emotional Causes of the Health Challenges and then to Treat the Causes and not the Symptoms!

ABOUT YOU

Today's Date _

Name_____ Date of Birth_____/_____/_____

Address_____ SS#_____/_____/_____

_____ Height_____Weight_____

_____ Age_____Sex _____

Marital Status: S M D W_____ Occupation_____

Telephone (Home)_____ # of children_____

Telephone (Cell)_____ Email_____

Telephone (Work)_____Referred by_____

Person Responsible for account Self / Spouse / Parent

Is your condition a result of an auto injury? Yes / No

Is you condition a work related injury? Yes / No

MAIN HEALTH CONCERN

What is your biggest health concern? _____

How long have you had this condition/concern? _____

Is your problem getting better, worse or is it constant? _____

If worse, what time of day is the most difficult?

_____morning_____afternoon_____evening_____night

Is it interfering with your work?_____Sleep_____Exercise_____Other_____

What do you believe is wrong with you? _____

List other problems you have now _____

List past operations and dates _____

Have you ever been hospitalized other than for surgery? _____

Have you ever had any mental or emotional disorders? _____

Your Current Condition

Please list any natural supplements you currently take and for what conditions (not hormones):

_____

_____

Are you allergic to any foods, drugs, etc? _____

Do you have any dental problems? _____

Do you wear arch supports? _____ Heal lifts? _____ Special shoes? _____

Date of your last physical exam? _____ Dr. _____

Do you have a belly button ring or other than the ear lobe? _____

Please describe all body piercing and/or tattoos wherever they may be located _____

_____

Do you wear eyeglasses? Yes No If yes, when did you last get your prescription fulfilled (# of months ago)? _____

Describe your present exercise habits: _____

_____

_____

_____

Please list the main health problems in your family. Include any medications they use.

Name: Relation: Problem:

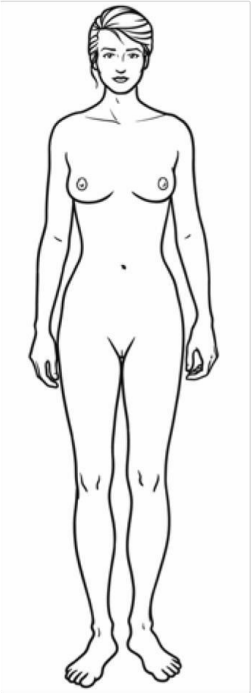
_____

_____

_____

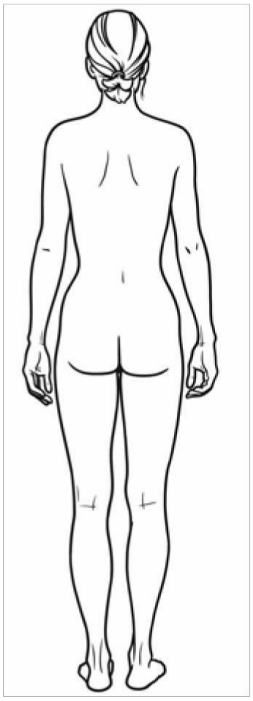
Pain Severity Level

Draw a line from each type of pain / symptom that you are experiencing to the corresponding area of your body where you have the pain. Using the chart below rate each pain / symptom by writing the pain severity on each line.



Achy
Burning
Cramping
Dull
Electric Shock
Numbness
Radiating
Sharp
Shooting
Stabbing
Stiffness
Swelling
Throbbing
Tingling

Other pain_____



	None		Mild			Moderate				Severe		
Pain Severity	0	1	2	3	4	5	6	7	8	9	10	
	No Pain		Annoying pain		Pain causes you to slow down				Pain limits your ADL			
ADL = Activities of Daily Living			Aware of discomfort Able to do activities soreness, ache, stiff		Takes longer to complete work May be unable to do demanding work. Hurt, pain, very sore				Some difficulties with sleep sharp pain, stabbing			

METABOLIC ASSESSMENT FORM

PART I

Please list your 4 major health concerns in the order of their importance:

1. _____
2. _____
3. _____
4. _____

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

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

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

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

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

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

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

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

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. Form credited to Datis Kharrazian

Category IX

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

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

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

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

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

Category XVI (Menopausal Females Only)

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 Females Only)

How many years have you been menopausal? _____

Since menopause, do you ever have uterine bleeding?	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 breasts	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

How many alcohol beverages do you 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? Yes No If yes, how many times a day: _____ Do you smoke pot? Yes No If yes, how often? _____

Other drugs? Yes No If yes, what and how often? _____

Rate your stress levels on a scale of 1–10 during the average week: _____

Please list any medications you are currently taking and for what conditions. (Include any bioidentical hormones you are currently using such as DHEA, pregnenolone, progesterone, estrogen, testosterone, etc.). If hormones, what doses and for how long? Are they oral or sublingual, patch, cream, or gel? How do you apply product? How long have you taken these medications or hormones for? _____

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Notice Of Privacy Practices (HIPAA). **Effective date: April 14, 2003**

This notice describes how health information about you (as a patient of this practice) may be used and disclosed and how you can get access to your individually identifiable health information.
Please review this notice carefully.

A. Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood orurine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your PHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health care operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

4. Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

5. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

B. Your rights regarding your PHI:

You have the following rights regarding the PHI that we maintain about you:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Dr. Ilya Skolnikoff, D.C. at (415) 459-4313 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate **reasonable** requests. You do not need to give a reason for your request.

2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request**; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Doctor at Triad Of Health, 4340 Redwood Highway,Suite D318,San Rafael, CA 94903
Your request must describe in a clear and concise fashion:

- The information you wish restricted,
- Whether you are requesting to limit our practice's use, disclosure or both,
- To whom you want the limits to apply.

3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to the Doctor at (415) 459-4313 in order to inspect and/or obtain a copy of your PHI. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to the Doctor at Triad Of Health, 4340 Redwood Highway, Suite D318, San Rafael, CA 94903. You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact the Doctor at (415) 459-4313.

6. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact the Doctor at (415) 459-4313. All complaints must be submitted in writing. **You will not be penalized for filing a complaint**.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. *Please note*: we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact the Doctor at (415) 459-4313.

You are giving Triad Of Health permission to communicate with you by fax, email and phone conversation. We may take photos of you and reserve the right to use your photos in promotional material unless you say otherwise. To repeat, we have permission to use your image in any videos, testimonials or promotional materials.

_____ _____

(patient signature) (today's date)

THREE DAY DIET DIARY

Please write down everything that you have had to eat and drink during the previous 3 days. This will ensure that you receive the best care and diagnosis possible.

	Today	Yesterday	2 Days Ago
Breakfast			
Snack			
Lunch			
Snack			
Dinner			
Snack			
Notes			

FEMALE HEALTH HISTORY QUESTIONNAIRE

1. List your history of GYN procedures or surgeries (ovaries, hysterectomy, tubal ligation, breast, etc.)

_____

_____

_____

2. Date of last pelvic/gynecological exam: _____ Last Pap test: _____ Last mammogram: _____

3. Last thermography? _____ Unusual results? _____

4. List significant non-GYN health issues (diabetes, surgeries, etc.): _____

_____

_____

_____

LIFESTYLE INDICATORS *(Please circle appropriate answer)*

1. How would you rate your stress handling? (1=Poor, 10=Excellent) 1 2 3 4 5 6 7 8 9 10

REPRODUCTIVE HEALTH HISTORY *(Please fill in or circle the appropriate answer)*

1. Your age at onset of menarche (first period):_____Approximate date of onset _____

2. Are you currently using a method of birth control? Yes No

If yes, what method? _____

3. Are you, or have you used *(please circle)*oral, injected, patch, or ring hormone contraceptives, or used Emergency Contraception (aka "the day after" pill)? Yes No When and for how long? _____

4. Are you, or have you used an IUD? Yes No If yes, when and for how long? _____

What type of IUD did you use? Copper Hormone Other _____

5. Please describe problems that you may have experienced associated with the use of any and all birth control methods (such as yeast, heavy/light bleeding, mood, weight gain, acne, sweet cravings, fatigue, depression, palpitations, etc.)

_____

_____

_____

6. Have you used, or are you currently using fertility treatment? Yes No

If yes, please explain _____

7. Have you been pregnant before? Yes No Age(s) of children _____

Number of pregnancies: _____ Details/Complications _____

Number of live births: _____ _____

Miscarriages: _____ _____

Premature births: _____ _____

Cesarean births: _____ _____

Stillbirths: _____ _____

Abortions: _____ _____

Ectopic pregnancies: _____ _____

8. If you have had a miscarriage, how many weeks pregnant were you? _____

9. Have you had an abnormal Pap test? Yes No Diagnosis/Reason: _____

Treatment and/or Medication: _____

10. Have you had a vaginal infection? Yes No If yes, what? _____

Treatment and/or Medication: _____

11. Any history of: Ovarian cysts Yes No Uterine fibroids Yes No Endometriosis Yes No

Fibrocysticic Breasts Yes No Polycystic Ovarian Syndrome (PCOS) Yes No

FOR CYCLING-AGE WOMEN *(Please fill in or circle the appropriate answer)*

1. First day of last menstrual period (LMP)_____Have you had a tubal ligation? Yes No When? _____

2. Has there been any recent change in your cycle or symptoms associated with your cycle? Yes No

If yes, please give details: _____

_____

_____

_____

_____

3. How many days is your current cycle? (Counted from the first day of your period to the first day of your next period.)

<20_____20–30_____30–40 _____ 40–50_____>50 _____

4. How many days does menstruation typically last? _____

5. Is your cycle regular? Yes No Not Always Details: _____

6. Typical menstrual flow: Light Medium Heavy Details: _____

7. How many *pads* and/or *tampons* (circle) are used on heavy days? _____

8. Do you pass clots? Yes No How often? _____

9. Do you spot? Yes No At what point in your cycle? _____

10. Do you experience cramping? None Mild Moderate Severe

At what point in your cycle? _____

11. Do you experience abnormal vaginal discharge? Yes No If yes, when? _____

12. Do you experience vaginal itching and/or odor? Yes No If yes, when? _____

13. Do you experience breast tenderness? None Mild Moderate Severe

At what point in your cycle? _____ Change in breast size? Yes No

14. Do you experience nipple discharge? Yes No If yes, when?_____Color? _____

FOR MENOPAUSAL WOMEN *(Please fill in or circle the appropriate answer)*

1. Your age at the onset of menopause: _____ Year of onset: _____

2. Have you had a hysterectomy? Yes No If yes, which? Complete*(ovaries AND uterus)* or Partial*(uterus only)*

3. Date of hysterectomy:_____ Reason for hysterectomy: _____

4. List any other GYN-related surgeries: _____

5. Describe your experience transitioning into menopause *(symptoms, strong emotions, thoughts, unusual stressors, etc.):*

6. Have you utilized any alternative, complementary, or natural remedies in your management of menopause? Yes No

If yes, what? _____

For how long? _____

9. Have you had or do you have any vaginal spotting or bleeding since menopause? Yes No

If yes, when?_____ Were you evaluated and/or treated by a GYN? Yes No

Treatment: _____

PLEASE DESCRIBE YOUR CYCLE HISTORY

10. How would you have described your menstruation? Easy Uncomfortable Difficult Debilitating

11. What was your typical menstrual flow? Light Medium Heavy

12. When you were cycling would you consider your cycle regular? Yes No

If no, explain: _____

Please describe any "treatment" ever received for cycle issues: _

SLEEP HABITS

1. How do you sleep? Well Trouble falling asleep Trouble staying asleep Insomnia

How long has this been happening? _____

2. How many hours do you sleep a night on average? _____

3. Do night sweats wake you up? Yes No How often? _____

4. Do you wake up tired? Yes No How long has this been happening? _____

5. Is your room completely dark when you sleep at night? *(No night light, street lamp, TV, etc.)* Yes No

6. Do you get at least 30 minutes of outside daylight time, several days each week? Yes No

7. Do you experience warm or hot flashes? Yes No

INSTRUCTIONS: *Check either "Ongoing" or "Just w/Period" for each problem that applies to you. Check both if the problem is onf;!oin 7 and worse with your p eriod. Then rate the severity.*

S GNS & SYMPTOMS	ONGOING	JUST w/PERIOD	MILD	MODERATE	SEVERE	MORE NFORMAT ON
Mood swings						
Anxiety/Nervousness						
Overly Reactive/Short fuse						
Irritability						
Depression						
Lowered self-esteem/self-image						
Caretake others before yourself						
Sadness/Crying						
Foggy thinking						
Memory difficulties						
Fatigue						
Constant hunger						
Sweet cravings (carbs/chocolate)						
Caffeeine/Stimulant cravings						
Salt cravings						
Headaches/Migraines						
Body/Joint Aches/Backache						
Weight gain						
Weight loss						
Water retention						
Bloating						
Irritable bowel						
Constipation						
Light-colored stool						
Loose stool/Diarrhea						
Nausea/Vomiting						
Acne						
Excessive facial hair						
Body/Head hair loss						
Dry skin/Brown spots						
Lowered libido						
Heightened libido						
Hot flashes						
Night sweats						
Breast tenderness/Swelling						
Nipple discharge						
Vaginal infections						
Urinary frequency						
Incontinence						
Vaginal dryness						
Painful intercourse						

Any other symptoms? _____

PATIENT POLICIES

Please read and initial at the beginning of each paragraph to indicate your agreement with the policies.

