Informed Consent

It is understood by the undersigned, that the advice sought by this office includes methods that are considered alternative by consensus mainstream medicine. It is also understood that in addition to traditional Chiropractic care, laboratory tests to determine functional imbalances of hormones, gastrointestinal function, minerals and amino acids may be requested since these factors could be an underlying cause of your complaints. Consequently, the advice of this office could include recommendations in dietary changes, the use of supplements, exercise patterns, sleep habits, environmental exposure, and interpersonal relationships that could be either directly or indirectly related to the development of illness.

We very much believe in a person being involved in his/her own health care and encourage you to ask questions and participate in decisions surrounding diagnostic and treatment procedures. When necessary it may be advantageous to remain on medications, or consult with other health care providers for additional information and procedures. Nutritional supplements are necessary in most cases and are best filled by companies recommended by this office. My investigation and experience has led me to the opinion that these companies offer products of greater quality. If you desire to buy supplements from other sources you are free to do so.

Furthermore, with your signature below you understand and agree that this office makes no representations, claims or guarantees that your health problem can be improved with the treatment provided. However, we will do our best to help you accomplish your health care goals.

You also acknowledge receipt of, and opportunity to review this consent. Furthermore, you understand that I am relying upon your signature on this consent in consideration of accepting you as a new patient.

_____ _____

Patient or Legal Guardian Printed Name Signature Date

Natural Health Chiropractic
Dr. Paul Goldstein

495 Union Ave. Suite 1B, Middlesex NJ 08846
Ph: 732-271-0400 Fax: 732-271-0275

Personal Information:

Name_____ Social Security #_____
Address_____
City_____State_____Zip_____
Home Telephone_____Age____Birthdate_____Marital Status M S W D
Work Telephone_____# Children_____Emergency Contact_____
Occupation_____Referred by_____ Emergency phone_____
Cellular phone_____ E-mail_____

Health Information:

What is your major complaint?_____
_____
Other complaints: _____
How long have you had this condition? _____
Have you had this or similar condition in the past? _____
Any family history of this condition? _____
What activities aggravate your condition? _____
Is this getting progressively worse? Yes_____ No_____ Constant _____ off and on _____
Is this interfering with your: Work_____ Sleep_ ____ Daily routine _____ Other_____
How long has it been since your really felt good? _____
Other doctors who treated this condition _____
List surgical operations and years: _____
_____
Drugs you now take (circle): Pain killers, Muscle relaxers, Tranquilizers, Insulin, Sleep, Birth Control, Depression, Antibiotics, Other _____
Age of mattress _____ please check: comfortable_____ uncomfortable _____
Are you wearing: Heel lifts _____ Sole lifts _____ Orthotics _____
Have you been in an auto accident?
Please check: past yr. _____ past 5 yrs. _____ over 5 yrs. _____ Never _____
Have you had any other personal injury or accident? Yes_____ No _____
Please describe: _____

Family Health History:

Name	Relation	Past and Present Health Problems

Dr. Paul Goldstein
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www.naturalhealthchiropractic.com

Patient Name_____

Your first appointment is scheduled on: _____ at _____o'clock.

Congratulations on taking this crucial step towards improving your health naturally.
Enclosed is the paperwork that will help the doctor understand your health history.
If possible, please mail or fax this information back to us, along with a copy of your insurance card prior to your first visit or bring it with you on your initial visit.

Most initial appointments are 60-90 minutes due to the taking of the health history and the comprehensive nature of the exam. Medicare insurance will not cover it, and other insurances may not cover the exam cost in full however subsequent office visits/treatments will be covered if you have an insurance deductible and it has been met.

