**CONSENT FOR WELLNESS SERVICES**

I, _____, hereby request and consent to Functional Medicine consultation from One Source Wellness & Chiropractic.

I understand that I have the right to ask questions and discuss to my satisfaction with my Doctor.

- My diagnosis(es) or condition(s) identified by my treating provider (i.e. medical doctor),
- The nature, purpose, goals and potential benefits of the proposed wellness consultation,
- The inherent risks, complications, potential hazards or side effects of my naturopathic wellness consultation,
- The probability or likelihood of success,
- Reasonable available alternatives to the proposed wellness consultation,
- Potential consequences if a healthy lifestyle is not followed and / or nothing is done.

I acknowledge that nothing in the techniques or methods of natural healing is for the purpose of diagnosing, treating, alleviating, mitigating, curing or preventing of disease in accordance with conventional medical science in any way or manner whatsoever. I clearly understand that all the teaching and methods of natural medicine as administered by One Source Wellness & Chiropractic are for the sole purpose of assisting people to learn how to build and maintain their health and well-being. As a patient of One Source Wellness & Chiropractic, I agree to always seek medical advice for medical treatment.

I confirm that I have read and fully understand the above prior to signing.

_____ _____

Signature of Patient Date

Email: drpaul@brookfieldwellness.com | Ph: 262-244-7600 | website: brookfieldwellness.com

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**EMAIL CONSENT**

Email offers us an easy and convenient way to communicate between office visits. For us to serve you best, we ask that you follow the below guidelines for email communication.

Conditions for email communication:

- Emails are great for asking general questions that do not require detailed discussion and for clarification of previous recommendations.
- Emails are not meant to replace in-person of phone appointments, nor are they meant to discuss new wellness concerns or receive new wellness consultations.
- Although we do check email regularly, we cannot guarantee that we will be able to answer your email right away nor can we guarantee that we will receive it. Call the office if the matter is urgent or if you do not hear back from me within a reasonable amount of time.
- Confidentiality is not guaranteed with emails! It is like sending a postcard in the mail.
- Email is never appropriate for emergency situations. Please call your medical treatment provider or your local emergency department.
- Emails may be added to your patient chart.

**Finally, either one of us can revoke permission to use the email system at any time.**

- □ **YES,** I would like the option to correspond via email. I agree to and understand the terms of email communication as detailed above.
- □ **NO,** I do not want to correspond via email.

Name: _____

Email Address: _____

Signature: _____ Date: _____

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**YOUR HEALTH INFORMATION PRIVACY RIGHTS**

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain privacy rights concerning your health care information. Under this law a health practitioner generally cannot give your information to your employer, use or share your information for marketing or advertising purposes, or share private notes about your mental health counseling sessions without your written consent. As one of your health providers it is our responsibility to keep your information safe and secure. We also need to make sure that your information is protected in a way that does not interfere with your healthcare. It is important that you understand that your information can be used and shared in the following ways:

- For your healthcare & wellness coordination. Multiple healthcare providers may be involved in your treatment directly and indirectly.
- With your family, friends, relatives, or others that you identify who are involved in your healthcare or healthcare bills.
- To protect the publics health, such as reporting when the flu is in your area.
- To make required reports to the police, such as gunshot wounds.
- Obtain payment from third party payers.

To provide you with service that best meets your privacy needs, please tell us how best to contact you when needed. Please check all that apply:

___Please do not phone me at home. Use this alternate phone number: _____

___Please do not phone me at work. Use this alternate phone number: _____

___Please do not leave messages on my answering machine.

___Please do not contact me by email.

___Please send mail, including my bills, to this alternate address:
_____

___Other request (please describe):_____

---

**Patient name**

_____ _____

**Patient Signature** **Date**

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**CONTACT INFORMATION**

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ _____ _____

Mobile Home Work

Email:_____

How did you hear about us? ☐ Friend _____ ☐ Doctor/ Health Provider_____

☐ Google/ internet search ☐ Social Media

☐ Other

Emergency Contact: Name_____

Phone_____

Relationship to you_____

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**ADULT HEALTH INTAKE**

Name: _____

Date of Birth: _____ Gender: Female _____ Male _____

Occupation:_____ Hours worked per week:_____

Marital Status: Married_____ Partnership_____ Separated_____ Divorced____Widowed_____Single___

Live with: Spouse_____ Partner _____ Parents _____ Children _____ Alone _____ Friends _____

Other _____

Do you have Medicare or Medicaid? Yes _____ No _____

Are you currently receiving healthcare? Yes _____ No _____

If yes, where and from whom? _____

If no, when, where, and why did you last receive healthcare?

_____

What are your primary health concerns in order of importance?

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

List any current and past diagnoses or major illnesses (include dates)

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

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**CONTEXT OF CARE REVIEW**

Successful heathcare and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. The Nature of your responses to the following questions will help me understand your needs and how to help you reach your health goals. Your time, thoughtfulness and honesty in completeing this overview will greatly aid me to assist your health needs.

Why did you choose to come to One Source Wellness?

What three expectations do you have from this visit to our office?

What long term expectations do you have from working with One Source Wellness?

What expectations do you have of me personally as part of your health and wellness team?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits: (please list)

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

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## FAMILY HISTORY

Please check where applicable:

| | Father | Mother | Sibling(s) | Maternal Grandmother | Maternal Grandfather | Paternal Grandmother | Paternal Grandfather | Child(ren) | Spouse |
|---|---|---|---|---|---|---|---|---|---|
| Age of living | | | | | | | | | |
| Cancer | | | | | | | | | |
| Diabetes | | | | | | | | | |
| Heart Disease | | | | | | | | | |
| Heart Murmur | | | | | | | | | |
| High Blood Pressure | | | | | | | | | |
| Stroke | | | | | | | | | |
| Epilepsy | | | | | | | | | |
| Mental Illness | | | | | | | | | |
| Asthma | | | | | | | | | |
| Hayfever, Hives | | | | | | | | | |
| Autoimmune Disease | | | | | | | | | |
| Kidney Disease | | | | | | | | | |
| Liver Disease | | | | | | | | | |
| Gallbladder Disease | | | | | | | | | |
| Ulcer | | | | | | | | | |
| Glaucoma | | | | | | | | | |
| Cataracts | | | | | | | | | |
| Anemia | | | | | | | | | |
| Goiter | | | | | | | | | |
| Arthritis | | | | | | | | | |
| Tuberculosis | | | | | | | | | |
| Age/Cause of Death | | | | | | | | | |

## YOUR HEALTH HISTORY

### Allergies

Please list anything you are sensitive or allergic to:

**Foods:**

**Medications:**

**Environment:**

### Hospitalizations and Surgery

What hospitalizations and surgeries have you had? When?

## Major Traumas

Please list any major traumas you have experienced:

### Childhood Illnesses

Have you had:

| | | | | | |
|---|---|---|---|---|---|
| Scarlet Fever | Yes | No | Polio | Yes | No |
| Chicken Pox | Yes | No | Mumps | Yes | No |
| Measles | Yes | No | German Measles | Yes | No |
| Small Pox | Yes | No | Whooping Cough | Yes | No |
| Allergies | Yes | No | Rashes | Yes | No |
| Asthma | Yes | No | Chronic ear infections | Yes | No |

### Childhood Immunizations

Have you had:

| | | | | | |
|---|---|---|---|---|---|
| Polio | Yes | No | Pertussis | Yes | No |
| Tetanus | Yes | No | Diphtheria | Yes | No |
| Measles | Yes | No | Chicken Pox | Yes | No |
| Mumps | Yes | No | Small Pox | Yes | No |
| Influenza (HiB) | Yes | No | Tuberculosis | Yes | No |
| Rubella | Yes | No | Meningococcus | Yes | No |
| Have you ever had a bad reaction to a vaccine? | Yes | No | If yes, what and when? | | |

### Medications

List prescription and over the counter medications you currently take (please list name of medication, dosage and date started).

List vitamins, minerals, and any other supplements you currently take (please list name of vitamin or supplement, dosage and date started):

Screening Test (please indicate most recent date where applicable)

General Physical _____ Screening bloodwork _____

Bone scan/DEXA _____ (women 65+) Mammogram _____ (women 40 +)

Prostate exam/ PSA _____ (men 50+) Colonoscopy _____ (women/men 50 +)

Gyn & breast exam/ PAP smear _____ (women 18+)

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**REVIEW OF SYSTEMS**

## General

Height _____
Weight now: _____ Weight 1 year ago: _____
Highest adult weight: _____ When? _____ Lowest adult weight: _____ When? _____

**Yes = condition you have not; No = A condition you've never had; Past = condition you've had in the past**

**Head**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Headaches | Yes | No | Past | Head injury | Yes | No | Past |
| Migraines | Yes | No | Past | Hair loss | Yes | No | Past |
| Other: | | | | | | | |

**Eyes**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Poor Vision | Yes | No | Past | Cataracts | Yes | No | Past |
| Glasses or contacts | Yes | No | Past | Glaucoma | Yes | No | Past |
| Tearing/dryness | Yes | No | Past | Eye infections | Yes | No | Past |
| Eye pain | Yes | No | Past | Blurriness | Yes | No | Past |
| Other: | | | | | | | |

**Ears**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Poor hearing | Yes | No | Past | Ringing/noises | Yes | No | Past |
| Excess wax | Yes | No | Past | Chronic infections | Yes | No | Past |
| Other: | | | | | | | |

**Nose and Sinuses**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Frequent colds | Yes | No | Past | Nose bleeds | Yes | No | Past |
| Congestion | Yes | No | Past | Sneezing often | Yes | No | Past |
| Sinus infections | Yes | No | Past | Runny nose | Yes | No | Past |
| Hay fever | Yes | No | Past | Loss of smell | Yes | No | Past |
| Other: | | | | | | | |

**Mouth and Throat**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Dentures | Yes | No | Past | Frequent sore throat | Yes | No | Past |
| Cavities | Yes | No | Past | Gum problems | Yes | No | Past |
| Sore lips/tongue | Yes | No | Past | Teeth grinding | Yes | No | Past |
| Jaw/TMJ pain | Yes | No | Past | Difficulty swallowing | Yes | No | Past |
| Hoarseness | Yes | No | Past | Cold/canker sores | Yes | No | Past |
| Other: | | | | | | | |

**Neck**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Lumps | Yes | No | Past | Swollen glands | Yes | No | Past |
| Goiter | Yes | No | Past | Pain or stiffness | Yes | No | Past |
| Other | | | | | | | |

**Respiratory**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Asthma | Yes | No | Past | Tuberculosis | Yes | No | Past |
| Wheezing | Yes | No | Past | Persistent cough | Yes | No | Past |
| Bronchitis | Yes | No | Past | Cough up mucus | Yes | No | Past |
| Pneumonia | Yes | No | Past | Cough up blood | Yes | No | Past |
| Other: | | | | Difficult breathing on exertion | Yes | No | Past |

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**Cardiovascular**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart disease | Yes | No | Past | High blood pressure | Yes | No | Past |
| Murmurs | Yes | No | Past | Low blood pressure | Yes | No | Past |
| Palpitations | Yes | No | Past | Ankle/leg swelling | Yes | No | Past |
| Fainting | Yes | No | Past | Other: | | | |

**Blood/Peripheral Vascular**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia | Yes | No | Past | Deep leg pain | Yes | No | Past |
| Leukemia | Yes | No | Past | Cold hands/left | Yes | No | Past |
| Vein inflammation | Yes | No | Past | Easy bleeding or bruising | Yes | No | Past |
| Blood clots | Yes | No | Past | Varicose veins | Yes | No | Past |
| Other: | | | | | | | |

**Gastrointestinal**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heartburn | Yes | No | Past | Frequent nausea | Yes | No | Past |
| Change in thirst | Yes | No | Past | Frequent vomiting | Yes | No | Past |
| Change in appetite | Yes | No | Past | Vomiting blood | Yes | No | Past |
| Ulcers | Yes | No | Past | Blood in stool | Yes | No | Past |
| Hemorrhoids | Yes | No | Past | Undigested food in stool | Yes | No | Past |
| Gallbladder | Yes | No | Past | Belching/passing gas excessively | Yes | No | Past |
| Liver disease | Yes | No | Past | Pain/cramping in abdomen | Yes | No | Past |
| Diarrhea | Yes | No | Past | Frequency of bowel movements: | | | |
| Constipation | Yes | No | Past | Is this a recent change? | Yes | No | |
| Other: | | | | | | | |

**Urinary**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Bladder infections | Yes | No | Past | Frequency in day | Yes | No | Past |
| Kidney infections | Yes | No | Past | Frequency at night | Yes | No | Past |
| Incontinence | Yes | No | Past | Painful urination | Yes | No | Past |
| Stones | Yes | No | Past | Difficult urination | Yes | No | Past |
| Other: | | | | | | | |

**Immune**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Frequent infections | Yes | No | Past | Chronic fatigue | Yes | No | Past |
| Slow wound healing | Yes | No | Past | Chronically swollen glands | Yes | No | Past |
| Other: | | | | | | | |

**Skin**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rashes | Yes | No | Past | Lumps | Yes | No | Past |
| Hives | Yes | No | Past | Color change | Yes | No | Past |
| Itching | Yes | No | Past | Warts | Yes | No | Past |
| Eczema | Yes | No | Past | Acne | Yes | No | Past |
| Psoriasis | Yes | No | Past | Shingles/Herpes | Yes | No | Past |
| Other: | | | | | | | |

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**Musculoskeletal**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Weaknesss | Yes | No | Past | Spasm or cramps | Yes | No | Past |
| Tremors | Yes | No | Past | Broken bones | Yes | No | Past |
| Joint pain or stiffness | Yes | No | Past | Joint swelling | Yes | No | Past |
| Where: | | | | Where: | | | |
| Other: | | | | | | | |

**Neurologic**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Seizures | Yes | No | Past | Memory loss | Yes | No | Past |
| Sciatica | Yes | No | Past | Numbness or tingling | Yes | No | Past |
| Paralysis | Yes | No | Past | Vertigo/dizziness | Yes | No | Past |
| Autism | Yes | No | Past | ADD/ADHD | Yes | No | Past |
| Other: | | | | | | | |

**Endocrine**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Diabetes | Yes | No | Past | Hypothyroid | Yes | No | Past |
| Fatigue | Yes | No | Past | Hyperthyroid | Yes | No | Past |
| Night sweats | Yes | No | Past | Excess thirst | Yes | No | Past |
| Seasonal depression | Yes | No | Past | Excess hunger | Yes | No | Past |
| Crave salt | Yes | No | Past | Heat/Cold intolerance | Yes | No | Past |
| Dark circles under eyes | Yes | No | Past | Symptoms when miss meals | Yes | No | Past |
| Other: | | | | | | | |

**Female Reproductive**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age menses began: | | | | Age menses ended: | | | |
| #Days of flow: | | | | # Days between periods: | | | |
| # Pregnancies: | | | | Regular cycles | Yes | No | Past |
| # Live Births | | | | Bleeding between periods | Yes | No | Past |
| # Miscarriages | | | | Painful Periods | Yes | No | Past |
| # Abortions | | | | PMS | Yes | No | Past |
| Difficulty conceiving | Yes | No | Past | Excessive flow | Yes | No | Past |
| Vaginal discharges | Yes | No | Past | Menopausal symptoms | Yes | No | Past |
| Vaginal infections | Yes | No | Past | Painful intercourse | Yes | No | Past |
| Pelvic infections | Yes | No | Past | Sexual difficulties | Yes | No | Past |
| Vaginal dryness | Yes | No | Past | Sexually transmitted disease | Yes | No | Past |
| Breast pain or tenderness | Yes | No | Past | Sexually active | Yes | No | Past |
| Breast lumps | Yes | No | Past | Sexual orientation | Heterosexual | Homosexual | Bisexual |
| Nipple discharge | Yes | No | Past | Type of birth control: | | | |
| Last PAP/GYN exam: | | | | Abnormal PAP: | | | |
| Level of Sexual desire: 0 1 2 3 4 5 6 7 8 9 10 | | | | | | | |
| Other: | | | | | | | |

**Male Reproductive**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hernias | Yes | No | Past | Enlarged prostate | Yes | No | Past |
| Testicular pain | Yes | No | Past | Sexually transmitted disease | Yes | No | Past |
| Testicular masses | Yes | No | Past | Sexually active | Yes | No | Past |
| Discharges or sores | Yes | No | Past | Sexual orientation | Heterosexual | Homosexual | Bisexual |
| Infertility | Yes | No | Past | Sexual difficulties | Yes | No | Past |
| Level of sexual desire 0 1 2 3 4 5 6 7 8 9 10 | | | | | | | |
| Other: | | | | | | | |

**Mental/ Emotional**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Mood swings | Yes | No | Past | Tension/difficulty | Yes | No | Past |
| Depression | Yes | No | Past | Considered/attempted suicide | Yes | No | Past |
| Anxiety | Yes | No | Past | Poor Concentration | Yes | No | Past |
| Memory problems | Yes | No | Past | Obsessive or Compulsive | Yes | No | Past |
| Panic attacks | Yes | No | Past | Easy/frequent crying | Yes | No | Past |
| Other: | | | | | | | |

## HEALTH & LIFESTYLE HABITS

Hobbies: _____

Exercise (what kind, how often) :_____

Sleep: # hours/night _____ Sleep well? _____ Well rested? _____

Stress level (check one): High _____ Moderate _____ Low _____

Major stressors: _____

Do you have a religious or spiritual practice? Yes No

**Typical Food Intake**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

| Do you use? | Yes | No | Past | Amount | Frequency | Have you ever been treated for: |
|---|---|---|---|---|---|---|
| Alcohol | | | | | | Alcoholism: Yes No |
| Tobacco | | | | | | |
| Caffeine | | | | | | Eating disorder: Yes No |
| Recreation drugs | | | | | | Drug dependence: Yes No |
| Type of recreational drugs: | | | | | | |