1. **Cancellation Policy:**
   _____ There is a 2-business day cancellation policy. (The term "business day" refers to Monday through Friday.) Same-day cancellations will be charged the FULL FEE for that visit. The only exception is a local emergency or medical emergency accompanied by a signed doctor's note. Without a signed doctor's note, you will be charged the full fee for the missed visit.

2. **Payment Policy:**
   _____ Payment in full is expected before or at the time of service. Accepted payment methods include MasterCard, Visa, American Express, Discover, check, cash, Zelle, or Care Credit.

3. **Appointment Procedure:**
   _____ Please fill out your chart upon arrival for each appointment. If the chart is not readily available, please ask for it.

4. **Clothing Requirements and Treatment Flow:**
   _____ Wear cotton or natural fiber clothing to your treatment sessions. No dresses or skirts unless pants are worn underneath. Sit on the treatment table after entering the treatment room.

5. **Jewelry and Metal Objects:**
   _____ Remove all jewelry, metal objects, belts, and wallets before the session. This includes earrings, belly button rings, toe rings, hand rings, watches, etc. Use the provided ceramic tray in the treatment room for these items.

6. **Treatment Protocol:**
   _____ Follow the doctor's recommended care schedule for maximum results. Missed appointments should be rescheduled promptly. In-office programs expire after 14 months.

7. **Lifestyle Changes:**
   _____ Make the necessary lifestyle changes and follow up on referrals to other healthcare providers. Your results will be compromised if you do not adhere to these recommendations.

8. **Payment Responsibility:**
   _____ You are responsible for all payments.

9. **Insurance Billing:**
_____ If you wish to bill your insurance, we will provide a receipt so you can submit the claim. Our office will not bill your insurance for you.

10. **No Refunds or Returns:**
_____ There are no refunds or returns for nutrients purchased or any services provided, regardless of use or condition. This policy is strictly enforced without exceptions. Bonus visits can never be refunded as they are a bonus.

11. **Office Pharmacy:**
_____ Our office stocks a complete nutraceutical, whole food, solid herbal, liquid herbal, flower essence, and homeopathic pharmacy. Please do not bring your herbs or nutrients unless requested.

12. **Appointment Scheduling:**
_____ Use the provided link to schedule, reschedule, or cancel appointments. Ensure you receive a confirmation by text, email, or phone. If you do not receive a reminder, please repeat the action.

Patient Information:

_____
Patient Name — Please Print

_____ _____
Patient or Legal Guardian Signature Date

INFORMED CONSENT FOR CHIROPRACTIC CARE

Like all forms of health care Chiropractic care offers tremendous benefit may also provide some level of risk. This level of risk is most often very minimal, yet in rare cases injury has been associated with chiropractic care. The types of complications that have been reported secondary to chiropractic care include sprain/strain injuries, irritation of a disc condition, and rarely, fractures. One of the rarest complications associated with chiropractic care, occurring at a rate between one instance per one million to one per two million cervical spine (neck) adjustments may be a vertebral artery injury that could lead to stroke.

Prior to receiving chiropractic care at Triad Of Health Family Wellness Clinic, a health history and physical examination will be completed. These procedures will assist us in determining if chiropractic care is needed, or if any further examinations or studies are needed. In addition, they will help us determine if there is any reason to modify your care or provide you with a referral to another health care provider. All relevant findings will be reported to you along with a care plan prior to beginning care.

I understand and accept that there are risks associated with chiropractic care and give my consent to the examinations that the doctor deems necessary, and to the chiropractic care including spinal adjustments, as reported following my assessment.

The information I have provided on these forms is true and accurate to the best of my knowledge. I give Dr. Ilya Skolnikoff permission to render care to me.

_____

Patient Name — Please Print

_____ _____

Patient or Legal Guardian Signature Date

_____ _____

Witness Signature (Dr. or Office Staff) Date

Drug Awareness Disclosure Form

I,_____, acknowledge that any and all information, advice and / or feedback regarding prescription medications I receive from Dr. Ilya Skolnikoff and any of his affiliated practitioners and physicians is for informational purposes only. I acknowledge that it is not a specific recommendation to alter the dosage, stop altogether, or begin any prescription medication whatsoever.

By signing this I have acknowledged that I am solely responsible for any alterations I make in my medications. I also realize that it is my responsibility to coordinate any such changes with the prescribing physicians, pharmacists or any others in order to safely and properly do so.

Date_____

Signature_____