The following represents a sample of our fees.
Initial Exams (60-90 minutes) $100.00-$195.00 Lab Test consultation fee $35.00
Limited Initial Exam/Re-exam (half hour) $25.00-$85.00
Orthopedic Supports prices vary
Office Visit (15 minutes) $55.00 (Missed appoint. w/o 24 hr. notice:
Extended Office Visit (half hour) $65.00-75.00 first time N/C, second time $55.00)
Very Extended A.K. Office Visit (one hour) $125.00
Modalities
(Electrical stim, Ultrasound, Soft tissue mobilization) $20.00-35.00 ea. P.E.M.F. 30 min. $35.00 60 min. 70.00 Exercise with Oxygen Therapy (EWOT) $35.00
Hyperbaric Oxygen 60 min. $100.00, 90 min. $135.00 10% discount for 5 sessions and 15% discount for 10+ sessions pre-paid.

Insurance

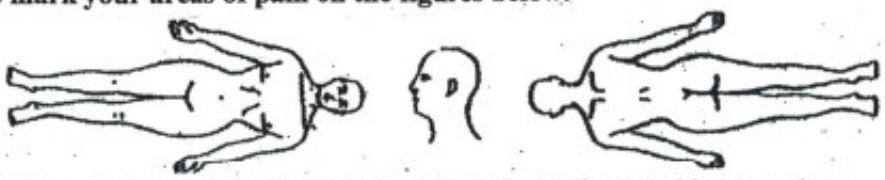
If you wish for us to file the insurance for you, please email or fax us a copy of your insurance card along with your date of birth and the date of birth of the policy holder if it is someone other than you. My participating with your insurance plan does not guarantee full coverage. Deductibles, copays, maintenance care and uncovered services may apply.

Specific Instructions

1. Bring in completed paperwork (if you cannot fax it in time for your appointment)
2. Bring in all supplements you may be taking.
3. Bring in (or fax) any results from lab tests such as blood work, x-rays, MRI's etc.
4. Do not wear perfume or cologne (many of our patients are chemically sensitive).
5. Continue taking any prescription medications, however, stop taking supplements for at least one day prior to your appointment.

List the date of your last Physical Examination _____

Please mark your areas of pain on the figures below.



Please list any disease or condition that may have been diagnosed by a previous physician: _____

Please check if you have you had any difficulty with the following:

Head: Headaches _____ Dizziness/Fainting _____ Sinus _____ Other _____
Eyes: Glasses _____ Pain _____ Inflammation _____ Other _____
Ears: Hearing _____ Ringing _____ Pain ____ Wax accumulation _____ Other _____
Nose: Smell _____ Hayfever ____ Head colds _____ Obstruction ____ Other _____
Throat: Speech ____ Tightness ____ Pain ____ Thyroid ____ Tonsils ____ Other _____
Neck: Stiffness _____ Grating _____ Pain _____ Tension _____ Other _____
Right Shoulder: Pain _____ Stiffness _____ Bursitis _____ Other _____
Left Shoulder: Pain _____ Stiffness _____ Bursitis _____ Other _____
Elbows: R ___ L ___ **Wrists**: R ____ L ____ **Hands**: R ___ L ___
Heart: Pain ____ Spasms _____ Palpitations _____ Attack _____ Other _____
High Blood Pressure: _____ When? _____ Low Blood Pressure: _____ When? _____
Lungs: TB _____ Pain around chest _____ intercostal neuritis _____ Other _____
Abdomen: Stomach _____ Liver _____ Gall Bladder _____ Intestines _____
Reflux _____ Gas _____ Constipation _____ Diarrhea _____ Other _____
Kidneys _____ Hemorrhoids _____ Tenderness of abdomen _____
Female: Pain _____ Cramping _____ Irregularity _____ Menopausal hot flashes _____ Other _____
Male: Frequent urination _____ wake at night to urinate? _____ Other _____
Do you have: Inner tension _____ Nervousness _____ Difficulty Sleeping _____
Numbness in any body part _____ Cramps _____ Swelling _____
Anemia _____ Fainting _____ Weakness _____ Painful joints _____
Swollen joints _____ Pain in upper back _____ Pain in middle back _____
Pain in lower back _____
Pain in Hips ___ R _____ L _____ Thigh ___ R _____ L _____ Knee ___ R ___ L ____
Pain in Calf ___ R _____ L _____ Ankle ___ R _____ L _____ Foot ___ R ___ L _____

Insurance Information:

Is your condition due to an auto accident or job related injury? Yes _____ No _____
Do you have Health Insurance? Yes _____ No _____ If yes,
Name of Insurance Company _____
Policy # _____
Are you covered by Medicare? Yes _____ No _____ If yes,
Health Insurance # _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this Chiropractic office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to this Chiropractic office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Patient's Signature: _____ Date: _____
Guardian or Spouse's Signature: _____ Date: _____
Doctors Signature: _____ Date: _____

Metabolic Assessment Form™

Name: _____ **Age:** _____ **Sex:** _____ **Date:** _____

PART I

Please list your 5 major health concerns in order of importance:

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

PART II **Please circle the appropriate number 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 relieved 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 or "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

Increasing frequency of food reactions	0	1	2	3
Unpredictable food reactions	0	1	2	3
Aches, pains, and swelling throughout the body	0	1	2	3
Unpredictable abdominal swelling	0	1	2	3
Frequent bloating and distention after eating	0	1	2	3
Abdominal intolerance to sugars and starches	0	1	2	3

Category III

Intolerance to smells	0	1	2	3
Intolerance to jewelry	0	1	2	3
Intolerance to shampoo, lotion, detergents, etc	0	1	2	3
Multiple smell and chemical sensitivities	0	1	2	3
Constant skin outbreaks	0	1	2	3

Category IV

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 food found in stools	0	1	2	3

Category V

Stomach pain, burning, or aching 1-4 hours after eating	0	1	2	3
Use of antacids	0	1	2	3
Feel hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief by using antacids, food, milk, or 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 VI

Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness last 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

Category VI *(Cont.)*

Nausea and/or vomiting	0	1	2	3
Stool undigested, foul smelling, mucus like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3

Category VII

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
Burpy, fishy taste after consuming fish oils	0	1	2	3
Difficulty losing weight	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 VIII

Acne and unhealthy skin	0	1	2	3
Excessive hair loss	0	1	2	3
Overall sense of bloating	0	1	2	3
Bodily swelling for no reason	0	1	2	3
Hormone imbalances	0	1	2	3
Weight gain	0	1	2	3
Poor bowel function	0	1	2	3
Excessively foul-smelling sweat	0	1	2	3

Category IX

Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep going/get started	0	1	2	3
Get light-headed if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, or have 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 X

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 and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Symptom groups listed on this form are not intended to be used as a diagnosis of any disease or condition.

Category XI

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

Category XII

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under a high amount 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 XIII

Edema and swelling in ankles and wrists	0	1	2	3
Muscle cramping	0	1	2	3
Poor muscle endurance	0	1	2	3
Frequent urination	0	1	2	3
Frequent thirst	0	1	2	3
Crave salt	0	1	2	3
Abnormal sweating from minimal activity	0	1	2	3
Alteration in bowel regularity	0	1	2	3
Inability to hold breath for long periods	0	1	2	3
Shallow, rapid breathing	0	1	2	3

Category XIV

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 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 hair loss	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Category XV

Heart palpitations	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

Category XV *(Cont.)*

Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XVI *(Males Only)*

Urination difficulty or dribbling	0	1	2	3
Frequent urination	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel emptying	0	1	2	3
Leg twitching at night	0	1	2	3

Category XVII *(Males Only)*

Decreased libido	0	1	2	3
Decreased number of spontaneous morning erections	0	1	2	3
Decreased fullness of erections	0	1	2	3
Difficulty maintaining morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decreased physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVIII *(Menstruating Females Only)*

Perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle (greater than 32 days)	Yes	No
Shortened menstrual cycle (less than 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	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XIX *(Menopausal Females Only)*

How many years have you been menopausal? _____ **years**

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 alcoholic 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 do you eat raw nuts or seeds per week? _____

Rate your stress level on a scale of 1-10 during the average week: _____

How many times do you eat fish per week? _____

How many times do you work out per week? _____

List the three worst foods you eat during the average week: _____ _____ _____

List the three healthiest foods you eat during the average week: _____ _____ _____

PART IV

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions: